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RESEARCH ARTICLE

Do therapists' subjective variables impact on psychodynamic psychotherapy outcomes? A systematic literature review

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Background: Despite growing attention to the general therapist effects in a wide range of clinical settings, little is known about the individual, cross-situational, and therapy–nonspecific variables that impact on the differential effectiveness of clinicians. The current study is a systematic review of the evidence relating to the influence of therapist's subjective characteristics on outcomes of psychodynamic psychotherapies.

Method: A multistage and systematic search of articles published between 1987 and 2017 identified 30 relevant studies, which were organized into 6 areas according to the specific therapist's variable considered.

Results: Therapists' interpersonal functioning and skills showed the strongest evidence of a direct effect on treatment outcomes. Furthermore, there were preliminary evidence that therapists' attachment styles, their interpersonal history with caregivers, and their self-concept might affect outcomes through interaction effects with other constructs, such as technical interventions, patient's pathology, and therapeutic alliance. The high variability between studies on therapists' overall reflective or introspective abilities and personality characteristics suggested the need for more systematic research in these areas, whereas therapists' values and attitudes showed small effects on therapeutic outcome.

Conclusions: The present review clarifies how a deep examination of the contribution of therapists' subjective characteristics can help elucidate the complex association between relational and technical factors related to the outcome of psychodynamic treatments.

KEYWORDS

patient outcome, psychodynamic psychotherapy, systematic review, therapist characteristics, therapist effect

1 | INTRODUCTION

Despite most practice guidelines depict therapists who perform procedures on *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) categories of psychiatric disorders without considering the contribution of their individual and subjective characteristics (Norcross, 2011), growing evidence demonstrates that therapists significantly differ in their effectiveness (Crits-Christoph & Mintz, 1991; Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Goldberg, Hoyt, Nissen-Lie, