

Associations between the personal style of the therapist, empathy and theory of mind among Argentine psychotherapists

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Abstract: The personal style of the therapist refers to the dispositions, traits and attitudes that the therapists display in their professional practice. The associations between personal style of the therapist, empathy and theory of mind, have yet to be examined. This study analyzed the associations between personal style of the therapist, empathy and theory of mind among therapists, while considering the effect of their theoretical background and other contextual and individual variables. The study sample consisted of 152 Argentine therapists. Personal style and empathy were assessed through self-report questionnaires (Personal Style of the Therapist Questionnaire and Interpersonal Reactivity index, respectively), while theory of mind was evaluated with the Reading in the Eyes test. Cognitive empathy was associated with a broader attentional focus and higher emotional expressiveness, while affective empathy led to stronger commitment and a higher emotional impact of therapy on the therapist. In addition, psychoanalysts and cognitive behavioral therapists exhibited personal style of therapist differences in their spontaneity and emotional distance, and cognitive behavioral therapists showed higher levels of engagement.

Keywords: Personal style of the therapist; empathy; theory of mind; clinical psychology.

Asociaciones entre el estilo personal del terapeuta, la empatía y teoría de la mente en psicoterapeutas argentinos

Resumen: El estilo personal del terapeuta se refiere a las disposiciones, rasgos y actitudes que los terapeutas exhiben en su práctica profesional. Las asociaciones entre estilo personal del terapeuta, empatía y teoría de la mente aún no han sido examinadas. Este estudio analizó las relaciones entre estilo personal del terapeuta, empatía-rasgo y teoría de la mente en psicoterapeutas, considerando la potencial influencia de su marco teórico y otras variables contextuales e individuales. La muestra estuvo compuesta por 152 psicoterapeutas argentinos. El estilo personal del terapeuta y la empatía se evaluaron a través de cuestionarios de autoinforme (Cuestionario de Estilo Personal del Terapeuta y el Índice de Reactividad Interpersonal, respectivamente), mientras que teoría de la mente se evaluó a través del test de Lectura de Mente en la Mirada. La empatía cognitiva se asoció a un foco atencional más amplio y mayor expresividad emocional, mientras que la empatía afectiva llevó a un mayor compromiso e impacto emocional de la terapia en el terapeuta. Adicionalmente, psicoanalistas y terapeutas cognitivo-conductuales exhibieron diferencias de estilo personal del terapeuta en la espontaneidad y distancia emocional y terapeutas cognitivo-conductuales mostraron mayores niveles de compromiso.

Palabras clave: Estilo personal del terapeuta; empatía; teoría de la mente; psicología clínica.

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Introduction

Psychotherapy research has been concerned with the role of the therapist since its beginnings (Rosenzweig, 1936). For this reason, different models to study therapists' behavior have emerged. Heinonen

and Nissen-Lie (2019) proposed to divide therapists' characteristics in two categories: demographic or personal and professional (those shaped by their clinical training). However, these characteristics do not act in isolation, but rather interact with each other (Nissen-Lie et al., 2017), which is why an integrating framework is needed. The construct of therapeutic style has been proposed to integrate both personal and professional aspects of the therapist. It has recently been described as "a habitual way of working" (p. 6), which is influenced by factors such as personality and training (Zhou et al., 2021). It is a recent conceptualization based both on theoretical contributions and interviews with experts.

The personal style of the therapist (PST) has been defined as "a set of singular conditions which lead a therapist to operate in a particular way in his/her work. This refers to the regular characteristics that each therapist imprints on his work as a result of his peculiar way of being, regardless of the focus of his work and the specific requirements of his intervention." (Fernández-Álvarez & García, 1998, p. 352). PST is a model to understand the activity of the therapist that consists of five factors (Fernández-Álvarez et al., 2003): attentional (which describes how the therapists gather information from their patients), operative (which describes how they carry out therapeutic interventions), engagement (their degree of commitment to their therapeutic activities), expressive (which refers to emotion expression and management during the sessions), and instructional (the way in which they establish the therapeutic setting). The attentional and operative factors correspond to the technical aspects of the psychotherapist's role, while the expressive and engagement factors are related to motivational and emotional aspects. The instructional factor encompasses all these aspects (Castañeiras et al., 2008).

Along with the theoretical development of the PST, a self-report instrument was designed to explore these concepts, the *Personal Style of the Therapist Questionnaire* (PST-Q; Fernández-Álvarez et al., 2003). The psychometric properties of the PST-Q have been found to be consistent with the underlying theoretical model (Castañeiras et al., 2008; Fernández-Álvarez et al., 2003). It was developed in Argentina and adapted to several countries, like Portugal (Moura de Carvalho et al., 2011), Chile (Quiñones et al., 2010), Ecuador (Kantor, 2011), Brazil (Silva-Palma & Guedes-Gondim, 2016) and Spain (Prado-Abril et al., 2019). Convergent validity has been assessed via its correlation with the therapists' verbal behavior (Fernández-Álvarez et al., 2017).

Several lines of research have applied the PST-Q to study the associations of PST with professional and personal therapist variables. Significant associations have been found with therapists' personality (e.g., Casari et al., 2019; Genise, 2015; Genise & García, 2016), as well as with other professional factors such as theoretical background (for a review, see Casari et al., 2018).

It should be noted that PST was originally proposed to be independent from theoretical orientation (Fernández-Álvarez et al., 2003). However, several studies indicate that certain style features covary systematically with specific theoretical orientations (for a review, see Casari et al., 2018). Psychoanalysts' PST profiles have been found to be quite consistent: broad attentional focus, preference for spontaneous interventions, greater emotional distance, low degree of commitment to the task, and an inclination towards a rigid therapeutic setting (Casari et al., 2019; Castañeiras et al., 2006, 2008; Oliveira et al., 2007; Fernández-Álvarez et al., 2005; Ferreira et al., 2019; Silva-Palma & Guedes-Gondim, 2016; Vázquez & Gutiérrez, 2015). The PST profile of cognitive behavioral therapists seems to be the opposite: narrow attentional focus, preference for structured interventions, and an inclination towards a more flexible therapeutic settings (Casari et al., 2019; Castañeiras et al., 2006, 2008; Oliveira et al., 2007; Fernández-Álvarez et al., 2005; Ferreira et al., 2019; Vázquez & Gutiérrez, 2015). The PST profile of systemic therapists was found to be very similar to those of cognitive behavioral therapists, except for the preference for structured interventions (Casari et al., 2019). Finally, integrative therapists' PST profiles are characterized by rigid therapeutic settings (Casari et al., 2019).

Bateman and Fonagy (2016) defined mentalizing (also known as "theory of mind"; ToM) as a preconscious response that includes the perception and interpretation of one's own and others' behaviors. Regarding personality factors, there is almost no available research on the links between PST, ToM, and empathy. However, it has been claimed that higher mentalizing skills would allow a better adjustment of the therapeutic setting and the PST to the patient's needs and that ToM should have a larger impact on the PST instructional factor (Corbella et al., 2009). However, this possibility has not been addressed yet. On the other hand, a study examining the potential link between empathy and PST found no association between the PST-Q and a cognitive and affective empathy test in a sample of 20 Peruvian psychologists (Cáceres Rivera, 2019).

Therapist empathy was defined by Rogers (1959) as the ability to internalize the client's experiences

and internal perceptions. It provides the conditions for compassion, but also for behaviors targeting the regulation of these subjective experiences and perceptions. In other words, empathy in therapy can be described as the therapist's skill to understand the client's feelings and thoughts, and, at the same time, as the therapist's ability to express their concern and compassion for their clients.

It has been shown that empathy helps to build and improve therapeutic alliance (Horvath, 2018; Malin & Pos, 2015; Watson et al., 2020), while some studies also indicate that clinical psychologists exhibit higher empathy scores than the general population (Putrino et al., 2021; Santamaría-García et al., 2017). On the other hand, professional variables such as years of experience or patient load may also have an impact on empathy. For instance, professionals who had more years of experience (> 10 years) and saw more patients per week in average showed lower affective empathy scores (Putrino et al., 2021; Santamaría-García et al., 2017). Therefore, it is relevant to consider training, clinical experience and current practice when studying empathy in psychotherapists.

Mentalizing is closely related to cognitive aspects of empathy. As was the case with empathy, ToM has been considered a beneficial skill for therapist-client relationships. On the other hand, it has not been extensively studied in therapists. A recent study showed that therapists' mentalizing skills were improved after a social cognition training (Steinmair et al., 2021). Furthermore, Rogoff et al. (2021) examined self-mentalizing skills (awareness and understanding of one's own cognitive and affective processes) and cognitive empathy (mentalizing skills for others' mental processes) among psychotherapists, the general population, and patients with bipolar disorder. They found an advantage for therapists in "self-" (but not "other-") mentalizing skills. In this way, they showed that clinical training improved at least one aspect of mentalizing processes. Nevertheless, a potential limitation is that they only included psychodynamic therapists (therefore, they were not able to detect potential differences between theoretical backgrounds). In the same line, a previous study analyzed psychotherapists' performances on a series of mentalizing tasks based on non-verbal (gaze, facial expression) and verbal cues (Hassenstab et al., 2007). A specific advantage for therapists (compared to age- and sex-matched controls) was observed for verbal mentalizing tasks, while no differences were found for non-verbal tasks. In addition, their emotional distress responses to other people's suffering were significantly lower, indicating that they were better at regulating

negative emotions during social interactions. While this study included therapists from diverse theoretical backgrounds, it did not control for this variable systematically.

To measure empathy, we chose one of the most validated and widely used self-report instruments (Neumann & Westbury, 2011), the Interpersonal Reactivity Index (IRI; Davis, 1983). The IRI consists of four subscales that measure cognitive (*perspective taking and fantasy*) and affective (*empathic concern and personal distress*) aspects of empathy. In addition, we considered the suggestion of Neumann and Westbury (2011) that it is important to measure empathy in a more indirect way to reduce a potential social desirability bias among health professionals. Therefore, we also included a performance-based index of mentalizing, the Reading the Mind in the Eyes Test (RMET; Baron-Cohen et al., 2001). This task requires the participants to infer mental states from facial expressions (specifically, from the eye region). The RMET seems to be a promising alternative because it is based on the ToM construct, which is closely related to cognitive empathy (Baron-Cohen et al., 2001; Völlm et al., 2006). In addition, a study found that it correlates with self-report measures of empathy (Lawrence et al., 2004).

Considering the lack of studies examining the links between PST, empathy and ToM, this work aimed to study their associations in Argentine therapists. Since PST seems to covary with theoretical background (Casari et al., 2018, 2019), we included the therapists' framework as an additional variable. We also took into account a series of indicators, namely the therapists' clinical training, years of experience, patient load and their current practice setting. We expected to find significant associations between PST factors, empathy scores and ToM performances. More empathic therapists might show higher expressiveness and engagement scores, while better mentalizing performances might lead to higher instructional scores (Corbella et al., 2009). Moreover, we expected to find significant differences on PST dimensions according to the therapists' theoretical background, particularly between cognitive behavioral therapists and psychoanalysts (less expressiveness, engagement, broader attentional focus, and less structured interventions in the latter). In addition, we expected to find effects from clinical experience variables on PST dimensions: more years of experience (and/or a higher patient load) might lead to lower involvement, while less experienced therapists might favor narrower attentional focus and more structured interventions.

Method

Participants

A total of 162 Argentine psychotherapists completed an online survey (which assessed sociodemographic information, clinical experience, PST, empathy and ToM – see the *Procedure* section). Eight of them described their framework as “existentialist” and two indicated “other”. Since these numbers were too low for statistical comparisons, these subjects were excluded from the analysis. The final study sample consisted of 152 Argentine therapists (133 of them female, age range: 24-63 years old, M age \pm SD : 35.63 \pm 7.98 years). The most frequent theoretical orientations were cognitive-behavioral therapy (44.7%) and integrative therapy (21.7%). Regarding academic background, most of the participants had taken post-graduate courses or held degrees (44.7. %), 34.9% had a clinical specialization, while only 8.6. % had a master’s degree, and 3.9% a PhD. Therapists’ median years of experience was 5

(interquartile range, IQR : 7) and the patients per week median was 15 (IQR : 12). Most of the therapists were private practitioners (55.3%) or worked both in the private and the public sectors (20.3%) (see Table 1 for details).

Instruments

Personal Style of the Therapist Questionnaire (PST-Q; Fernández-Álvarez et al., 2003). The PST-Q is a self-report measure consisting of 36 items presented as statements to which each therapist should respond according to their degree of agreement on a Likert scale, ranging from 1 (totally disagree) to 7 (totally agree). The 36 items are grouped into five factors, with two extremes each. Attentional factor (PST-a): broad or open attention versus focused or narrow attention; operative factor (PST-o): spontaneous way of work versus structured plan of treatment; expressive factor (PST-exp): emotionally distanced versus closer; engagement factor (PST-eng): low engagement versus high engagement; instructional factor (PST-i): flexible versus rigid. The PST-Q has satisfactory psychometric properties according to confirmatory factor analyses and good reliability indexes for all factors (Castañeiras et al., 2008; Fernández-Álvarez et al., 2003). According to Fernández-Álvarez et al. (2003), reliability levels analyzed using Cronbach’s alpha were acceptable: attentional factor ($\alpha = .80$), operational factor ($\alpha = .76$), instructional factor ($\alpha = .69$), engagement factor ($\alpha = .75$), expressive factor ($\alpha = .75$). Similar values were found for the current sample: attentional factor ($\alpha = .71$), operational factor ($\alpha = .70$), instructional factor ($\alpha = .72$), engagement factor ($\alpha = .71$), expressive factor ($\alpha = .73$).

Interpersonal Reactivity Index (IRI; Davis, 1983). The IRI Spanish version (Muller et al., 2015) was applied. This instrument evaluates empathetic disposition via two cognitive (perspective taking and fantasy) and two emotional (empathic concern and personal distress) factors. The perspective taking subscale (IRI-PT) assesses the ability to adopt the perspectives of others in everyday life, the fantasy subscale (IRI-FS) measures the proclivity to identify with fictitious characters, the personal distress subscale (IRI-PD) refers to the propensity to feel uncomfortable about the distress of others, and finally the empathic concern subscale (IRI-EC) evaluates the tendency to experience feelings of compassion and sympathy for others’ misfortunes. The instrument consists of 28 items, each adopting a 5-point Likert scale ranging from 0 (“does not describe me very well”) to 4 (“describes me very well”). An adaptation and validation study for the Argentine population found

Table 1. Descriptive statistics of therapist variables

Variables	M (SD) $n = 152$
Age (in years)	35.63 (7.98)
Sex	
Men	12.5%
Women	87.5%
Clinical experience (in years)	7.07 (5.49)
Theoretical background	
Cognitive behavior therapy	44.7%
Integrative	21.7%
Systemic	15.8%
Psychoanalysis	17.8%
Post-graduate formation	
Post-graduate courses	44.7%
Clinical specialization	34.9%
Master	8.6%
PhD	3.9%
None	7.9%
Patients per week	16.36 (10.55)
Clinical practice context	
Private and public	20.3%
Private practice	55.3%
Private institution	15.8%
Public	8.6%

adequate internal consistency values for all scales ($.65 < \alpha < .73$; Muller et al., 2015). Cronbach's alpha indexes for the current study were the following: perspective taking ($\alpha = .76$), fantasy ($\alpha = .76$), personal distress ($\alpha = .72$) and empathic concern ($\alpha = .73$).

Reading the Mind in the Eyes test (RMET; Baron-Cohen et al., 2001). The RMET Argentine version (Roman et al., 2012) was applied. This instrument evaluates ToM skills. It consists of 36 pictures that show the upper facial section, the eye region, of men and women. Each picture is accompanied by four words describing mental states. From these four alternatives, subjects are required to choose the one that best describes the thoughts and feelings expressed in the picture. The RMET has been applied in more than 250 studies and is one of the most widely accepted and validated measures of ToM performance (Baron-Cohen et al., 2015). It has shown adequate internal consistency ($\alpha = .60$; Dehning et al., 2012; Serafin & Surian, 2004) and good reliability (Férrandez-Abascal et al., 2013; Vellante et al., 2013). Cronbach's alpha for the current study was $\alpha = .62$.

Procedure

Participants were recruited through social networks, university mailing lists, and private institutions. They were informed that their participation would be voluntary, anonymous, and with no economic compensation. In addition, they were told that they could decide to end their participation at any time, without negative consequences. Once they expressed their consent to participate, they moved on to an online survey that collected information about their age, sex, theoretical orientation, years of experience and current clinical practice (private/public setting, average number of patients per week). After completing the survey, three instruments were administered in Google Forms format: RMET, IRI, PST-Q. All the study protocols were in accordance with the ethical standards of the Helsinki Declaration and local regulations. The project was approved by the Ethical Committee of the National Council for Scientific and Technical Research, Mendoza, Argentina.

Statistical analysis

Pearson correlation coefficients were calculated to explore the associations between study variables. Theoretical background effects were analyzed with a one-way ANOVA for RMET scores, while a MANOVA was applied for IRI scores. The contribution of study

variables to PTS factors was examined with hierarchical regression models. The first step of the model included age, sex, years of experience, average patients per week, and theoretical background (cognitive behavioral therapy – CBT – as reference category, systemic, integrative, and psychoanalysis). The second step added RMET and IRI scores. Casewise diagnostics were applied to identify outliers (standardized residuals above 3 or below -3; Cousineau & Chartier, 2010). Since no outliers were detected, no data was removed from the analyses. Assumptions of normality, homoscedasticity, and linearity were checked by inspection of normal quantile plots of residuals, standardized residuals scatter plots and observed versus predicted values, respectively. The independence of error assumption was met for all models ($1.94 < \text{Durbin-Watson} < 2.13$). Variance inflation factors (*VIF*) indicated that multicollinearity was not a concern in any of the models ($1.02 < \text{VIF} < 1.45$). Adjusted *R* squared measures were considered as indicators of model fit.

Results

Associations between PST, empathy, ToM and contextual factors

Descriptive statistics for PST, empathy and ToM measures can be found in Table 2. A complete list of Pearson correlation coefficients calculated for the study variables can be found in Table 3. Significant associations were found between PST and empathy measures. PST-a (attentional focus) decreased with IRI-PT (perspective taking) but increased with IRI-PD (discomfort with distress of others) scores and was negatively associated with the number of patients per week (higher scores mean narrower attentional focus). PST-eng (engagement) was significantly associated with all cognitive and emotional empathy scales (higher scores mean more engagement). PST-o (spontaneity) scores were not associated with empathy, but decreased with therapist age and ages of experience, leaning towards less structured frameworks (higher scores mean more structured). PST-exp (emotional distance) scores were associated with both cognitive empathy measures and IRI-EC (compassion/sympathy), although this last effect was rather weak (higher scores mean more expressiveness). No significant associations with PST-I (flexibility) were found (higher scores mean more rigid setting). No significant correlations between RMET and IRI (IRI-FAN: $r = -0.06$, $p = .466$; IRI-PT: $r = -0.12$, $p = .144$; IRI-EC: $r = -0.05$, $p = .565$; IRI-PD: $r = 0.08$, $p = .300$) or between RMET and PST measures (PST-a: r

= -0.08, $p = .352$; PST-eng: $r = .02$, $p = .771$; PST-o: $r = -0.11$, $p = .174$; PST-exp: $r = 0.1$, $p = .210$; PST-i: $r = 0.02$, $p = .815$) were observed. In addition, no theoretical framework effects were found for IRI or RMET (RMET: $F(3, 148) = 0.72$, $p = .544$; IRI: $Wilks \lambda = 0.94$, $F(12, 384) = 0.78$, $p = .667$).

Table 2. Descriptive statistics of outcome variables

Variable	<i>n</i>	<i>M</i>	<i>SD</i>	Minimum	Maximum
PST-a	152	14.61	5.56	4	28
PST-eng	152	17.39	4.97	4	28
PST-o	152	18.17	6.05	5	34
PST-exp	152	16.35	5.15	4	27
PST-i	152	11.84	3.77	3	21
IRI-FAN	152	20.94	5.47	9	33
IRI-PT	152	26.31	4.53	13	35
IRI-EC	152	26.52	4.09	11	35
IRI-PD	152	17.15	4.65	7	28
RMET	152	67.1%	14.8%	10	90

Note. PST: personal style of the therapist; a: attentional factor; eng: engagement factor; o: operative factor; exp: expressive factor; i: instructional factor; IRI: Interpersonal Reactivity Index; FAN: fantasy; PT: perspective taking; EC: empathic concern; PD: personal distress; RMET: Reading the Mind in the Eyes test (% of correct responses).

Regression analyses of PST factors

Individual hierarchical multiple regression models were applied to identify the main predictors for each PST factor. Table 4 describes the coefficient statistics. An extended version of Table 4 can be found in the supplementary materials.

PST attentional factor (PST-a). The second step of the model increased the explained variance significantly, accounting for 10.3% of PST-a scores (adj. $R^2 = 0.10$; $\Delta R^2 = 0.17$, $p = .002$; $F(12, 139) = 2.45$, $p = .006$). Patients per week ($\beta = -0.21$) and IRI-PT ($\beta = -0.23$) were associated with lower PST-a (broader attentional focus), while IRI-PD predicted higher PST-a (narrower attentional focus; $\beta = 0.20$).

PST engagement factor (PST-eng). The full model increased the explained variance significantly, accounting for 19.2% of PST-eng scores (adj. $R^2 = 0.19$; $\Delta R^2 = 0.20$, $p < .001$; $F(12, 139) = 3.99$, $p < .001$). Engagement scores increased with both measures of emotional empathy (IRI-EC: $\beta = 0.19$; IRI-PD: $\beta = 0.25$). In addition, PST-eng was lower in systemic than cognitive behavioral therapists ($\beta = -0.59$), while this effect did not reach significance for integrative therapists ($\beta = -0.15$; $p = .071$), higher scores meaning more engagement.

PST operative factor (PST-o). Only the first step of the model was significant, accounting for 19.6% of the

Table 3. Pearson correlations between demographic and clinical experience variables, PST, IRI and RMET measures

	1	2	3	4	5	6	7	8	9	10	11	12	13
1.age	—												
2.ageexp	0.69***	—											
3.patweek	0.20*	0.32***	—										
4.PST-a	0.01	-0.03	-0.20*	—									
5.PST-eng	0.01	-0.02	-0.02	0.12	—								
6.PST-o	-0.18*	-0.22**	-0.04	0.15	0.07	—							
7.PST-exp	-0.09	0.03	0.12	-0.44***	0.14	0.22**	—						
8.PST-i	0.07	0.04	0.09	-0.19*	-0.05	0.17*	0.07	—					
9.IRI-FAN	-0.18*	-0.10	0.03	-0.02	0.27	0.13	0.21**	-0.06	—				
10.IRI-PT	-0.05	-0.04	-0.02	-0.24**	0.22	0.06	0.36***	0.05	0.30***	—			
11.IRI-EC	0.04	0.02	0.11	-0.11	0.35	-0.03	0.19*	-0.07	0.36***	0.40***	—		
12.IRI-PD	-0.10	-0.03	0.10	0.20*	0.30	0.1	-0.04	-0.05	0.28***	-0.13	0.24**	—	
13.RMET	0.04	0.10	0.07	-0.08	0.02	-0.11	0.10	0.02	-0.06	-0.12	0.05	0.08	—

Note. Ageexp: ages of experience; patweek: patients per week; PST: personal style of the therapist; a: attentional factor, eng: engagement factor; o: operative factor; exp: expressive factor; i: instructional factor; IRI: Interpersonal Reactivity Index; FAN: fantasy; PT: perspective taking; EC: empathic concern; PD: personal distress; RMET: Reading the Mind in the Eyes test (% of correct responses); * $p < .05$, ** $p < .01$, *** $p < .001$.

Table 4. PST regression analyses

Outcome	Predictor	Estimate	SE	Standard estimate	Outcome	Predictor	Estimate	SE	Standard estimate
PST-a: Model 2					PST-o: Model 1				
	Age	0.03	0.08	0.05		Sex			
	Yearsexp	0.02	0.11	0.02		Women – men	-31.52	13.60	-0.52*
	Patweek	-0.12	0.05	-0.21*		Theory			
	Sex					Integrative – CBT	-24.91	11.63	-0.42*
	Women – men	0.73	13.62	0.13		Systemic – CBT	-23.73	13.06	-0.39°
	Theory					Psychoanalysis – CBT	-61.32	12.86	-1.10***
	Integrative – CBT	-15.11	11.49	-0.27	PST-exp: Model 2				
	Systemic – CBT	-0.45	12.73	-0.08		Age	-0.14	0.07	-0.21
	Psychoanalysis – CBT	-18.69	12.99	-0.34		Yearsexp	0.12	0.10	0.12
	RMET	-0.43	0.30	-0.11		Patweek	0.07	0.04	0.14
	IRI-FAN	0.03	0.09	0.03		Sex			
	IRI-PT	-0.29	0.11	-0.23*		Women - men	-11.09	12.01	-0.22
	IRI-EC	-0.10	0.13	-0.07		Theory			
	IRI-PD	0.24	0.11	0.20*		Integrative – CBT	10.19	10.13	0.20
PST-eng: Model 2						Systemic – CBT	-11.05	11.22	-0.21
	Age	0.07	0.07	0.11		Psychoanalysis – CBT	-23.79	11.45	-0.46*
	Yearsexp	-0.02	0.09	-0.03		RMET	0.41	0.26	0.12
	Patweek	-0.03	0.04	-0.07		IRI-FAN	0.07	0.08	0.07
	Sex					IRI-PT	0.34	0.10	0.30***
	Women - men	-0.09	11.55	-0.02		IRI-EC	0.05	0.11	0.03
	Theory					IRI-PD	-0.08	0.09	-0.069
	Integrative – CBT	-17.70	0.97	-0.37°	PST-i: Model 2				
	Systemic – CBT	-29.42	10.80	-0.60**		Age	0.04	0.06	0.08
	Psychoanalysis – CBT	-0.69	11.02	-0.14		Yearsexp	-0.04	0.08	-0.06
	RMET	0.11	0.25	0.03		Patweek	0.04	0.03	0.10
	IRI-FAN	0.11	0.08	0.12		Sex			
	IRI-PT	0.16	0.10	0.15		Women - men	-14.62	0.99	-0.39
	IRI-EC	0.23	0.11	0.19*		Theory			
	IRI-PD	0.27	0.09	0.25**		Integrative – CBT	0.01	0.83	0.00
PST-o: Model 1						Systemic – CBT	-0.63	0.92	-0.17
	Age	-0.11	0.08	-0.15		Psychoanalysis – CBT	-0.63	0.94	-0.17
	Yearsexp	-0.17	0.11	-0.16		RMET	0.06	0.22	0.02
	Patweek	0.04	0.05	0.06		IRI-FAN	-0.05	0.07	-0.07
						IRI-PT	0.09	0.08	0.11
						IRI-EC	-0.09	0.09	-0.09
						IRI-PD	0.01	0.08	0.01

Note. PST: personal style of the therapist; a: attentional factor; eng: engagement factor; o: operative factor; exp: expressive factor; i: instructional factor; yearsexp: years of experience; patweek: patients per week; CBT: cognitive behavioral therapy; RMET: Reading the Mind in the Eyes test; IRI: Interpersonal Reactivity Index; FAN: fantasy; PT: perspective taking; EC: empathic concern; PD: personal distress; ° $p < .1$, * $p < .05$, ** $p < .01$, *** $p < .001$.

variance (adj. $R^2 = 0.20$; $F(12, 139) = 4.12$, $p < .001$). PST-o scores were lower (more spontaneous) when comparing psychoanalysts ($\beta = 0.39$) and integrative therapists ($\beta = -0.17$) to cognitive behavioral therapists, while a non-significant trend was observed for systemic therapists ($\beta = -0.14$, $p = .071$). In addition, PST-o scores were lower for women ($\beta = -0.52$).

PST expressive factor (PST-exp). The final model accounted for 19.6% of the variance (adj. $R^2 = 0.19$; $\Delta R^2 = 0.13$, $p < .001$; $F(12, 139) = 3.87$, $p < .001$). PST-exp scores increased with IRI-PT ($\beta = 0.30$). In addition, PST-exp scores were lower (indicating higher emotional distance) for psychoanalysts when compared to cognitive behavioral therapists ($\beta = -0.46$).

PST instructional factor (PST-i). The regression model was not significant, $F(12, 139) = 0.70$, $p = .755$.

Discussion

The current study has been the first to examine the associations between PST, empathy and ToM performance among Argentine therapists. Furthermore, we took into account potential effects of theoretical framework, years of experience and current practice variables. Significant associations were found between PST dimensions (excluding PST-i), cognitive and affective empathy measures, but not with ToM skills. In addition, we observed differences in PST dimensions between therapists from different theoretical backgrounds (particularly, CBT and psychoanalysis), while empathy and ToM measures did not differ significantly. We also found effects of sex and patient load over specific PST measures (PST-o and PST-a, respectively), but not of therapists' age or clinical experience. We will discuss these findings in detail in the following paragraphs.

We found that cognitive and affective empathy scores were significant predictors of attentional, engagement and expressive PST factors. In the case of PST-a, we were surprised to find these associations, because this dimension refers to more technical and cognitive aspects of the therapists' practice (Casari et al., 2017, 2018). PST-a characterizes selective attention during the therapy sessions. Therapists with higher perspective taking scores exhibited a broader attentional focus, taking into account a wider range of the patients' topics and expressions. Higher emotional distress was associated with narrower information selection. It might be the case that a stronger disposition to adopt other people's points of view may lead therapists to give more importance to the patients' behaviors, expressions and worries, letting them take the lead during the sessions. Conversely, a stronger reaction to the patient's negative

emotions might bias the therapist's attention towards the more emotionally salient or intense topics during the sessions, narrowing their focus. Quite in fact, it has been shown that more empathic subjects (1) show an attentional bias towards painful facial stimuli (Yan et al., 2016), (2) have more difficulty disengaging from painful stimuli (Bi et al., 2021), and (3) experience stronger emotional interference effects in stroop tasks (Thompson et al., 2022).

Regarding PST-eng, both measures of affective empathy predicted stronger commitment from the therapists, as well as a larger emotional impact and significance of their practice on their lives. This finding can be interpreted in terms of motivation and emotional resonance. Since empathic concern refers to feelings of sympathy and compassion towards others, higher EC scores might constitute a source of motivation for committing to achieve the therapy goals and ease the patients' suffering. On the other hand, therapists with higher IRI-PD scores tend to feel more distressed when confronted with the patients' suffering. This may lead to a larger impact of their clinical practice on their lives, thus increasing their PST-eng factor scores.

With respect to PST-exp, higher perspective taking scores increased emotional proximity in the therapeutic relation. Since the expressive factor is considered one of the emotional aspects of PST (Castañeiras et al., 2008), we would have expected an association with affective empathy aspects. However, we observed that it was the disposition to consider the psychological perspective of others that made the therapists more responsive and affectionate towards their patients. It might be the case that IRI-PT allowed for a better assessment of the patient's emotional needs, making these therapists more available to meet them.

Despite these associations, it should be noted that we did not find evidence supporting the claims of Corbella et al. (2009) that PST-i is the factor most closely related to the therapist's cognitive empathy. They proposed that a better perception and understanding of the patient's intentions and emotions might enhance the therapist's flexibility within the therapy setting, leading to a better adjustment of their style to the patient's needs. Nevertheless, we did not observe significant associations between PST-i and cognitive empathy. Since we cannot rule out this possibility on the basis of null results, further studies are needed to elucidate the potential link between these processes. To sum up, we found that cognitive empathy was associated with broader attentional focus and less emotional distance in therapists, while affective empathy contributed to increase their commitment and the emotional significance of their work.

Contrary to our expectations and theoretical predictions (Corbella et al., 2009), we did not find any significant associations between ToM performance and PST factors. Therefore, based on our results, we cannot conclude that mentalizing skills contribute significantly to any of our therapists' PST factors (but we cannot discard this possibility either). On the other hand, it should be noted that a previous study (Hassenstab et al., 2007) that compared experienced therapists and matched controls did not find differences in the RMET either. What they did observe was a better performance of experienced therapists in a verbal mentalizing task from the Movie for the Assessment of Social Cognition (Dziobek et al., 2006). Therefore, it might be the case that the mentalizing processes directly involved in the RMET are not the same than those that are engaged in psychotherapy or are not the ones associated the most with the therapist skills. The theory proposes that ToM enhances the therapist's ability to understand the patients' mental and emotional processes, leading to a better anticipation of their behavior and reactions, better empathic responses during therapy and better emotional self-regulation in therapist-patient interactions (Corbella et al., 2009). Quite in fact, better emotional regulation abilities have been observed for therapists during experimental tasks (Pletzer et al., 2015) and as a trait (Putrino et al., 2018). While this was not evident for RMET performance, we did find evidence of a contribution of empathy to PST factors, which is in line with the previous claims. Future studies should consider including different performance-based ToM measures to further examine its association with PST.

