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The Self-Critical Patient in Clinical Supervision: A Qualitative Study of Therapists' Alliance Struggles and Emotional Reactions in Short-Term Psychodynamic Psychotherapy for Depression

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The Self-Critical Patient in Clinical Supervision: A Qualitative Study of Therapists' Alliance Struggles and Emotional Reactions in Short-Term Psychodynamic Psychotherapy for Depression

Self-critical perfectionism has been linked to alliance impairments due to patients' distancing attitudes. However, systematic research on therapists' emotional experiencing when working with self-critical patients is scarce. This qualitative study explores how therapists perceive, emotionally experience, and react to self-critical patients' interpersonal dynamics. We studied narrative data from clinical supervisions where psychodynamic psychotherapists discussed self-critical patients (*N*=7) within the context of an RCT on Major Depressive Disorder. Consensual Qualitative Research was applied to identify recurrent patterns in the data. As a global impediment to treatment, therapists observed a pattern of non-engagement. Patients' superficial and avoidant way of communicating, hostility or aggressiveness in the alliance, and low or inaccurate treatment expectations emerged as main obstacles to the therapeutic process, evoking negative affect in therapists. More vulnerable aspects of the patient and case formulation emerged as having a mitigating effect on unfavorable therapist reactions. Our findings confirm longstanding clinical and theoretical accounts associating therapeutic work with self-critical patients with negative affect in therapists. Our study suggests that negative responses may be enacted in therapy which can reinforce poor alliance. We discuss the role of supervision in helping therapists to become aware of and manage negative responses, engage in case conceptualization, and advance clinical work.

Keywords: *Self-criticism, therapist responses, therapeutic relationship, supervision*

Self-criticism has been consistently linked with reduced chances of successful psychotherapeutic outcome, primarily because of impairments in the alliance (Hewitt et al., 2020; Miller et al., 2017). The concept of self-criticism was introduced by Sidney Blatt and colleagues as a component of the *two-polarities model* of personality development (Blatt, 2004, 2008). The two-polarities model is one of the best-studied and most empirically validated psychoanalytic theories to this date (Luyten, 2017). Drawing on core concepts in classic psychoanalytic thought (e.g., Freud, 1914/1958, 1926/1959; Loewald, 1962), it views psychological development as an ongoing dialectical process between two mechanisms underlying human experience: interpersonal relatedness (attachment) and self-definition (autonomy). The mechanism of *relatedness* involves affiliative needs and is oriented towards the establishment of gratifying, intimate, and reciprocal relationships. The mechanism of *self-definition* strives for an establishment of a solid and diversified sense of self (Blatt, 2004, 2008). According to the two-polarities model, psychological wellbeing involves a mature and dynamic balance between affiliative and self-assertive needs, whereas psychopathology involves a preoccupation with one of the respective dimensions (Blatt, 2008).

Blatt (2004, 2008) distinguished two broad personality types. The *dependent* personality type is preoccupied with issues of intimacy and characterized by fears of abandonment. The *self-critical* personality type is dominated by issues of self-worth and characterized by avoidance of interpersonal intimacy. The difference between the personality types is a matter of *relative* emphasis. Various configurations of dependent and self-critical features are conceivable with relatively pure cases existing only at the end poles of the continuum (Luyten et al., 2005). Nonetheless, the personality types are broadly associated with distinctive experiential modes (affect-driven vs. logic-driven), cognitive styles (impressionistic vs. analytic), quality of object relations (seeking closeness vs. autonomy),

attachment styles (anxious vs. avoidant), and modes of stress regulation (seeking support vs. isolation) (Levander & Werbart, 2012; Luyten, 2017).

As a diagnostic framework, the two-polarities model differs from more a-theoretical approaches (e.g., the *Diagnostic and Statistical Manual for Mental Disorders*) that often draw implicitly on a medical disease model (Blatt, 2008; Vanheule et al., 2019). In accordance with psychoanalytic thought, Blatt draws no categorical distinction between normal and abnormal development, nor between symptom and personality disorders (Luyten, 2017). Rather, the mechanisms of relatedness and autonomy are assumed to play a key role in all psychological functioning (Blatt, 2008). As such, psychopathology is not seen as a fixed disease entity, but rather as an exaggerated, more rigid, and less adaptive form of normal development (Luyten et al., 2005).

Over the years, a growing body of evidence has accumulated on the personality styles, especially in the context of depression (Luyten, 2017). Both a rigid emphasis on dependency and self-criticism is a vulnerability for the development of mental illness (Blatt, 2004, 2008). However, research examining clinical and non-clinical populations has suggested that dependency involves adaptive as well as maladaptive dimensions (e.g., longing for intimacy and closeness vs. clingy and claiming behavior) (Luyten et al., 2005), whereas self-criticism acts as a more pronounced deterrent to psychological and social wellbeing through negative mental representations of self and others (Hewitt et al., 2017, Mongrain, 1998). Apart from being especially vulnerable to life events associated with achievement and control, self-critical individuals may in fact contribute to the generation and sustenance of negative life events by selecting and acting upon the environment in personality-congruent ways (Luyten et al., 2005). Poor social skills that result from investing in self-definition rather than interpersonal relationships may lead to dysfunctional transactional cycles (Kiesler, 1983)

provoking, for instance, complementary rejection in others. This can contribute to further isolation, in turn increasing vulnerability to mental illness (Miller et al., 2017).

Because distancing attitudes and needs of self-critical individuals are expressed in various situations and contexts, it follows that they may also shape the therapeutic relationship (Hewitt et al., 2017; Miller et al., 2017). Based on the notion of *transference*, it is expected that self-critical patients will perceive and construct the therapeutic relationship in personality-congruent ways (Luyten, 2017). This expectation is in line with longstanding clinical accounts that have described self-critical patients as challenging to treat and with empirical research demonstrating impairments in the therapeutic relationship (Blatt & Zuroff, 2002; Hewitt et al., 2020; Miller et al., 2017). In a recent overview of evidence gathered from research on the relationship between self-criticism, alliance, and outcome, Miller and colleagues (2017) summarized how self-critical interpersonal dynamics may impede the therapeutic process. Perfectionistic features may keep patients from adhering to therapeutic demands such as engaging deeply with the therapist. It can be difficult for self-critical patients to open up to therapists because internal criticisms are readily projected onto the therapist, on the basis of which they expect or perceive to be criticized, judged, or rejected. Self-critical patients can also experience difficulties connecting to therapists due to their predominantly hostile and defensive relational style, which can create distance in the therapeutic relationship. Finally, perfectionistic attitudes and tendencies may impede self-critical patients' ability to recover from alliance ruptures, which can make a strong relationship more challenging to achieve or maintain.

The pathways to poor alliance described by Miller and colleagues (2017) are consistent with clinical accounts that have described self-critical patients as being critical, hostile, and distrustful of therapists (e.g., Asseyer, 2002; McWilliams, 2011; Salzman, 1980). Self-critical patients have also been described as self-concealing (i.e., low-self-disclosure)

and as resistant toward explorations of their inner, affective world (McWilliams, 2011). Counteractive defense mechanisms are also documented in the therapeutic context (i.e., rationalization, intellectualization, reaction formation) (Blatt & Shichman, 1983; McWilliams, 2011) through which psychological events are transformed into non-emotional experiences (Bowins, 2004). These characteristics, features, and treatment challenges bear a notable resemblance to classic psychoanalytic formulations about 'obsessional neurosis' (Freud, 1909/1955), 'obsessive personality' (Salzman, 1968), and 'obsessive-compulsive personality' (Shapiro, 1965). They are also in line with findings from a qualitative multi-case study by Levander and Werbart (2012) where psychoanalytic therapists found self-critical patients especially hard to engage in therapy.

