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Attachment anxiety, reflective functioning and well-being as predictors of burn-out and psychological distress among psychotherapists: A longitudinal study

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Abstract

Objective: This study aims to longitudinally investigate the effects of individual's factors on subsequent burn-out/psychological distress in a sample of mental health practitioners, testing if higher attachment anxiety and avoidance and lower reflective functioning (i.e., certainty and uncertainty of mental states) and well-being at baseline may lead to a greater psychological distress and burn-out 1 year later.

Methods: The sample consisted of 40 experienced psychotherapists (females: 72.5%; mean age: 47.40 ± 9.48 years) who completed a battery of questionnaires at baseline and 1 year later. Statistical analyses were conducted with Bayesian multiple linear regressions.

Results: Greater attachment anxiety and certainty about mental states and lower individual's well-being at baseline predicted greater burn-out 1 year later. Similarly, greater attachment anxiety and lower individual's well-being at baseline predicted psychological distress at 1 year follow-up. Of note, uncertainty of mental states and avoidant attachment were not associated with outcomes.

Conclusion: These findings suggest that the levels of burn-out and psychological distress among psychotherapists may be alleviated with interventions targeting attachment insecurity, specific aspects of reflective functioning (i.e., certainty about mental states) and well-being.

KEYWORDS
attachment, burn-out, distress, psychotherapists, reflective functioning, well-being

1 | INTRODUCTION

Psychotherapeutic work is considered one of the most emotionally demanding jobs due to the significant emotional involvement required of therapists while working with patients (Dattilio, 2015; Posluns & Gall, 2020). One could argue that—compared to the general population—mental health practitioners may be at a greater risk for experiencing two closely linked symptoms, namely, distress and burn-

out (Ahola et al., 2014; Hakanen & Schaufeli, 2012; Posluns & Gall, 2020). Some recent surveys showed that approximately 50% of psychotherapists reported at least some work-related distress (Kaeding et al., 2017; Simionato & Simpson, 2018; Westwood et al., 2017). Research indicates that work-related distress can lead to the development of occupational burn-out (Carmona-Barrientos et al., 2020; Lee et al., 2011; McCormack et al., 2018; Yang & Hayes, 2020).

Burn-out is a syndrome characterized by an 'unpleasant experience of work life with negative implications for performance, health, and well-being' (p.17) that has at its core three main features: mental exhaustion, depersonalization and negative self-assessment of one's own professional competencies (Maslach et al., 2009). When experienced by a mental health practitioner, burn-out may compromise the therapist's key competencies and his/her overall mental health, leading to negative consequences for client treatment outcomes, including also the impairment of the quality of the therapeutic alliance (Delgadillo et al., 2018; Salyers, Flanagan, et al., 2015; Salyers, Fukui, et al., 2015; Wampold, 2015; Zilcha-Mano et al., 2016).

Previous cross-sectional studies identified some potential predictors of distress and burn-out among healthcare practitioners, including work-related variables (e.g., caseload, working in the public sector, lower income and lack of social support) and individual characteristics (e.g., younger age, perfectionistic traits, lower flexibility and personal resources; Arrogante & Aparicio-Zaldivar, 2020; Emery et al., 2009; Nissen-Lie et al., 2021; Simionato & Simpson, 2018; Steel et al., 2015; Yang & Hayes, 2020; Posluns & Gall, 2020). However, to date, very few studies examined the longitudinal predictors of burn-out and its counterpart (i.e., psychological distress) among psychotherapists.

A first potential predictor may be well-being. Indeed, in several cross-sectional studies, higher well-being—that is, the subjective feeling of 'contentment, satisfaction, or happiness derived from optimal functioning' (McDowell, 2010, p.70)—was associated with lower burn-out symptoms (Beaumont et al., 2016; Hardiman & Simmonds, 2013; Linley & Joseph, 2007). Furthermore, interventions aimed at improving therapists' positive psychological well-being (e.g., mindfulness-based interventions) demonstrated effectiveness in reducing perceived work-related burden, thus providing evidence for self-care strategies in promoting quality of life (Lomas et al., 2018; Scarnera et al., 2009). Of note, most of the current literature on this topic are cross-sectional studies focused more on the negative effects of distress and burn-out on well-being, rather than on the predictive role of well-being on the future development of psychological distress and burn-out (McCormack et al., 2018; Yang & Hayes, 2020).

Another potential predictor of therapists' psychological distress and burn-out, which has also been consistently linked to therapy outcomes, is the reflective functioning (RF) or mentalizing. RF is the 'capacity to understand others' and one's own behaviour in terms of mental states' (Fonagy & Allison, 2014, p. 372). Two broad types of dysfunctions in RF are hypomentalizing and hypermentalizing. The first impairment, also called concrete thinking, can be described as the inability to consider complex models of mental states of self and others (Fonagy & Allison, 2014). On the contrary, hypermentalizing or

excessive mentalizing refers to the opposite tendency, where the individual over-attribute mental states to others without appropriate evidence available to support these attributions (Fonagy & Allison, 2014).