With respect to PST differences between theoretical frameworks, our results replicated some of the previous findings (for a review, see Casari et al., 2018). We found that psychoanalysts in our sample were more emotionally distant and spontaneous than cognitive behavioral therapists (Ferreira et al., 2019; Vázquez & Gutiérrez, 2015). These characteristics might be associated with the psychoanalytic concepts of transference management and evenly suspended attention. Cognitive behavioral therapists, on the other hand, showed a preference for structured interventions over psychoanalysts and integrative therapists (Casari et al., 2019) and higher engagement (when compared to systemic therapists). Since most CBT treatments and interventions follow specific protocols, it is not surprising that these therapists prefer more structured settings. However, this is the first time that higher engagement was observed in cognitive behavioral therapists when compared to systemic therapists (although a non-significant trend could be seen with respect to integrative therapists). This might

be indicative of stronger commitment with the therapy goals and/or stronger emotional resonance of therapy in their personal lives. This result should be replicated and further analyzed to elucidate this question.

Regarding the effects of contextual and individual variables on PST factors, we were unable to observe some of the previously reported findings (for a review, see Casari et al., 2018). Gómez et al. (2011) found that less experienced therapists showed more focused attention and preferred more structured interventions, while we did not observe any association between the years of experience and PST factors. As for demographic factors, Castañeiras et al. (2008) found that male therapists exhibited more focused attention, while a broader attention focus and more spontaneous interventions were observed in older therapists. In our case, more spontaneous interventions were observed in female therapists (see PST-o scores in the result section, lower scores for women), but no significant age differences were found in PST scores (see Table 4, no significant effect of age). In addition, a higher patient load (a variable that had not been considered in previous PST studies) was associated with a broader attention focus among our therapists. This finding might be interpreted as a cognitive load effect on the therapist's attention or a result of the more extensive clinical experience that comes with intense practice. Since this is the first time that this result is observed, it should be replicated and further examined in future studies.

Among the potential limitations of the study, we should mention that (most of the therapists were cognitive behavioral therapists (42%), while the proportion of other theoretical backgrounds was considerably lower (less than 20% each). Future studies conducted with less theoretically biased samples might be able to find additional framework effects. Furthermore, it might be possible that the RMET was not sensitive enough to measure those mentalizing processes that are more closely associated with psychotherapy. Considering that therapists exhibit higher scores on verbal ToM tasks (see Hassenstab, 2007), future studies should consider including more complex and/or more verbal mentalizing tasks to assess their potential association with PST. In addition, future studies might benefit from including additional objective apart from the self-report measures of empathic responses, such as skin-conductance responses, heart rate (van Zonneveld et al., 2017) or brain potentials (Coll, 2018). Another limitation could be that we did not consider other personality measures that are relevant to PST factors, such as the Big Five personality factors (neuroticism, extraversion, openness, conscientiousness, and agreeableness; Casari et al.,

2019; Corbella et al., 2008; Genise, 2015) or attachment (Botella et al., 2008; Corbella et al., 2009) [See Casari et al. (2018) for a review]. Moreover, we did not consider additional factors of clinical practice that have been shown to be associated with PST factors, such as the target population. For instance, PST differences have been found for therapists working with severely disturbed patients (with a schizophrenia, borderline personality disorder, or psychosis diagnosis; Rial et al., 2006), addictions (Casari et al., 2017), or child abuse (Casari et al., 2014). Furthermore, we cannot discard potential self-selection bias effects, since all our therapists volunteered to take part in the study. With respect to the potential limitations of online surveys for RMET data collection, it should be noted that a similar procedure has been used in previous RMET studies (Olderbak et al., 2015; Tabullo et al., 2018). Furthermore, similar results between web-based and in-lab testing have been reported for psychometric questionnaires and intelligence tests (for a review, see van Ballegooijen et al., 2016). Another limitation could be that we assumed that the examined effects would take the form of linear associations and did not consider the possibility of non-linear effects (such as quadratic relations). While this seemed like a reasonable approach for first approximation to the subject, this possibility might be explored in future works. Relatedly, we did not consider potential mediation or moderation effects, since our sample size was not high enough for structural equation or path analysis models. Future studies with larger samples might further elucidate the relations between PST, empathy and ToM.

To sum up, this study has been the first to examine how PST factors are associated with empathy and ToM among Argentine therapists from different theoretical backgrounds. We found that cognitive empathy contributed to expand attentional focus and to increase emotional expressiveness, while affective empathy was associated with stronger commitment to therapy and greater emotional impact. In addition, psychoanalysts and cognitive behavioral therapists exhibited PST differences in their spontaneity and emotional distance and cognitive behavioral therapists tended to be more engaged than integrative therapists (marginal trend observed for systemic therapists as well). Our findings show that empathy is significantly associated with several aspects of PST, highlighting its importance in the psychotherapy process. Taking these effects into account might help therapists to be more aware of the impact their own empathy might have on different aspects of their working styles, enabling them to plan and monitor their interventions accordingly. In addition, therapists might also consider the consequences of theoretical

frameworks on their style and make decisions to better meet the patients' needs.

Conflicts of interest

The authors have no conflicts of interest to declare.