Although impediments to the therapeutic process have been relatively well studied from the patient perspective, surprisingly little empirical research has been carried out on how therapists perceive, emotionally experience, and react to these interpersonal challenges. In a study by Zuroff and colleagues (2000; 2010) on the relationship between pre-treatment perfectionism and alliance, it was shown that while self-critical patients *perceived* their therapists as less supportive and empathic, therapists' *actual* attempts at alliance building were not impeded (Miller et al., 2017). As such, poor outcome, and alliance impairments have been primarily attributed to self-critical patients' failure to contribute appropriately to the relationship. Nonetheless, Zuroff and colleagues (2016) hypothesized that, in reaction to self-critical patients' defiant attitudes and behaviors, therapists' capacity for being authentic, accepting, and empathetic may effectively be undermined, further damaging the relationship. This is consistent with clinical observations describing self-critical patients as easily evoking negative affect in therapists: self-critical patients' hostile attitudes have been said to evoke feelings of being criticized and devalued in therapists (Marmarosh et al., 2009; McWilliams, 2011). McWilliams (2011) further argues that therapists may easily feel distanced from their

patients, or tired, annoyed, and bored in response to patients' resistance toward exploration of affects. These clinical observations are in line with research from Hewitt and colleagues (2008) finding that therapists experienced more negative affect toward patients with high levels of self-criticism compared with other patients.

Practitioners operating from the perspective of 'objective' or 'patient-induced' countertransference (Geltner, 2006; Winnicott, 1949) often view their emotional responses as sources of information about the patient. From a totalistic perspective on countertransference, these reactions can be understood as normal and predictable responses to patients' attitudes, behaviors, and broader interpersonal styles. However, to differentiate from the complex concept of countertransference, which has a controversial history with many diverging interpretations (Gelso & Hayes, 2007), we will simply refer to these phenomena with the more neutral term of 'therapist responses.'

Recently, three cross-sectional studies (Genova & Gazillo, 2018; Hennissen et al., 2019; Westerling et al., 2019) systematically studied therapists' responses in psychotherapy from the perspective of Blatt's theory (dependent vs. self-critical) or its transtheoretical equivalents (i.e., attachment theory, see Luyten, 2017). In all three studies, the Therapist Response Questionnaire (Zittel & Westen, 2003), a self-report measure for therapists, was used to map cognitive, behavioral, and emotional responses of therapists. Based on clinical-theoretical writings and accumulated empirical evidence, it was hypothesized that self-critical patients would elicit stronger disengaged (Genova & Gazillo, 2018; Hennissen et al., 2019; Westerling et al., 2019) or criticized/mistreated Hennissen et al., 2019) reactions from therapists compared with dependent patients. These hypothesized correlations were only confirmed in the study of Genova and Gazillo (2018). Without question, such inconsistencies call for further clarification through empirical research.

This study aims to contribute to the exploration of therapist responses in treatment with self-critical patients. Nomothetic research using self-report questionnaires to examine therapists' emotional responses has been significantly hampered by issues of limited instrument sensitivity and social desirability bias (Fauth, 2006; Singer & Luborsky, 1977). Further, findings from cross-sectional studies using self-report questionnaires have remained rather descriptive and of limited clinical usefulness because they provide little information on therapists' underlying meaning-making processes. In the past decades, qualitative research methods have been increasingly recognized for their ability to offer more in-depth and in-context understandings of complex clinical phenomena (Ponterotto, 2005). Aside from illuminating the *how* and *why* of dynamical processes, qualitative research has been shown to be especially effective for investigating the experiential world of patients and therapists (Binder et al., 2016; Levitt, 2015).

Using a qualitative methodology, this study aims to contribute to the field of empirical research on therapist responses in the context of Blatt's theory, more specifically in treatment with self-critical patients. We examine narrative data from clinical supervisions where psychodynamic therapists discuss their therapeutic work with self-critical patients. Two major advantages are associated with these data. First, clinical supervisions are especially informative on our subject of inquiry because patients are usually discussed in supervision when therapists encounter difficulties in treatment (e.g., stagnation, impasses, countertransference issues). Second, issues of social desirability are reduced compared with traditional methods of inquiry because ideally, the supervision context provides a safer environment for therapists to talk freely about clinical work with patients.

Through the analysis of supervision data, we aim to study how therapists make sense of patients' attitudes and behaviors in therapy and identify how therapists' emotional reactions are shaped in dynamic interaction with patients' interpersonal dynamics. We aim to

identify cognitive, behavioral, as well as emotional responses of therapists. We also aim to determine how therapists give meaning to these experiences during supervision and whether and how these experiences are influenced as a result of supervision. As such, we hope to advance our understanding of alliance difficulties in a way that is useful for clinical practitioners. A better understanding of the relational dynamic between patient and therapist may facilitate identification and awareness of relational pitfalls in therapy with self-critical patients. When recognized and appropriately attended to, therapists may be better equipped to safeguard optimal treatment conditions.

Method

Data set

The study is reported following the Journal Article Reporting Standards for Qualitative Research (JARS-Qual; Levitt et al., 2018). The data was drawn from a sample of 100 patient-participants partaking in the Ghent Psychotherapy Study (GPS, Meganck et al., 2017), a randomized controlled trial studying the differential efficacy of supportive-expressive and cognitive-behavioral interventions in dependent and self-critical depression. A total of 60 dependent and 40 self-critical patients were assigned to receive 16-20 manualized sessions of Psychodynamic Psychotherapy or Cognitive Behavioral Therapy. The study was approved by the Ethical Board of Ghent University Hospital in Belgium (Registration number B670201318127).

In the context of the GPS, therapists received bi-weekly (i.e., every other week) group supervisions from clinical supervisors experienced in cognitive behavioral therapy and psychodynamic therapy. These supervision sessions were audiotaped for research purposes. Therapists could discuss a patient of choice during any stage of the treatment. For the current study, we chose to focus on case presentations of psychodynamic therapists only, given the central role of the therapeutic relationship as well as transference and countertransference

processes in psychodynamic treatment models. All identifying information concerning patients and therapists has been changed to protect confidentiality.

Participants

Patients

The sample consists of seven self-critical patients (five males; two females) ranging in age from 28 to 59 years (*M* = 41.9, *SD* = 10.7). Patients met the criteria for Major Depressive Disorder (DSM-IV-TR, American Psychiatric Association, 2000), as assessed by the *Structured Clinical Interview for DSM-IV Axis I disorders* (First et al., 2002) and the *Hamilton Rating Scale for Depression* (Hamilton, 1967). DSM-IV-TR criteria were used as per protocol of the GPS of which our sample is a subset. Exclusion criteria for the GPS were current diagnosis of psychosis, bipolar disorder or presence of delusions, acute suicidal risk, primary diagnosis of substance abuse/dependence, and medical conditions preventing full participation in the treatment.

Therapists

The sample consists of three females and one male, ranging in age from 29 to 33 years (*M* = 31.5, *SD* = 1.7). All therapists were clinical psychologists with postgraduate training in psychoanalytic psychotherapy from a Freudian-Lacanian perspective and had 5 to 9 years of clinical experience prior to the study (see Table 1). They received 2 days of additional training based on Luborsky's (1984) manual for Supportive-Expressive Time Limited treatment for Major Depressive Disorder (DSM-IV-TR, American Psychiatric Association, 2000) in the context of GPS. The therapists functioned as each other's peers during the group supervisions. [ENTER TABLE 1 HERE]

Supervisors

Group supervision was led by two experienced psychotherapists in the field of psychodynamic and psychoanalytic psychotherapy. Both supervisors (one male in his forties; one female in her

thirties) were clinical psychologists and psychology professors with approximately 10 years of clinical experience and 3 to 6 years of experience as clinical supervisors in post-graduate training. Both had 3 to 5 years of experience working with Luborsky's (1984) manual in a clinical and research context.