Former studies have highlighted the positive effect of therapist's RF on different aspects of therapy outcomes, including working alliance, ability to resolve alliance ruptures, patients' outcomes and change and therapist effectiveness (Cologon et al., 2017; Reading et al., 2019). While some cross-sectional studies showed an association between RF and lower levels of psychological distress, others found inconclusive evidence (Falkenström et al., 2014; Katznelson, 2014). Further, enhancing therapists' RF through practice may reduce perceived psychological distress over time (Bennett-Levy, 2019), even though the effect of enhanced mentalizing abilities on burn-out remains unclear. Additional studies using a longitudinal design are warranted to understand better the role of RF in the progression of both burn-out symptoms and psychological distress among psychotherapists.

RF emerges through interactions with caregivers, and previous studies reported that RF is strongly influenced by attachment dimensions (Slade, 2005). That is, children of parents with secure attachments are more likely to develop a greater capacity to mentalize compared to children of parents with insecure attachments (Luyten et al., 2020). Attachment insecurity can be differentiated into anxious and avoidant dimensions. Individuals with greater attachment avoidance tend to suppress feelings, disengage from relationships and distance themselves from their emotions. Those with greater attachment anxiety tend to experience hyperactivation of emotions, fear abandonment in relationships and have difficulties in managing negative emotions (Bowlby, 1973). Further, attachment has been previously linked to therapist's health and therapy outcomes. Indeed, two recent systematic reviews highlighted how therapist's attachment style may contribute to therapy outcomes (Degnan et al., 2016) through the interaction with other well-known process variables (e.g., therapeutic techniques, patient's pathology and therapeutic alliance; Lingiardi et al., 2018). Different cross-sectional studies also found that anxious

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Key Practitioner Message

- We investigated three personal and therapy-non-specific variables of mental health practitioners, namely, attachment insecurity, reflective functioning and well-being.
- We tested if these variables predicted distress or burn-out 1 year later, through Bayesian analyses.
- Results were partly in accordance with literature and evidenced that attachment anxiety, well-being and certainty about mental states were longitudinally associated with outcomes.
- Therapists are warranted to attend to their own holistic well-being through a variety of self-care practices, so to better cope with negative long-term outcomes.

or insecure attachment dimensions were associated with occupational burden in large samples of psychotherapists (Nissen-Lie et al., 2021) or workers (Leiter et al., 2015; Pines, 2004; Vîrgă et al., 2019), respectively. These findings suggest that therapist's attachment style may play a role in perceived psychological distress and in the development of burn-out symptoms.

The aim of the current study is to investigate the longitudinal effects of therapists' well-being, RF and insecure attachment on their levels of distress and burn-out. Research on this topic would provide additional insights of some personal and therapy-non-specific variables (Beutler et al., 2004), which—according to other taxonomies—may fall within the 'attitudes, feature, or personality' characteristics of therapists (Wampold & Owen, 2021) and that have been largely neglected to date. Therefore, we conducted a longitudinal study with 1-year follow-up in a sample of experienced psychotherapists. According to previous findings on this topic (Leiter et al., 2015; Nissen-Lie et al., 2021; Pines, 2004; Vîrgă et al., 2019), we hypothesized that higher attachment anxiety will predict greater psychological distress and burn-out 1 year later, whereas higher RF and psychological well-being will predict lower psychological distress and burn-out 1 year later (Beaumont et al., 2016; Hardiman & Simmonds, 2013; Katznelson, 2014; Linley & Joseph, 2007).

2 | METHOD

2.1 | Participants

A total of 40 Italian psychotherapists (females: 72.5%; mean age: 47.40 ± 9.48 years) were recruited for this study. The majority (70%) of the participants were in a romantic relationship. Most had a master's degree in psychology ($n = 38$), and two had a Ph.D. in a related field. All attended a 4- to 5-year post-graduate specialization in a psychotherapy training institution. On average, participants worked in the private ($n = 30$) or both public and private sector ($n = 8$), practiced psychotherapy for a mean of 14 ± 9.45 years and had a median caseload of 15 patients. Finally, 70% of the entire sample followed an integrative approach to psychotherapy and 10% a psychodynamic approach.

2.2 | Procedure

The first wave of these data was collected online from a sample of Italian psychotherapists between October 2016 and November 2019. During this time, we recruited a total of 416 participants, 224 of those (53.8%) provided their email address to be contacted for a future follow-up study (further details are reported in Brugnera et al., 2021). Approximately 1 year after the first data collection, we emailed all those participants who agreed to participate—for a maximum of three times—asking them to complete the follow-up questionnaires. Study aims were first briefly mentioned in the email and then detailed in the first page of the survey. Sixty-nine individuals out of 224 participants (30.8% of the total) accessed the follow-up measures, of whom

48 (21.4% of the total) provided at least sociodemographic data and 40 (17.9% of the total) sufficient data for this study.