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Supplementary materials

Table 4. PST regression analysis: coefficients (extended version)

Predictor	Estimate	SE	95% Confidence Interval		t	p	Stand. estimate
			Lower	Upper			
PST-a: Model 2							
Age	0.04	0.08	-0.12	0.19	0.43	.667	0.05
Yearsexp	0.02	0.11	-0.21	0.24	0.14	.889	0.02
Patweek	-0.12	0.05	-0.21	-0.03	-2.53	.012	-0.21
Sex							
Women – men	0.73	13.62	-19.61	34.25	0.54	.592	0.13
Theory							
Integrative – CBT	-15.11	11.49	-37.82	0.76	-1.32	.190	-0.27
Systemic – CBT	-0.45	12.73	-29.64	20.71	-0.35	.726	-0.08
Psychoanalysis – CBT	-18.69	12.99	-44.38	0.70	-1.44	.153	-0.34
RMET	-0.43	0.30	-10.22	0.16	-1.43	.155	-0.11
IRI-FAN	0.03	0.09	-0.15	0.22	0.38	.707	0.03
IRI-PT	-0.29	0.11	-0.51	-0.06	-2.53	.012	-0.23
IRI-EC	-0.10	0.13	-0.35	0.15	-0.76	.446	-0.07
IRI-PD	0.24	0.11	0.03	0.44	2.23	.027	0.20
PST-eng: Model 2							
Age	0.07	0.07	-0.06	0.20	10.17	.311	0.11
Yearsexp	-0.02	0.09	-0.21	0.16	-0.26	.796	-0.03

Predictor	Estimate	SE	95% Confidence Interval		t	p	Stand. estimate
			Lower	Upper			
Patweek	-0.03	0.04	-0.11	0.04	-0.88	.382	-0.07
Sex							
Women - men	-0.09	11.55	-23.76	21.91	-0.08	.937	-0.02
Theory							
Integrative – CBT	-17.70	0.97	-36.95	0.16	-18.17	.071	-0.36
Systemic – CBT	-29.42	10.80	-50.77	-0.81	-27.26	.007	-0.59
Psychoanalysis – CBT	-0.69	11.02	-28.71	14.86	-0.63	.531	-0.14
RMET	0.11	0.25	-0.39	0.61	0.44	.663	0.03
IRI-FAN	0.11	0.08	-0.05	0.26	13.63	.175	0.12
IRI-PT	0.16	0.10	-0.03	0.35	16.71	.097	0.15
IRI-EC	0.23	0.11	0.02	0.45	21.86	.031	0.19
IRI-PD	0.27	0.09	0.09	0.44	30.05	.003	0.25
PST-o: Model 1							
Age	-0.11	0.08	-0.26	0.04	-1.43	.156	-0.15
Yearsexp	-0.17	0.11	-0.40	0.05	-1.50	.136	-0.16
Patweek	0.04	0.05	-0.06	0.13	0.78	.436	0.06
Sex							
Women – Men	-31.52	13.60	-58.40	-0.46	-2.32	.022	-0.52
Theory							
Integrative – CBT	-24.91	11.63	-47.89	-0.19	-2.14	.034	-0.41
Systemic – CBT	-23.73	13.06	-49.53	0.21	-1.82	.071	-0.39
Psychoanalysis – CBT	-61.32	12.86	-86.73	-35.91	-4.77	<.001	-11.01
PST-exp: Model 2							
Age	-0.14	0.07	-0.27	0	-1.98	.050	-0.21
Yearsexp	0.12	0.10	-0.08	0.31	1.18	.240	0.12
Patweek	0.07	0.04	-0.01	0.15	1.71	.090	0.14
Sex							
Women – men	-11.09	12.01	-34.83	1.27	-0.92	.357	-0.22
Theory							
Integrative – CBT	10.19	10.13	-0.98	3.02	1.01	.316	0.20
Systemic – CBT	-11.05	11.22	-33.24	1.11	-0.99	.326	-0.21
Psychoanalysis – CBT	-23.79	11.45	-46.44	-0.11	-2.08	.040	-0.46
RMET	0.41	0.26	-0.11	0.94	1.56	.122	0.12
IRI-FAN	0.07	0.08	-0.09	0.23	0.87	.389	0.07
IRI-PT	0.34	0.10	0.15	0.54	3.45	<.01	0.30
IRI-EC	0.05	0.11	-0.18	0.27	0.40	.687	0.04
IRI-PD	-0.08	0.09	-0.26	0.11	-0.82	.412	-0.07
PST-i: Model 2							
Age	0.04	0.06	-0.07	0.15	0.70	.483	0.08
Yearsexp	-0.04	0.08	-0.20	0.12	-0.50	.617	-0.06
Patweek	0.04	0.03	-0.03	0.10	11.48	.253	0.10

Predictor	Estimate	SE	95% Confidence Interval		t	p	Stand. estimate
			Lower	Upper			
Sex							
Women – men	-14.62	0.99	-34.11	0.49	-14.83	.140	-0.39
Theory							
Integrative – CBT	0.01	0.83	-16.29	16.58	0.02	.986	0.00
Systemic – CBT	-0.63	0.92	-24.47	11.97	-0.68	.499	-0.17
Psychoanalysis – CBT	-0.63	0.94	-24.89	12.30	-0.67	.505	-0.17
RMET	0.06	0.22	-0.37	0.49	0.26	.798	0.02
IRI-FAN	-0.05	0.07	-0.18	0.08	-0.72	.473	-0.07
IRI-PT	0.09	0.08	-0.07	0.25	10.98	.274	0.11
IRI-EC	-0.09	0.09	-0.27	0.09	-0.95	.342	-0.09
IRI-PD	0.01	0.08	-0.14	0.16	0.14	.891	0.01

Note. PST: personal style of the therapist; a: attentional factor; eng: engagement factor; o: operative factor; exp: expressive factor; i: instructional factor; yearsexp: years of experience; patweek: patients per week; CBT: cognitive behavioral therapy; RMET: Reading the Mind in the Eyes test; IRI: Interpersonal Reactivity Index; FAN: fantasy; PT: perspective taking; EC: empathic concern; PD: personal distress.