Procedure

Assessing patient personality type

Pre-treatment personality types were assessed at intake in the GPS using a prototype matching procedure (Appendix 1; Werbart & Forsström, 2014). Patients' degree of similarity to prototype vignettes was rated by assigning a score from 1 to 5 on a *relatedness* and *self-criticism* dimension. Based on the *Clinical Diagnostic Interview* (Westen, 2002) conducted on intake, three trained researchers (one interviewer, one postgraduate researcher, and one expert academic staff researcher) first rated the personality dimensions independently and subsequently discussed their ratings until consensus was reached (cf. Hill, 2012). Therapists and patients were blind to the results of the personality assessment.

Data selection and sampling

Patient case selection. For the current study, we aimed to select multiple cases for multiple therapists, enabling us to look for commonalities across patients and therapists. We used intensity sampling (Patton, 2002) on the assumption that purer cases exemplify our phenomenon of interest more clearly than mixed cases or cases with less pronounced personality features. We selected patients with a prototypical or quasi-prototypical personality configuration. We operationalized prototypicality by determining that consensus scores of the prototype matching procedure (Werbart & Forsström, 2014) should yield a difference of three or more points in favor of the *self-definition* dimension. When unable to find prototypical cases, we proceeded with quasi-prototypical cases. Quasi-prototypical cases were defined as cases with consensus scores approaching the prototype as much as possible.

Specifically, we selected patients where (1) consensus was reached that the personality type was predominately self-critical. Prior to reaching consensus, (2a) individual ratings of at least two raters reflected a predominantly self-critical personality type, and (2b) individual ratings of at least one researcher contained a prototypical score.

The abovementioned sampling criteria were carried out across all 20 self-critical participants who received psychodynamic psychotherapy in the GPS. The sampling method resulted in 15 potential patient cases. Of these 15 cases, only 10 were discussed in supervision. Three cases were excluded from analysis because the assigned therapist judged the patient to have an underlying psychotic personality structure, which strongly impacted the data. This resulted in seven final cases, of which three were prototypical and four were quasi-prototypical (see Table 1).

Supervision session selection. We examined supervision sessions containing introductory case presentations (i.e., therapists presenting the patient for the first time), because: (1) they provide rich, extensive, and in-depth clinical descriptions of patients and therapists' associated experiences; (2) they are highly informative on the phenomenon of interest; (3) they contain more 'raw' and unfiltered experiences of therapists in relation to patients (i.e., data from subsequent supervisions are more likely to be influenced and shaped by preceding supervisory processes). Of the seven case presentations, three patients were brought under supervision after therapy session 3, one after session 4, one after session 6 and 7, and one after session 12 (see Table 1). The cases were discussed during different supervision sessions (i.e., different moments in time), as the patients received psychological treatment at different periods during the research project. In the context of this study, this was an advantage because it reduces the risk of group dynamics influencing the data (e.g., therapists constructing the case and their experiences in accordance with peers).

Qualitative data analysis

Verbatim transcripts of supervision sessions were analyzed using Consensual Qualitative Research (CQR; Hill, 2012). The audio files closely accompanied the analysis of transcripts because paralinguistic features of the therapist's communication (e.g., pitch and tone of voice) seemed critical for the interpretation of the data. During the entire qualitative inquiry, discussions were held until consensus was reached. Given the pre-existing and naturalistic nature of our data (i.e., no interviews were used in contrast to common CQR practice), our research questions were developed and refined in dynamic interaction with the material. The research team first individually familiarized themselves with the data after which they held weekly meetings to discuss and agree on the nature and scope of the narrative content. After establishing the research questions, three domains or topic areas were nominated to segment the data: (1) Patients' typical attitudes and behaviors in therapy, (2) Therapists' cognitive, affective, and behavioral responses, and (3) Relevant supervisory processes. The first domain concerns therapists' descriptions of how patients' interpersonal dynamics typically manifested in therapy sessions. The second domain contains therapists' emotional reactions to these interpersonal dynamics. The third domain considers possible helpful facets of supervision in helping therapists deal with difficulties in the therapeutic relationship. Next, the raw data was coded into domains. The research team met weekly to discuss each case until consensus was reached regarding the coding of data in domains. Then, the raw data for each domain was condensed into core ideas representing the essence of what therapists said while remaining as close as possible to the data. Examples of core ideas are *"therapist describes patient's speaking as closed off, limited, and descriptive," "therapist feels herself dozing off during sessions" and "therapist discerns recurrent dynamic of not being good enough in patient's life."* Core ideas within domains of individual cases were then compared across cases (cross-analysis) and abstracted into categories and subcategories representing

meaningful recurrent patterns in the data. Refinements were made until consensus was reached and the most suitable descriptions for the (sub-) categories were identified.

Research team and quality control

We established a team with diverse research interests to obtain multiple perspectives on the data. The research team consisted of two doctoral students (the first and fifth author) and two post-doctoral researchers (second and fourth author) in clinical psychology (2 male; 2 female), all with 1.5 to 10 years of clinical experience. All team members identified with (one or multiple schools of) psychodynamic or psychoanalytic thought, maintaining that therapy always transpires under transference and countertransference and agreeing that transference phenomena (understood as repetitions of patients' interpersonal dynamics in therapy) can trigger or shape therapists' emotional reactions. They also agreed that emotional experiencing by therapists is an inherent and unavoidable part of therapy, although their viewpoints differed on the desirability of such emotions (in terms of helping or hindering the therapeutic process). Regarding conceptualization of therapist responses, the first and fifth authors drew more on totalistic / complementary perspectives on countertransference (see Gelso & Hayes, 2007), the concepts of objective / patient-induced countertransference (Geltner, 2006; Winnicott, 1949), and role-responsiveness (Sandler, 1976), as well as Kleinian, interpersonal, and object-relations theory acknowledging diagnostic and therapeutic merits of countertransference. Identifying mostly with Freudian-Lacanian theory, the second and fourth author adhered more to a classical conception of countertransference, maintaining that a strong emotional response always signals unresolved issues in the therapist which should be worked through in an individual analytic process (Wilson, 2013). They did not view the therapist's personal response as particularly informative of the patient. Despite these differences, all team members agreed that therapists should always engage in critical self-reflection when strong emotional reactions occur and should avoid acting out on impulses.

Two team members (first and second author) had been closely involved in the GPS where they assisted in the intake procedure, diagnostic assessment, data gathering, and follow-up of patients. They were familiar with some patients' stories and therapies yet had no prior knowledge of the supervision content. They were also acquainted with Blatt's (2004, 2008) two-polarities model and literature concerning self-criticism and poor alliance. The remaining team members had not been involved in the GPS and had no particular (theory-driven) expectations. This balanced composition in combination with consensual processes (Hill, 2012) enhanced reflexivity and ensured a critical and diversified outlook on the data.