This study was conducted in accordance with APA ethical standards for the treatment of human experimental volunteers. Those from the first wave who agreed to participate (i.e., provided informed consent) were subsequently redirected to a webpage detailing the overall aims of the research and the names and contact information of the researchers. Participants then had access to a demographic survey and a battery of questionnaires (see below for details). Inclusion criteria were (1) completed a post-graduate programme in a psychotherapy training institution or a medical degree with post-graduate specialization in psychiatry and (2) being an Italian native speaker.

2.3 | Measures

2.3.1 | Attachment

The Italian version of the Experiences in Close Relationships—Revised (ECR-R; Busonera et al., 2014; Fraley et al., 2000) is a 36-item self-report measure of attachment to romantic partners. The ECR-R measures two dimensions, namely, attachment avoidance (18 items) and attachment anxiety (18 items). Items are scored on a 7-point Likert scale (1 = strongly disagree; 7 = strongly agree). Mean total scores range from 1 to 7, with higher scores indicating greater attachment avoidance and/or attachment anxiety. In the current study, the reliability of both subscales at baseline was good to excellent (Anxiety: McDonald's $\omega = 0.87$; Avoidance: McDonald's $\omega = 0.90$).

2.3.2 | Self-reported RF

The Italian version of the Reflective Functioning Questionnaire (RFQ; Fonagy et al., 2016; Morandotti et al., 2018) is an eight-item self-report measure of RF or mentalizing. It measures two different domains: Certainty about mental states (RFQc) and Uncertainty about mental states (RFQu). As regards RFQc, very low scores on this scale reflect an excessive confidence in one's own knowledge of mental states, while high scores reflect a more genuine mentalizing (Sacchetti et al., 2019). As regards RFQu, very high scores on this scale reflect hypomentalizing (i.e., a lack of knowledge about mental states), while lower scores reflect a more genuine mentalizing (i.e., acknowledgment of the opaqueness of one's own mental states and that of others). For both subscales, total scores range from 0 to 18. Regarding the construct validity, the RFQ scales correlate in opposite directions with measures of perspective-taking, psychological distress, empathy and mindfulness and with both self-reported and clinician-rated measures of maladaptive personality functioning (Fonagy et al., 2016; Morandotti et al., 2018; Sacchetti et al., 2019). The RFQ scales also discriminate well between patients with personality or eating disorders and healthy controls, with patients scoring higher on the RFQu and significantly lower on the RFQc than controls (Morandotti et al., 2018; Sacchetti et al., 2019). In the current study, the reliability

of both subscales at baseline was fair to adequate (RFQc: McDonald's $\omega = 0.66$; RFQu: McDonald's $\omega = 0.75$).

2.3.3 | Well-being

The Italian version of the Psychosocial General Well-Being Index (PGWB; Dupuy, 1984; Grossi et al., 2002) is a 22-item self-report questionnaire that evaluates psychological and general quality of life during a 4-week period. Considered one the most psychometrically sound measures of self-perceived well-being (McDowell, 2010), the PGWB measures six health-related quality of life domains, namely, anxiety, depressed mood, positive well-being, self-control, general health and vitality, which can be summed into a total score. Each item is rated on a 6-point Likert scale (0 to 5). Total scores range from 0 to 110, with higher scores indicating greater well-being. In the current study, the reliability of the total score at baseline was excellent (McDonald's $\omega = 0.90$).

2.3.4 | Burn-out

The Italian version of the Maslach Burn-out Inventory (MBI; Maslach & Jackson, 1981; Sirigatti et al., 1988) is a 22-item self-report measure of burn-out. The MBI is a well-known and widely adopted measure that examines three components of burn-out, namely, emotional exhaustion (EE; nine items), depersonalization (D; five items) and personal accomplishments (PA; eight items). Once the D subscale score was reversed, the three components of burn-out were summed into a single total score. Each item is rated on a 7-point Likert scale (0 = never, 6 = every day). Total scores range from 0 to 132, with higher scores indicating greater burn-out symptoms. Norms and cut-offs for the Italian population have been provided elsewhere (Sirigatti & Stefanile, 1993). In the current study, the reliability of the total score was good (McDonald's $\omega = 0.85$).

2.3.5 | Psychological distress

The Italian version of the Kessler Psychological Distress Scale 10 (K10; Kessler et al., 2003) is a 10-item measure of psychological distress experienced during the last 4 weeks. Items are rated on a 5-point Likert scale (1 = None of the time; 5 = All the time). Total scores range from 10 to 50, with higher scores indicating greater psychological distress. Above the cut-off of 20, scores are indicative of the presence of mental disorders (Andrews & Slade, 2001). In the current study, the reliability of this measure was good (McDonald's $\omega = 0.86$).

2.3.6 | Statistical analysis

Data were initially examined through descriptive statistics, including means, standard deviations and frequencies. Then, we examined the correlations between all measures adopted in this study and tested for differences in longitudinal data through Bayesian correlations (setting the stretched beta prior width to 1.0) and Bayesian paired-sample t tests (setting the uninformed default Cauchy prior to 0.707). For the latter analysis, we additionally tested for the robustness of the tests, through a series of changes in the prior width. Finally, we tested our main hypothesis on the longitudinal predictors of psychological distress and burn-out among psychotherapists through a series of Bayesian multiple regression analyses. We selected an uninformed Jeffreys–Zellner–Siow prior with an r scale of 0.354 and modelled the prior uniformly to assign equal prior probabilities for each possible model. The dependent variables of the regressions were the K10 and the MBI total scores 1-year post baseline. The predictors measured at baseline were attachment insecurity (i.e., the ECR-R Attachment Anxiety and Attachment Avoidance subscales), RF (i.e., the RFQ Certainty and RFQ Uncertainty About Mental States subscales) and well-being (i.e., PGWB total score).

We adopted Bayesian approaches rather than frequentist statistic methods for two main reasons (Gaab et al., 2020). First, Bayesian analyses considers both the likelihood of the data under null hypothesis (i.e., H_0) and under alternative hypothesis (i.e., H_1), thus weighing the support (i.e., quantifying the evidence) for one model against the other (Wagenmakers et al., 2018). Second, Bayesian analyses do not depend on very large samples to yield reliable results (Van de Schoot & Depaoli, 2014). We determined the evidence in favour of the null versus alternative hypotheses by examining the Bayes factors (BFs). A BF between 1 and 3 was considered as weak evidence in favour of H_1, 3 > BF < 10 as a moderate evidence, BF > 10 as a strong evidence and BF > 100 as extreme evidence (Jeffreys, 1961). For ease of interpretation, we reported the BF_{10} (i.e., with the model associated with H_1 in numerator and model associated with H_0 in the denominator) for both the Bayesian correlations and the regressions and the BF_{01} (i.e., with the model associated with H_0 in numerator and model associated with H_1 in the denominator) for the Bayesian crosstabs, paired and independent samples t tests. Interested readers are referred to Schmalz et al. (2021) and to the special issue edited by Vandekerckhove et al. (2018) for additional information on Bayesian methods.

The analyses were run through JASP 0.16.4 (JASP Team, 2022). All tests were two-tailed.

3 | RESULTS

3.1 | Preliminary analyses

Preliminary analyses indicated no univariate outliers among data. However, the variables RFQu (both at T0 [baseline] and T1 [1-year post baseline]), MBI and K10 were moderately positively skewed, while ECR-R Avoidance (both at T0 and T1) was slightly positively skewed. A log10 or a square-root transformation corrected the violation of the assumption of normality.

We then examined the percentage of participants who scored above the suggested cut-offs for our dependent variables. Five

therapists (12.5%) had K10 scores between 20 and 24, which is suggestive of the presence of mild mental disorders, and two (5%) had scores between 25 and 29, suggesting the presence of moderate mental disorders (Andrews & Slade, 2001). As for the MBI, 19 participants (47.5%) had moderate-to-high levels of emotional exhaustion (i.e., an EE subscale score ≥14), nine (22.5%) had moderate-to-high level of depersonalization (i.e., a D subscale score ≥3) and 20 (50%) had moderate-to-high levels of low personal accomplishment (i.e., a PA subscale score ≤38) (Sirigatti & Stefanile, 1993).

Also, we tested for the presence of a sampling selection bias. Using Bayesian contingency tables and independent samples t tests, we compared the baseline sociodemographic and work-related variables (age, sex, years of professional experience, number of clients currently in treatment and therapeutic orientation) and the psychological variables of the current sample at baseline ($n = 40$) with those of the non-respondents ($n = 376$; reported previously by Brugnera et al., 2021). We found weak to moderate evidence in favour of H_0 (i.e., no group differences) for all variables examined except for age, which had weak evidence in favour of H_1 (i.e., presence of a between-group difference). That is, we found weak to moderate support for the hypothesis of no sampling selection bias in the current study sample (see Supporting Information for descriptives and detailed results).

The PGWB total score (both at T0 and at T1) was negatively correlated with psychological distress and burn-out symptoms. Similarly, the ECR-R Attachment Anxiety subscale (both at T0 and at T1) positively correlated with the K10 and MBI total scores. That is, the hypothesis of an association between ECR-R Attachment Anxiety at baseline and psychological distress 1 year later was 1099 times more likely than that of no linear associations between the two variables (H_0; $r = 0.62$, $BF_{10} = 1098.71$), and this likelihood indicated decisive evidence. On the contrary, the support for the correlation between Certainty and Uncertainty RFQ subscales and both K10 and MBI total scores was anecdotal (all BFs < 1).