By means of "bracketing" (Giorgi, 2009) the research team aimed to suspend theoretical and personal assumptions (e.g., own clinical experience with patients). This was achieved by staying as close as possible to the data and by avoiding overly interpreting data through any particular theoretical lens or one's own emotional response. At various phases of analysis, the researchers returned to the raw data ensuring that their interpretations were sufficiently grounded. The third author, a professor in clinical psychology and a PI of the GPS, served as an auditor in each step of the analysis, giving feedback to the primary research team. A final draft of the results was presented to the clinical supervisors of the GPS who found the identified patterns and processes to be an adequate and evocative reflection of their experiences with the supervisee-therapists.

Results

Table 2 represents the domains, categories, and subcategories for how therapists perceive, emotionally experience, and react to self-critically depressed patients. The findings are structured into three domains: patients' attitudes and behaviors, therapist response, and supervisory processes. In accordance with Hill et al. (2012), (sub-) categories are described as "General" if they occurred in 6 or 7 cases, "Typical" if they occurred in 4 or 5 cases, and "Variant" if they occurred in 2 or 3 cases.

Patients' attitudes and behaviors in therapy

The first domain describes how therapists perceived self-critical patients' interpersonal attitudes and behaviors in therapy. We identified two broad categories: "moments of non-engagement" and "moments of engagement."

Moments of non-engagement

Therapists primarily described self-critical patients' interpersonal style in terms of disengagement. They shared an overarching impression of not being let in by patients, which was seen as a significant obstacle to the therapeutic process. Four subcategories were identified for how patients were perceived: "standoffish or emotionally distant discourse," "bypassing explorative interventions," "hostility and aggressiveness in the alliance," and "low or inaccurate expectations of therapy."

Patients were perceived to cultivate a **standoffish and emotionally distant discourse** (General). Therapists found that the essential stuff of therapy (e.g., affects, desires, internal conflicts) was notably missing from sessions unless actively inquired upon. Therefore, therapists struggled to make sense of their patients' internal world: *"as if I have to connect all the dots myself"* (Case 7). Therapists referred to patients filling up sessions with rational, matter-of-fact things. For example, one therapist described the patient's communicative style as *"limited, very closed off [and] descriptive"* (Case 3). Another therapist described it as rationalized and storytelling: *"rational, pseudo-intellectualistic [...] using a lot of difficult words"* or *"blah-blah-blah"* (Case 4). Patients would also be reserved and unexpressive, as was the case in a therapy where "*there is not much of any spontaneous speaking"* and where the therapist felt that he needed to *"squeeze it [the information] out"* (Case 1).

Therapists also noticed that patients **bypassed explorative interventions** (General). More specifically, they observed that attempts to elicit a more affectively invested or subjectified discourse were heavily deflected. Patients tended to respond with facts, would

avoid or twist the topic, or would shut down: "w*henever I try to capture something meaningful, it is gone, [...] whenever I try to bite into something, it is gone"* (Case 1). Therapists' ineffectiveness to elicit a more emotionally vulnerable stance resulted in an impression of being *"stuck"* / *"in an impasse"* (Case 1) with patients. One therapist determined that her patient kept *"playing that same old record"* despite her continuous efforts to *"pull him out of his [prefabricated] discourse"* (Case 3). Another therapist observed: *"If I ask the patient to elaborate, he reacts very disinterested, like 'pfft, I don't know'. He sighs and laughs everything off"* (Case 7).; Therapists interpreted patients' evasive behavior in terms of resistance with which patients were self-concealing their thoughts and feelings: "*It feels as if he is blocking something off [...] He is not letting me in. [...] I believe it is pure resistance with regard to his own feelings"* (Case 7).

Further, therapists detected occasional, to frequent signs of interpersonal **hostility or aggressiveness in the alliance** (General). These attitudes and behaviors were also seen as distancing attitudes and manifestations of resistance. The nature and context of these hostile attitudes differed in each case. With some patients, hostility was conveyed explicitly. In Case 6, the therapist described the patient as *"very defensive [and] hostile"* and the sessions as *"laden"*: *"she was putting up a fight [...] as if she had gotten a letter from her doctor forcing her to come."* In most cases, however, therapists identified hostile attitudes on a rather implicit, non-verbal, level. For example, one therapist felt as if a patient was continuously trying to keep his aggression in check, *"like a volcano about to erupt"* (Case 2). In another case, aggression was sensed in a patient's disinterested and cynical reactions: *"there's something laden [...] something of a frustration"* (Case 7). Another therapist recurrently sensed *"pronounced hatred"* in a patient's way of looking at her in response to explorative questions: *"If I say something then he looks at me with these penetrating eyes, as if he is*

looking right through me but with great anger […] and then he responds, usually with a justification or a refutation of what I said" (Case 3).

Finally, therapists struggled with patients' **low or inaccurate expectations of therapy** (Typical). In some cases, patients voiced low expectations of therapy. In Case 1, the therapist recalled the patient saying: *"I really just don't have any expectations."* In Case 7, the patient's disinterested attitude toward people also manifested in therapy: "*he comes [to therapy] with the idea of 'I don't expect much' […] He claims he does not engage anymore with people. […] He often says '[people] don't affect me.'"* In other cases, patients voiced expectations that did not resonate with therapists' ideas about psychotherapy, such as learning tips and tricks or a more symptomatic approach: *"[he] expected concrete tools and advice. […] I told him that [therapy] is a place to speak your mind, to untangle some knots and reflect on things. Tips and advice, that is not really my job"* (Case 4). Given these expectations, therapists tended to deduce that patients wanted a quick fix rather than truly engaging in the therapeutic work: *"[She] prefers the safe way of focusing on the symptom, even [when realizing] that the effect is short-term and not long-term"* (Case 6).

Moments of engagement

Against the background of non-engagement, therapists also identified moments where patients seemed to engage more in therapy. We distinguished two subcategories: "glimpses of vulnerability" and "good work ethic."

Despite patients' overall non-engaging attitude, therapists identified occasional **glimpses of vulnerability** (Typical). Therapists discerned that their patients sometimes let their guard down both verbally and non-verbally. As such, patients were experienced as engaging more in therapy. For example, patients were more cooperative and agreeable at moments, adopted a more affectively invested discourse, were more reflective, or became emotional in response to questions or interventions. In Case 7, the therapist got the

impression that the patient *"wants to give [therapy] a chance, despite his low expectations."* In Case 1, the therapist noticed how the patient's *"sadness and grief appeared enormously when she spoke of the relationship with her mother in terms of abandonment."* In Case 6, the therapist narrated that amidst her patient's general defensiveness, the patient unexpectedly presented herself in a very authentic and vulnerable manner: *"She started crying. That woman literally broke down. [...] It was as if that hard shell around her completely collapsed."* However, these moments were rather short-lived because patients then quickly resorted to their habitual (more non-engaging) pattern: *"the next session I continued optimistically [assuming there had been a break-through]. But again, [she was] very hostile, unconscious aggression. [A] Difficult and painful session just to get something out of her"* (Case 6).

In two cases, therapists narrated that their patients cultivated a **good work ethic** (Variant) and that a positive alliance had been installed. These therapists found that the initial difficulties regarding these patients' distancing behavior had dissolved. Patients were perceived as engaging on a more genuine and personal level; they were more vulnerable and allowed therapists to explore their affects, desires, and conflicts. In Case 5, the therapist described her patient's engagement in treatment: *"I get the impression that he rather enjoys telling his story [...] I feel that the analytic work has started. He is really immersed in it [and] he really reflects on things"* (Case 5). In Case 2, the therapist observed that a relationship of trust and confidentiality was created by virtue of the therapist's attempts to remove taboo concerning her patient's aggressive phantasies: "*I get the impression that by asking questions and by sometimes naming his naughty thoughts in his place, that he is loosening up, like 'okay, I am not being judged here' [...] he is feeling more and more comfortable with me."*

Therapist response

This domain describes therapists' affective, cognitive, and behavioral responses to patients' interpersonal dynamics in treatment. We identified three categories: "more active therapist," "negative emotional responses," and "positive emotional responses."

More active therapist

Firstly, all therapists in our study reported a sense of being **more active in therapy than usual** (General), in response to patients being standoffish and emotionally distant. Some therapists tried to facilitate dialogue by asking a lot of questions: *"I am very direct; I almost ask one question after another"* (Case 2) / *"The sessions have a very strong question-and-answer dynamic. [...] [I have to] initiate the interaction time and time again"* (Case 1). Another therapist stated that she *"could not afford [herself] not to ask any questions"* because the patient *"needed"* those to be able to speak (Case 5). Therapists also narrated that they had to actively explore the more affective, subjective dimensions of their patients' stories because this information was not presented spontaneously: "*I very actively have to inquire on those things. If I do not actively ask him, he starts talking about [factual things]* (Case 4). By being actively present in therapy, therapists sometimes succeeded in making sessions more productive: *"when I actively intervene, he becomes more vulnerable, there is more emotion, his speaking becomes more affectively invested"* (Case 4). Nonetheless, as mentioned earlier, therapists also frequently observed that their attempts redirect the conversation were met with avoidance or defiance. This resulted in therapists experiencing the sessions as exhausting: *"physically drained after two sessions"* (Case 7).

Negative emotional responses

Secondly, therapists described or expressed a variety of negative emotional reactions toward self-critical patients. Therapists evaluated the clinical work as considerably frustrating due to patients' non-engagement. We identified four subcategories: "annoyance and impatience," "resignation or withdrawal," "criticized or intimidated," and "feelings of rejection."

The perception that patients were avoiding having to talk about subjective experiences evoked feelings of **annoyance and impatience** (Typical) in therapists. Especially when a trusting, productive relationship was not established after multiple sessions, therapists became increasingly frustrated with their patients. The intensity of negative reactions varied from case to case, indicating between-patient differences but possibly also between-therapist differences in perception and management of this therapeutic obstacle. In two cases, therapists got increasingly annoyed by (among other reasons) a patient's idealizing discourse about the partner because the patient did not allow more ambivalent or negative feelings to be explored. Some therapists anxiously attempted to elicit more meaningful material given the remaining number of sessions and felt an urge to frustrate their patients: *"I fantasize about flagrantly interrupting him, short sessions, really bring out some of that aggression"* (Case 4). Other therapists experienced an impulse to confront patients with interpretations: *"at a certain moment I got a bit sick of [the idealizing discourse about the patient's wife], so I said: "but do you actually feel* attracted *to her? [...] it seems as if you immediately need to counterbalance your negative emotions toward her"* (Case 5). Therapists acknowledged that they were not always successful in containing their frustrations and feelings of impatience but stated that they felt almost pressured by the patient to engage in more blunt interventions: *"He almost forces me to the point [of confrontation] because he is always stuck in that same thing"* (Case 3).

Therapists also showed subtle or blatant signs of **resignation or withdrawal** (Typical). Some therapists found their patients' superficial discourse boring and distracting. One therapist experienced a feeling of tuning out: *"it is tormenting to listen to him [...] it makes me doze off. [...] He is just rocking me and himself asleep" (Case 4).* Therapists also narrated that, when their attempts to get closer to the patient were unsuccessful, they felt less inclined to keep prodding for information. As a result, they came to embody more of an awaiting

attitude in which they simply registered what patients brought to the session. One therapist reported to have given up on explorative inquiring to alleviate both her own and her patient's discomfort: "*I have given up at this time, because my questions frustrated him and me as well. So, I just let it go"* (Case 7). The therapist also neglected to explore a dream mentioned by the patient in a session: *"I did not even bother, because he would have brushed it off anyway."* Again, therapists differed in how they dealt with their perceived ineffectiveness to get closer to patients. For example, for two therapists there was a subtle inclination to project own assumptions on blanks in the patient's story while at the same time becoming more modest with interventions. Other therapists showed more extreme signs of withdrawal as their ability to actively listen to patients became impaired: *"this man annoyed me so much […] that my countertransference prevented me from listening"* (Case 4).Furthermore, therapists reported poor alliance and feelings of being **criticized and intimidated** (Typical) in response to manifestations of interpersonal aggressiveness and hostility in patients. One therapist narrated: *"the more the session progressed, the smaller I became: smaller in my words, in what I said, and how I said it. And the more ground I gave her"* (Case 6). The intensity and pervasiveness of these feelings differed from case to case. Some therapists were able to overlook these tensions in the alliance after feeling somewhat perplexed initially: *"It was a little offensive, but I did not take it personally"* (Case 1). Others struggled more not to take their patient's attacks personally*: "I thought 'I am not* forcing *you to be here!' […] I was quite overwhelmed, thinking 'hey, I am just doing my* job *here, calm down!'"* (Case 6). In a more extreme case, a therapist experienced strong feelings of intimidation that even resulted in feelings of being threatened: *"I do not easily feel uncomfortable with intimidating men. [But] last time, I heard the last colleague leaving, and I thought: 'Oh no, now we are all alone. He* knows *it is only him and me now.' Gosh, I feel like he is capable of doing something to me!"* (Case 3).

Lastly, in therapies where patients' non-engaging attitudes and behaviors were manifestly and dominantly present, therapists gradually developed **feelings of rejection** (Variant). Therapists tended to interpret the non-compliance in terms of a refusal to engage in therapy and attributed therapeutic obstacles to interpersonal defiance or willful resistance in patients. This impression led therapists to perceive and present their patients in a rather negative and rejecting manner, especially when patients' expectations of therapy did not resonate with their own perception about the goal of treatment. Some therapists seemed really stuck in a negative perception of the patient, while others voiced more ambivalent feelings. For example, in Case 1, the therapist got *"the chills"* from a patient's *"affectless, subjectively void"* discourse when talking about close relationships. The therapist's rejecting attitude mainly manifested in the form of occasional judgmental remarks about the patient in supervision (e.g., blaming or mocking the patient, describing the patient as *"weird"* and her statements about others as *"absurd"*). Some therapists became skeptical of continuing treatment: *"What can you do [...] in twenty sessions with someone like that? I feel like nothing is really working. [...] I am at a dead end"* (Case 1). In two cases, therapists acted upon these feelings of rejection: one therapist felt so *"creeped out"* (Case 3) by the patient that she unilaterally broke off treatment in the second half of the therapy sessions. Another therapist explicitly demanded that a patient proved engagement in therapy: *"I said to her: 'look, I'm going to give you a new appointment, but I need you to think about it. Because engagement works both ways here'"* (Case 6). The treatment was terminated the next session on mutual agreement that a different type of therapy would benefit the patient more.

Positive emotional responses

Although positive feelings were not at all predominant in most case presentations, therapists also reported or expressed positive emotional reactions toward patients. Two subcategories

were identified: “moved by patient’s authenticity and suffering,” and “enjoying sessions in the context of good alliance.”

Therapists were genuinely **moved by patients’ authenticity and suffering** (General). Momentary glimpses of otherwise well-contained authenticity seemed to mitigate more negative emotional responses in therapists. Positive emotions such as positive regard, empathy, compassion, and acceptance were reported or expressed when patients were more authentic and engaging in therapy: *“sometimes he responds [to questions] in a surprisingly direct and honest manner”* (Case 2). Therapist reacted positively when patients’ defensive wall crumbled down: *“because I had seen her like that, I was suddenly able to love her”* (Case 6). These moments of vulnerability were significant moments for therapists because they seemed to signal that there was something therapists could work with and as such provided hope for the future direction of treatment: *“I decided that I would keep trying, that it is okay. And I felt more able to endure that next session”* (Case 6).