Regarding the Bayesian paired-sample t tests comparing means at baseline to 1 year follow-up, we found moderate support for H_0 for all pairs of variables examined, indicating that H_1 (i.e., the effect size is different from zero) was 3.179 up to 5.404 less likely than H_0 (i.e., that the effect size is absent; BF_{01} ranges = 3.179–5.404). These tests were also robust to wide and ultrawide changes in the prior confidence interval width. Thus, results suggested that the psychological dimensions were stable up to 1 year after the first data collection. All means, standard deviations, BF factors and error percentage for the Bayesian paired t tests are reported in Table 1, while all Pearson's r and BF factors are reported in Table 2.

3.2 | Main analyses

The results of the Bayesian linear regression provided support for most aspects of the hypothesis regarding predicting burn-out. The best model (i.e., with the highest BF) was the one in which higher levels of burn-out 1 year later were predicted by higher baseline scores in Attachment Anxiety and RF Certainty about mental states and by lower levels of Well-Being ($BF_{10} = 2741.99$; see Table 3). Attachment Avoidance was not a significant predictor of burn-out. This model explained 51.4% of the variance in the dependent variable. The PGWB scale contributed the most to this prediction ($BF_{Inclusion} = 13.375$; see Table 4), followed by ECR-R Attachment Anxiety ($BF_{Inclusion} = 3.475$) and RFQ Certainty ($BF_{Inclusion} = 3.147$).

Results of the Bayesian linear regression also supported aspects of the hypothesis regarding predicting distress. The best model was one in which higher psychological distress 1 year later was predicted

TABLE 1 Means, standard deviations and results of Bayesian paired-sample t tests for all measures used in this study, both at T0 and at T1 ($N = 40$)

	T0 Mean (SD)	T1 Mean (SD)	BF_{01}	Error %
ECR-R Anxiety	2.52 (0.85)	2.42 (0.80)	3.179	5.281^{e-6}
ECR-R Avoidance	2.34 (0.94)	2.34 (0.97)	5.857	1.016^{e-5}
RFQc	10.78 (3.89)	10.55 (4.23)	5.404	9.367^{e-6}
RFQu	1.55 (2.49)	1.05 (1.68)	3.404	9.367^{e-6}
PGWB	83.30 (10.07)	82.23 (10.85)	4.063	6.968^{e-6}
MBI Total	\	28.38 (12.63)	\	\
MBI EE	\	16.53 (9.64)	\	\
MBI D		1.85 (3.09)		\
MBI PA		38.00 (4.77)		\
K10	\	15.50 (4.23)	\	\

Note: ECR-R Avoidance and RFQu—at both T0 and T1—were square root and log10 transformed, respectively, to correct their deviation from normality. Data reported in the table are untransformed for ease of interpretation.

Abbreviations: BF, Bayes factor; ECR-R, Experiences in Close Relationships—Revised; K10, Kessler Psychological Distress Scale 10; MBI, Maslach Burn-out Inventory (EE, Emotional Exhaustion; D, Depersonalization; PA, Personal Accomplishment; in the MBI Total score, the PA subscale score was reversed, so that greater total scores indicate greater burn-out symptoms); PGWB, Psychosocial General Well-Being Index; RFQ, Reflective Functioning Questionnaire (Certainty and Uncertainty about mental states subscales).

TABLE 2 Zero-order and Bayesian correlations among all the study variables ($N = 40$)

Variable(s)		1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1. MBI T1	Pearson's r	\										
	BF₁₀	\										
2. K10 T1	Pearson's r	0.68*	\									
	BF₁₀	16,829.94	\									
3. ECR-R Anx T0	Pearson's r	0.54*	0.62*	\								
	BF₁₀	106.44	1098.71	\								
4. ECR-R Anx T1	Pearson's r	0.52*	0.60*	0.76*	\							
	BF₁₀	65.64	702.42	1.309^{e+6}	\							
5. ECR-R Avoid T0	Pearson's r	0.19	0.27	0.57*	0.38	\						
	BF₁₀	0.39	0.76	249.20	3.17	\						
6. ECR-R Avoid T1	Pearson's r	0.31	0.15	0.57*	0.59*	0.75*	\					
	BF₁₀	1.16	0.30	274.75	510.21	464,036.61	\					
7. RFQc T0	1	−0.02	−0.15	−0.38	−0.25	−0.37	−0.36	\				
	BF₁₀	0.20	0.30	3.07	0.62	2.85	2.39	\				
8. RFQc T1	Pearson's r	−0.17	−0.25	−0.36	−0.40	−0.35	−0.28	0.65*	\			
	BF₁₀	0.33	0.60	2.51	4.92	2.22	0.87	3613.69	\			
9. RFQu T0	Pearson's r	0.19	0.11	0.32	0.11	0.35	0.28	−0.64*	−0.42	\		
	BF₁₀	0.39	0.25	1.30	0.25	2.05	0.83	2319.53	7.08	\		
10. RFQu T1	Pearson's r	0.35	0.29	0.46*	0.38	0.34	0.36	−0.53*	−0.50	0.71*	\	
	BF₁₀	2.02	0.92	14.58	3.11	1.81	2.33	82.78	31.89	48,315.34	\	
11. PGWB T0	Pearson's r	−0.62*	−0.58*	−0.62*	−0.59*	−0.37	−0.44	0.33	0.30	−0.41	−0.49*	\
	BF₁₀	1373.12	358.69	1054.42	485.61	2.69	9.96	1.66	1.072	5.68	25.19	\
12. PGWB T1	Pearson's r	−0.56*	−0.81*	−0.65*	−0.67*	−0.40	−0.35	0.06	0.22	−0.07	−0.21	0.73*
	BF₁₀	197.95	2.966^{e+7}	3630.99	9878.64	4.93	2.12	0.21	0.50	0.22	0.43	228,070.93