In two cases, the therapists really **enjoyed sessions in the context of a good alliance** (Variant). When patients were perceived as cooperative and engaging, therapists found them enjoyable to work with. In Case 5, for instance, a therapist expressed positive regard toward a patient because the latter showed a good working ethic. Her patient’s constructive working attitude had caused her to reconsider her initial perception of him: *At first, I thought ‘Oh, my God,’ but I actually find him quite pleasant in his speaking and also [his attitude] toward me”* (Case 5). In another case, negative feelings regarding a patient’s aggressive phantasies were contained within the feeling that a therapeutic process had started, and that the relationship ‘worked’: *“We are on the same wavelength. We also have this kind of humor between us that works. […] I feel comfortable around him"* (Case 2). This resulted in therapists evaluating the therapeutic work with these patients as positive and gratifying: *“It is really enjoyable!”* (Case 2).

Supervisory processes

This domain describes relevant supervisory processes associated with therapist responses. We identified three categories: "reframing therapeutic obstacles using case conceptualization," "questioning own position in the alliance," and "motivation to work with the patient."

During supervision, therapists **reframed therapeutic obstacles using case conceptualization** (General). They used the psychoanalytic theoretical framework (e.g., theory on transference, subjective logic, and defense mechanisms) to reinterpret patients' distancing attitudes and behaviors. In Case 7, the therapist first presented her patient in supervision as very defiant, someone who "*won't allow any [thoughts and feelings] to be concretized."* During supervision, she gradually came to understand the patient's resistance in terms of *"difficulties in mentalization."* This therapist also came to view the patient's evasive reactions in therapy as a lawful coping mechanism in view of childhood trauma: *"Something of a [narcissistic] defeat. Rejected by that girl and his father [...] It is something self-preserving. Because, if he were to open that door [to his feelings], what would he encounter? [...] He might have good reasons to be [detached]."* In Case 6, the patient's verbal attacks on the therapist were understood from the perspective of a deeply engrained conflict. The therapist discerned a *"cold and unresponsive"* upbringing and a recurrent dynamic of *"trying very hard but never being good enough."* As such, the therapist observed a parallel between the patient's hostile behavior in therapy and the patient's typical way of relating to others in life: *"a dynamic of engaging in conflict [with others]."* Thus, challenging patient behavior was reinterpreted from a 'not willing' to a 'not able' to form a close connection. Therapeutic obstacles were perceived separately from the patient-therapist relationship and viewed within the context of the patient's broader interpersonal functioning and personal life history.

During supervision, therapists also came to **question their own position in the alliance** (Typical). More specifically, therapists reflected critically on their own negative attitudes and behaviors toward the patient and considered their possible impact on the alliance and treatment progress. For example, in Case 3, the therapist was convinced that the patient was picking up on her frustrations during sessions: *"He can tell that I am annoyed. Not that I am pressuring him like that but apparently it shows."* The therapist hypothesized that her attempts to elicit more meaningful material could have been strengthening the patient's defensiveness. Another therapist brought the patient in supervision because she suspected that her decreased attention during sessions had kept her from preventing a psychological decompensation during treatment: *"I am afraid that I missed something [...] "Throughout that horribly boring and dull discourse, he may have said something important, and I may not have heard it"* (Case 4). Therapists also considered ways in which their unfavorable perceptions and attitudes could unwillingly lead to a repetition of harmful relational patterns in therapy. In Case 3, for example, the therapist became aware that her antipathy for the patient may be validating a relational script of being rejected by others: "*you can feel that I am almost having the same repulsion as others. [I have] to stay out of that dynamic."* In Case 4, the therapist realized that similar to others in the patient's life, she might have been implicitly communicating to the patient that he was not meeting expectations: *"At one point I thought: I have to make sure that I am not [embodying the role of] the one who also says 'Come on, pick it up a notch'"* (Case 4). Not all therapists actively engaged in critical self-reflection regarding their own position in the alliance. Some therapists were more stuck in a negative apperception and mainly used the supervision hour to vent about patients. In these cases, the supervision group helped therapists to arrive at a more self-critical stance by raising awareness to excessive negativity, potential enactments, and harmful repetitive patterns in therapy.

Finally, during supervision, therapists developed a renewed **motivation to work with patients** (Typical). The abovementioned supervisory processes had a mitigating effect on therapists' negative emotional responses. Through case formulation, patients' behavior seemed to become more understandable and bearable for therapists. Because they had begun to think differently about patients, therapists gradually embodied a more empathic stance: "*there is something mechanical about her. It is really painful; I actually feel for her"* (Case 1). Therapists observed that the act of being in supervision improved their thinking about the case: *"I have been listening to that man for six sessions and I was fantasizing and thinking about [the case], but you need the ear of others to be able to [properly] construct something"* (Case 5). Therapists were able to identify ways to proceed further with patients because they identified ways to reposition themselves in the alliance. In some cases, the therapists concluded that they might have to lower the bar for their patients: *"I think I will just have to give him some time"* (Case 5). Other therapists looked for more active ways to work productively with patients:

> Perhaps I should approach him more from the position of the mother […] maybe I should regard him as […] someone who needs guidance […] someone who needs to grow in the elaboration of his identity. I think it would be good to help him with that (Case 3).

However, the mitigating effect of supervision on therapists' emotional responses did not have an entirely linear unfolding. Therapists who were currently confronted with a troublesome therapeutic alliance seemed to oscillate (i.e., go back and forth) between positive, negative, and more ambivalent feelings toward their patients, indicating that they still struggled with hindering emotional responses despite supervision.

Discussion

With this qualitative study, we aimed to expand our knowledge on alliance impairments in therapy with self-critical patients. More specifically, we intended to examine how therapists

perceive, emotionally experience, and react to self-critical patients' distancing interpersonal dynamics. We studied narrative data from clinical supervisions where psychodynamic therapists discussed their clinical work with 7 self-critical patients for the first time.

In line with the results from Levander & Werbart's (2012) qualitative multi-case study, therapists in our study described self-critical patients as hard to engage in therapy. The attitudes and behaviors described by therapists are highly similar to the transferences and defense mechanisms specified in clinical-theoretical writings on self-criticism (see Introduction) and with Freud's (1909/1955), Shapiro's (1965), and Salzman's (1968) conceptualizations of 'obsessional neurosis', 'obsessive personality,' and 'obsessive compulsive personality.' Our study shows that therapists mainly struggled with self-critical patients' non-engaging attitudes and behaviors in therapy, manifesting mostly in the form of a self-concealing or evasive communicative style (i.e., patients *talked* but did not *speak*), hostility or interpersonal aggressiveness in the alliance (e.g., defensiveness, intimidation, verbal attacks), and limited motivation for therapy (e.g., wanting a quick fix). Consistent with previous empirical research on self-criticism and poor alliance (see Hewitt et al., 2020; Miller et al., 2017), these aspects seemed to interfere strongly with the therapeutic process.

Considering the impact of patients' interpersonal dynamics on the therapist's emotional response, our findings offer valuable additions to the existing literature. Although the presence of negative therapist affect has been consistently described in clinical-theoretical literature, empirical research has so far not provided uniform results (see Introduction). Although hostile, oppositional, and non-compliant patient behavior has been associated with more negative emotional reactions in therapists (Bandura et al., 1960; Hill et al., 2003; Markin et al., 2013; Røssberg & Friis, 2003; Sharkin, 1989), such reactions have not been clearly or consistently found in studies investigating Blatt's two-polarities model. While a study by Hewitt and colleagues' (2008) suggested that self-critical patients are less 'liked' by

therapists than other patients, recent cross-sectional research (Genova & Gazillo, 2018; Hennissen et al., 2019; Westerling et al., 2019) does not clearly indicate that therapists treating self-critical patients are strongly affected on an emotional level.

In contrast, our findings revealed a wide range of negative emotions, ranging from annoyance, impatience, and boredom, to withdrawal, intimidation, and even rejection. It is possible that the narrative accounts from supervision produced much richer and ecologically valid data compared with previous studies that typically rely on self-report measures. Self-report measures are known to be vulnerable to limited sensitivity, social desirability bias, and lack of depth (Fauth, 2006; Singer & Luborsky, 1977). Our study illustrates that negative affect can manifest itself subtly: not only in the form of momentary emotions and behavioral interventions but in fact penetrating therapists' entire thinking process of patient and therapy. Our data and method of analysis further enabled us to transcend the mere descriptive character of extant research by examining therapists' meaning-making process in dynamic interaction with patient behavior. This enabled us to gain a deeper understanding of the interpersonal mechanisms that can trigger negative therapist affect. We could infer that therapists' abilities to remain authentic, accepting, and empathetic were heavily undermined by patient-initiated pressures on the alliance (cf. Zuroff et al., 2016). These pressures may have been intensified by external constraints (e.g., time limit, termination nearing) as well as internal demands (e.g., wanting to successfully treat a resistant patient).

Our findings also suggest that the therapists could have contributed to poor alliance through enactments of negative affect. Outspoken enactments included blunt, confronting, or ill-timed interventions. More subtle enactments included impatiently attempting to elicit more meaningful material from patients or becoming increasingly resigned over time. Although therapists in our study were aware that they (had) experienced negative affect, they were not always successful in controlling their frustrations. Some even described a feeling of being

forced by the patient. These observations diverge greatly from Zuroff and colleagues' (2000; 2010) study where a poor alliance was mainly due to self-critical patients' failure to contribute to the relationship, but where therapists' alliance-building efforts seemed unaffected. It is possible that negative affect is communicated in subtle ways that are difficult to detect through traditional research methods (Maroda, 2010; Miller et al., 2017). Our study raises the question of how effective therapists truly are at preventing negative affect from permeating the therapeutic relationship. Negative affect, even in its subtlest form, may be readily picked up by self-critical patients who are especially wary of signs of rejection (Miller et al., 2017).

Safran (1993) famously described alliance ruptures as windows into patients' core conflicts. When viewed from the perspective of *objective* or *patient-induced countertransference* (Winnicott, 1949; Geltner, 2006)*,* the above-mentioned emotional responses can be understood as somewhat normal and predictable reactions triggered by patients' typical ways of relating. From the perspective of complementary identification (Racker, 1968) and 'role-responsiveness' (Sandler, 1976) therapists may be *pulled* into negative impulses by the patient's transference maneuvers. From the perspective of concordant identification (Racker, 1968) and projective identification (Ogden, 1982), self-critical patients may make therapists feel what they feel by being overly critical.

In clear contrast with empirical research on objective countertransference presenting therapist reactions as rather fixed and unambiguous responses to patient characteristics (see Stefana et al., 2020), our study attests to the dynamical and layered character of these phenomena. Namely, our study provides information on what might be positive and helpful anchors in therapy. To begin with, instances of authenticity and vulnerability during therapy sessions, although sparse, seemed especially significant for therapists. These moments were embraced and appeared to have a favorable impact on therapists' affective processing by

counterbalancing negative impulses and offering a hopeful perspective on treatment. Further, we were able to identify supervisory processes that substantially influenced therapists' perceptions of their patients. More specifically, supervision helped therapists to obtain a more non-emotional perspective on patients through case conceptualization. By viewing experienced challenges through the lens of psychodynamic or psychoanalytic theory (e.g., theory on transference, subjective logic, defense mechanisms), therapists came to understand patients' overt attitudes and behaviors as manifestations of deeper, structurally engrained conflicts instead of as willful and momentary expressions of non-engagement or opposition. Therapists subsequently seemed able to somewhat disentangle from feeling personally provoked. This observation is in line with the processes of "decentering" and "depersonalizing" described by Hayes and colleagues (2015), and with the importance of conceptualizing ability as a principal skill in successful countertransference management (Van Wagoner et al., 1991). Although negative impulses were seldom dissolved in their entirety after this first supervision session, reformulation of patient dynamics seemed to create headspace for therapists, making them able to better understand the experienced hardships in therapy and resulting in a renewed eagerness to work with patients.

Both from a methodological and clinical perspective on therapist responses, exchanging a static for a dynamical view can offer a way out of a negative relational spiral between patient and therapist. Frustrations and other negative affect may result in an inadvertent repetition of harmful relational patterns when therapists fail to adequately understand the nature of patients' dysfunctional beliefs (Safran et al., 1990). Incessant prodding, gentle teasing, or a wish to shake or even punish the patient (Asseyer, 2002) may create power struggles that confirm self-critical patients' perceptions of the therapist as an intruder or a depreciatory other. Likewise, an increasing state of mental resignation may cause therapists to miss out on important unconscious communication (Asseyer, 2002),

thereby repeating a pattern of rejection and distrust. It appears that supervision, through case conceptualization, may function as a principal tool in avoiding a repetition of such harmful patterns, because it stimulates therapists to actively reposition themselves in the relationship.

Limitations

To our knowledge, this is the first systematic qualitative study to examine in-depth the perceptions, emotions, and reactions of therapists treating self-critical patients. As with most qualitative research designs, the time-intensive character of data analysis enabled us to study only a small dataset, which comes at the cost of statistic generalization (Polit & Beck, 2010). Therefore, our findings may not be representative for other therapies, especially therapies with patients showing less pronounced personality features, therapies not discussed in supervision, or therapies without a pre-established time limit, all of which may be characterized by different alliance processes. Studying patient cases from supervision, especially those exhibiting extreme personality features (i.e., prototypical patients), can however warrant analytic (i.e., theoretical) generalization (Polit & Beck, 2010) because they are particularly illuminating for how maladaptive interpersonal dynamics are played out in therapy. Hence, such studies can facilitate the identification of relational pitfalls. The restricted number of available cases within the GPS may however have led to an undersaturation of data (O'Reilly & Parker, 2012).

As part of a member checking procedure (Birt et al., 2016), a draft of the findings was sent to the clinical supervisors on the assumption that they were in the best position to evaluate shared meaning making processes in the group, whereas the supervisees (i.e., therapists) could only provide a partial experience of this overarching process. Yet trustworthiness of this study could have been enhanced by obtaining feedback from the therapists given that they were the primary data source.