Note: Correlations with BF > 10 are marked with asterisks.

Abbreviations: BF, Bayes factor; ECR-R, Experiences in Close Relationships—Revised (Anxiety and Avoidance subscales); K10, Kessler Psychological Distress Scale 10; MBI, Maslach Burn-out Inventory; PGWB, Psychosocial General Well-Being Index; RFQ, Reflective Functioning Questionnaire (Certainty and Uncertainty about mental states subscales).

TABLE 3 Results of the Bayesian linear regression analyses of well-being, attachment insecurity and reflective functioning at baseline (T0) predicting burn-out and distress 1-year post baseline (T1)

	$P(M)$	$P(M|data)$	BF_M	BF_{10}	R^2
Model comparison—MBI at T1					
Null model	0.031	8.913^{e-5}	0.003	1.000	0.000
* ECR-R Anxiety (T0) + RFQc (T0) + PGWB (T0)	0.031	0.244	10.026	2741.992	0.514
ECR-R Anxiety (T0) + RFQc (T0) + PGWB (T0) + RFQu (T0)	0.031	0.173	6.474	1938.467	0.541
ECR-R Anxiety (T0) + ECR-R Avoidance (T0) + RFQc (T0) + PGWB (T0)	0.031	0.085	2.892	957.402	0.519
ECR-R Anxiety (T0) + ECR-R Avoidance (T0) + RFQc (T0) + PGWB (T0) + RFQu (T0)	0.031	0.079	2.667	888.932	0.552
ECR-R Anxiety (T0) + PGWB (T0)	0.031	0.066	2.176	735.830	0.429
RFQc (T0) + PGWB (T0)	0.031	0.062	2.039	692.392	0.427
PGWB (T0)	0.031	0.058	1.911	651.439	0.374
RFQc (T0) + PGWB (T0) + RFQu (T0)	0.031	0.036	1.167	407.051	0.452
ECR-R Anxiety (T0) + ECR-R Avoidance (T0) + PGWB (T0)	0.031	0.031	0.978	343.154	0.446
Model comparison—K10 at T1					
Null model	0.031	4.624^{e-5}	0.001	1.000	0.000
* ECR-R Anxiety (T0) + PGWB (T0)	0.031	0.254	10.582	5503.664	0.494
ECR-R Anxiety (T0) + RFQc (T0) + PGWB (T0)	0.031	0.118	4.143	2549.761	0.512
ECR-R Anxiety (T0)	0.031	0.103	3.560	2227.500	0.416
ECR-R Anxiety (T0) + PGWB (T0) + RFQu (T0)	0.031	0.103	3.551	2222.616	0.508
ECR-R Anxiety (T0) + ECR-R Avoidance (T0) + PGWB (T0)	0.031	0.091	3.105	1968.807	0.504
ECR-R Anxiety (T0) + ECR-R Avoidance (T0) + RFQc (T0) + PGWB (T0)	0.031	0.042	1.351	903.377	0.517
ECR-R Anxiety (T0) + RFQc + PGWB (T0) + RFQu (T0)	0.031	0.039	1.257	842.547	0.515
ECR-R Anxiety (T0) + ECR-R Avoidance (T0) + PGWB (T0) + RFQu (T0)	0.031	0.036	1.166	783.978	0.513
PGWB (T0)	0.031	0.036	1.150	773.763	0.380

Note: In these analyses, the 10 best models were compared with the null model ($N = 40$). The best model is marked with an asterisk.
Abbreviations: BF, Bayes factor; ECR-R, Experiences in Close Relationships—Revised (Anxiety and Avoidance subscales); K10, Kessler Psychological Distress Scale 10; MBI, Maslach Burn-out Inventory; PGWB, Psychosocial General Well-being Index; RFQ, Reflective Functioning Questionnaire (Certainty and Uncertainty about mental states subscales).

by higher Attachment Anxiety and lower Well-Being at baseline ($BF_{10} = 5503.66$). RFQ scores and Attachment Avoidance did not predict distress. This model explained 49.4% of the variance in the dependent variable. Attachment Anxiety contributed the most to this prediction ($BF_{Inclusion} = 11.609$), followed by Well-Being ($BF_{Inclusion} = 3.488$). Post hoc analyses adding caseload and working experience as covariates in Bayesian regressions yielded to identical results. That is, adjusting for these covariates did not affect our results.

4 | DISCUSSION

The present study aimed to investigate the predictive role of baseline RF, insecure attachment and well-being on the levels of burn-out and

psychological distress 1 year later in a sample of experienced psychotherapists, by using a Bayesian approach. In our sample of psychotherapists, 20% up to 50% reported moderate to high levels of psychological distress and burn-out symptoms. This is consistent with previous research that found that between 20% and 40% of psychotherapists reported some symptoms of burn-out at some point during their career (Yang & Hayes, 2020). Given the well-known negative effects of burn-out on both practitioners' well-being and therapy quality, identifying predictors of psychological distress and symptoms of burn-out among psychotherapists should be considered a priority for research in clinical and training settings.

We found evidence that higher attachment anxiety, higher certainty about mental states and lower well-being predicted therapist's burn-out a year later. We also found evidence that higher attachment anxiety and lower well-being predicted therapist's psychological

TABLE 4 Posterior summaries of coefficients for the Bayesian linear regression analyses on MBI and K10 total scores ($N = 40$)

	P(incl)	P(incl|data)	$BF_{Inclusion}$	Mean	SD
Coefficient—MBI					
Intercept	1.000	1.000	1.000	1.417	0.021
ECR-R Anxiety	0.500	0.777	3.475	0.057	0.042
ECR-R Avoidance	0.500	0.279	0.387	−0.013	0.050
RFQc	0.500	0.759	3.147	0.010	0.008
PGWB	0.500	0.930	13.375	−0.007	0.003
RFQu	0.500	0.382	0.618	0.032	0.063
Coefficient—K10					
Intercept	1.000	1.000	1.000	1.177	0.013
ECR-R Anxiety	0.500	0.921	11.609	0.053	0.025
ECR-R Avoidance	0.500	0.258	0.348	−0.007	0.029
RFQc	0.500	0.286	0.400	8.331^{e-4}	0.002
PGWB	0.500	0.777	3.488	−0.003	0.002
RFQu	0.500	0.260	0.352	−0.007	0.024

Abbreviations: BF, Bayes factor; ECR-R, Experiences in Close Relationships—Revised (Anxiety and Avoidance subscales); K10, Kessler Psychological Distress Scale 10; MBI, Maslach Burn-out Inventory; PGWB, Psychosocial General Well-Being Index; RFQ, Reflective Functioning Questionnaire (Certainty and Uncertainty about mental states subscales).

distress at 1 year post baseline. Overall, these findings support the notion that personal factors (i.e., levels of attachment anxiety and of certainty about mental states) and well-being (i.e., one's capacity for personal growth, self-actualization and fulfilment of one's own potential and true nature) may play a role in the development of burn-out and distress among psychotherapists.

More specifically, we found moderate-to-strong evidence that well-being at baseline was a negative predictor of both therapist's burn-out symptoms and psychological distress after 1 year, thus supporting the hypothesis that well-being may act as a key protective factor. That is, therapists who cultivate a greater positive well-being (e.g., through self-care and mindfulness practices) may safeguard themselves from work-related stress and negative affect that sometimes are characteristics of their work (Bennett-Levy, 2019; Dattilio, 2015; Davis & Hayes, 2011; Lomas et al., 2018). Given that well-being has also been linked to more adaptive emotion regulation strategies, it could be argued that therapists who cultivate greater psychological and overall quality of life could also better regulate their emotions and engage in more proactive self-care strategies, subsequently leading to a lower distress and burn-out (Karreman & Vingerhoets, 2012; Zapf, 2002).

A second finding from our Bayesian linear regression was that anxious attachment positively predicted both distress and burn-out symptoms 1 year later, while no evidence for the effects of avoidant attachment on both dependent variables was found. These results are in line with previous findings reporting the effect of anxious attachment on burn-out symptoms (Leiter et al., 2015; Nissen-Lie et al., 2021; Pines, 2004; Vîrgă et al., 2019). Therapists with high levels of attachment anxiety may over-amplify the negative affects experienced during the therapeutic work (Strauss & Petrowski, 2017), which could lead to greater burn-out and distress symptoms in the

long run. Individuals with higher levels of attachment anxiety are characterized by a greater difficulty in trusting others and regulating their negative emotions (Mikulincer & Shaver, 2007). They may respond to stressful events by adopting emotion-focused or hyperactivating coping strategies, which in turn sustain or escalate their worries and keep their attachment systems activated (Brugnera et al., 2019). Our findings are also consistent with previous clinical research which highlighted that anxiously attached individuals, including therapists, have reduced abilities to cope with occupational distress and are at a higher risk of developing burn-out syndrome (Gökdağ, 2021; Leiter et al., 2015; Mikulincer & Shaver, 2007, 2019; Nissen-Lie et al., 2021; Pines, 2004; Vîrgă et al., 2019).