Another methodological constraint concerns the nested character of our data, which is a consequence of the broader study design from which the data were drawn. Only four therapists participated in the psychodynamic condition of the GPS, meaning that some patients received treatment from the same therapist. Moreover, because of our data selection and sampling method (i.e., prototypical and quasi-prototypical patients only), some therapists contributed more data than others (two therapists had a single case, one had two cases, and one had three cases). This makes it difficult to distinguish between patient and therapist effects. Between-therapist variability may confound the observed impact of patients on therapists. This is important since not all patients might affect all therapists in the same way. Notwithstanding the observed shared patterns, much variability occurred in the intensity and pervasiveness of therapist responses, in the extent to which these responses were perceived as hindrances to clinical work, and in observed productivity of supervision. This variability might be related to individual differences in therapists' ability to grapple with non-compliance and aggression in patients (Yulis & Kieser, 1968). Aside from therapists' level of comfort with aggression, "utopic ideas" about psychotherapy (Werbart, 2007), ideal-patient phantasies (Smith, 2004), or (other) personal investments may make some therapists more vulnerable to enmeshment than others. Unfortunately, we were unable to gain much insight into personal aspects that may explain these observed idiosyncrasies in therapists. Therapists participating in our study mainly focused on what patients did and appeared somewhat reluctant to discuss personal investments in supervision. This is most likely a consequence of these therapists' antecedent Freudian-Lacanian training where emotional responses are not seen as particularly informative of patients and where personal immersion is preferably worked through in an individual analytic process (Dulsster et al., 2021). This is a significant limitation, and it would be useful for future studies to incorporate a more integrative perspective on countertransference (see Gelso & Hayes, 2007) into analysis.

Implications: Practice and Research

Treating self-critical patients may be challenging, especially in short-term therapy. However, it might not be helpful for therapists to dwell too intensively on self-critical patients' non-engagement, nor to attempt to 'force' the treatment process. Focusing too much on patients' non-engagement may result in patient blaming and could cloud therapists' critical reflection on their own position in the relationship. Aside from stimulating awareness of negative affect and differentiating between purposeful clinical interventions and defensive reactions (i.e., enactments), a critical function of supervision lies in encouraging and aiding therapists to engage in case conceptualization. This helps therapists to obtain a fresh perspective of the case and to come to an understanding of potentially harmful dynamics between themselves and their patients. As such, therapists can disentangle from a damaging relationship and embody a different position. Possibly more so than with other patient types, it may be necessary for psychodynamic therapists to actively cultivate case conceptualization during therapy sessions to counterbalance negative affect and identify more fruitful ways of working in short-term treatments.

On a methodological level, our study meets the demand for more elaborate, in-depth research designs to study therapist responses (see Fauth, 2006). Narrative data from clinical supervisions are excellent sources of information to study therapists' inner experiences. Although social desirability bias is inherently difficult to overcome given the delicate nature of the topic (Fauth, 2006; Singer & Luborsky, 1977), our method of inquiry produced rich and in-context findings, also enhancing the clinical usefulness of empirical research for practitioners (Kazdin, 2008). Further research should study the dyadic interactions between patient and therapist even more thoroughly. For instance, considering the temporal aspect associated with alliance and studying the long-term impact of (continued) supervision on the process and outcome of treatment are topics worthy of investigation. Future studies should

also examine more personal and unconscious investments of the therapist (i.e., vulnerabilities, unresolved conflict) and should study the role of the therapist's personal analytic process and clinical supervision in managing these more intimate aspects. Methodologies that allow for a rich and fine-grained scrutiny of complex dynamic processes, such as case study designs (McLeod & Elliott, 2011), can be especially well-suited to study these facets.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Table 1

Therapist and patient sample characteristics.

Therapist		Patient			
Therapist	**Exp***	**Case**	**Proto****	**Treat*****	**Sup******
Therapist 1	9	Case 1	P	20	7
Therapist 2	6	Case 2	Q	20	3
		Case 3	Q	11	4
Therapist 3	5	Case 4	Q	20	12
		Case 5	P	20	6
		Case 6	Q	4	3
Therapist 4	8	Case 7	P	20	3

Note. * Clinical Experience in years; ** Prototypicality of patient personality style in terms of similarity to prototype vignettes. P=Prototype: a difference of at least three score points between the self-critical and dependent dimension as reflected by diagnostic raters' consensus scores. Q=Quasi-Prototype: approximation of the prototype as reflected by diagnostic raters' individual scores; *** Treatment duration as reflected by number of therapy sessions received in the study; **** Number of therapy sessions after which the patient was discussed in supervision.

Table 2

Domains, categories, and subcategories for how therapists perceive, emotionally experience, and react to self-critical depressed patients based on data from preliminary group supervisions (N=7).

Domain/ Category / Subcategory	**Frequency**
Domain 1. Patient attitudes and behaviors	
Moments of non-engagement	
Standoffish / emotionally distant discourse	*General*
Bypassing explorative interventions	*General*
Hostility / aggressiveness in the alliance	*General*
Low / inaccurate expectations of therapy	*Typical*
Moments of engagement	
Glimpses of vulnerability	*Typical*
Good work ethic	*Variant*
Domain 2. Therapist response	
More active therapist	*General*
Negative emotional responses	
Annoyance / impatience	*Typical*
Resignation / withdrawal	*Typical*
Criticized / Intimidated	*Typical*
Feelings of rejection	*Variant*
Positive emotional responses	
Moved by patient's authenticity and suffering	*General*
Enjoying sessions in context of good alliance	*Variant*
Domain 3. Supervisory processes	

Reframing obstacles using case conceptualization	*General*
Questioning own position in alliance	*Typical*
Motivation to work with patients	*Typical*

Note. "Frequency" indicates the number of occurrences of the (sub) category in the data set (Hill et al., 2012). *General* = present in 6 to 7 cases; *Typical* = present in 4 to 5 cases; *Variant* = present in 2 to 3 cases.

Appendix 1. Prototype matching procedure (Werbart & Forsström, 2014, p.18) used to assess patient personality type in accordance with Blatt's two-polarities model.

Anaclitic persons are preoccupied by issues of relationship to significant others. They endeavour to maintain close, intimate relationships and have difficulties in setting limits to others. They tend to appease and ingratiate themselves with others in order to be liked and easily get stuck in relationships which make them feel being taken advantage of. They easily become involved in relationships, and tend to idealize and to be influenced by others. They tend to care for others and try to bring about reconciliation when in conflict. Sexuality is used in service of affection, intimacy and relatedness. They are emotionally naive, trusting, living in the present, sensuous, focus on feelings, but may at the same time be afraid of strong feelings in relationships to others. They easily feel alone, abandoned, helpless and discouraged. They tend to be passive and remain silent, sulk and suffer instead of objecting. They are distractible, intuitive, their thinking is figurative, easily affected by impressions and focused on feelings. They strive to reach integration and cohesion and tend to minimize differences. These characteristics can, on occasion, be seen as a defence against conflicts caused by excessive competitiveness (e.g. achieving certain goals).	**Introjective persons** are preoccupied by issues of boundaries between themselves and others. They strive for autonomy, reason, power and prestige. They are assertive, want to fend for themselves, to function independently and to achieve results. They strive to preserve a sense of being effective and objective, in control, and emotionally neutral. They tend to be well-organized, steady, responsible, reliable, accurate, cautious and methodical. They want to learn, train, know, and often are perceived by others as work addicts and perfectionists. They are critical towards others and themselves easily feel criticized, not being good enough, and readily compare themselves with others. They tend to be avoidant or dismissive in their relationships and to use aggression in service of self-definition. They focus on overt behaviour, logic, consistency and causality. Their thinking is analytic and literal with critical evaluation of details and separate elements. They tend to disregard the context and to sharpen differences. These characteristics can, on occasion, occur as a defence against conflicts caused by overwhelming intimacy needs.
1. Little or no match (description does not apply) *2. Some match (person has some of these features)* *3. Moderate match (person has significant features of this prototype)* *4. Good match (it is such a person)* *5. Very good match (person exemplifies this personality type; prototypical case)*	

Note. Anaclitic = Dependent; Introjective = Self-critical