Finally, contrary to expectations, we found moderate evidence for the role of higher certainty about mental states on determining later burn-out symptoms among psychotherapists. Also, levels of RF certainty or uncertainty did not predict psychological distress 1 year later. It is possible that therapists with a higher capacity to mentalize may be more emotionally engaged with patients during the therapeutic work, and despite its importance as a therapeutic factor, emotional engagement could lead to further problems related to over-identification with clients and their distress. In addition, one of the core features that distinguished burn-out syndrome from psychological distress is the negative self-assessment of one's own professional competencies. Given that making judgements of one's own capacities implies a degree of mentalizing skills, we might speculate that more genuine mentalizing may increase therapists' likelihood to experience symptoms specifically related to the negative self-assessment (Falkenström et al., 2014; Fülöp et al., 2011; Maslach et al., 2009). The link between greater certainty about mental states and psychological distress need further investigations.

The present research is among the few studies that investigated the longitudinal predictors of distress and burn-out symptoms in a sample of experienced psychotherapists. Indeed, one of the main strengths of our study relies on the exploration of some of the least studied therapists' factors that may indirectly affect therapy outcomes (Beutler et al., 2004; Wampold & Owen, 2021). However, some limitations must be acknowledged. First, our sample included only Italian mental health practitioners who adopted a specific treatment approach (i.e., integrative), and therefore, our results may not be generalizable to other cultures, populations or therapists of other therapeutic approaches. Second, the generalizability of our findings may be limited by the small sample size and the low response rate at 1-year follow-up. Thus, selection bias cannot be excluded, even if a comparison between the current study sample and the full sample from which participants were drawn (Brugnera et al., 2021) showed little or no evidence of biased sampling. In addition, it is well known that Bayesian analyses do not depend on very large samples to provide reliable results from which to generalize to a population (Van de Schoot & Depaoli, 2014). Third, we did not include other work-related variable (e.g., supportive work environment) and psychological variables (e.g., emotion regulation and coping) that may be predictors or mediate the association among psychological factors, distress and burn-out symptoms. These variables may be studied in future research to assess the mechanisms by which attachment insecurity, well-being and mentalizing might lead to burn-out and distress in psychotherapists. Fourth, our results may be partially biased by the shared measurement variance among instruments (e.g., attachment anxiety, distress and burn-out may rely on very similar psychological tendencies, such as the trait neuroticism). Finally, we investigated attachment and RF only through self-report measures, while other interview-based measures (i.e., the Adult Attachment Interview and the Reflective Functioning Scale) could have provided alternative estimates of the attachment styles and mentalizing stances of the participants. Moreover, future research should improve consistency of reporting of burn-out among psychotherapists by adopting multidimensional burn-out measures. Although the MBI has been considered the gold standard for the measurement of burn-out, using scales that cover a broad range of burn-out symptoms, such as helplessness, tedium and work-related fatigue are also warranted (Simionato & Simpson, 2018).

In conclusion, this study deepens the understanding of the predictors of distress and burn-out symptoms among mental health practitioners, a topic with potential implications for therapist effectiveness (Heinonen & Nissen-Lie, 2020; Yang & Hayes, 2020). Our findings suggest that training programmes may focus specifically on fostering well-being and self-care of psychotherapists as protective factors (alongside occupational factors) against future work-related distress and burn-out. A recent review suggested that therapists who attend to their own holistic well-being through a variety of self-care practices may better cope with negative outcomes (Posluns & Gall, 2020). These practices may address specific areas of functioning, including awareness, balance, flexibility, physical health, social support or spirituality (for a review, see Posluns & Gall, 2020). Furthermore, the results of the current study provide additional evidence on the negative impact of attachment anxiety on therapists, suggesting that personal psychotherapy and supervision may improve current well-being (Brugnera et al., 2021) and decrease the risk of experiencing psychological distress and burn-out among psychotherapists in the long run (Bennett-Levy, 2019; Lomas et al., 2018; O'Donovan & May, 2007). Thanks to a good working alliance and the transformative potential of an empathic attachment relationship with a supervisor or one own's therapist, trainees or mental health practitioners may become acquainted with their own emotional self, work on their insecure internal working models and adopt a proactive stance toward self-care (Ensink et al., 2013; Mikulincer & Shaver, 2007; Posluns & Gall, 2020). One may also consider specific mentalization trainings for therapists (e.g., Ensink et al., 2013) which, through mindfulness-based programmes or self-care workshops, may help to reduce that emotional over-engagement with patients which is supposedly linked with worse long-term personal outcomes.

CONFLICT OF INTEREST

The authors report no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.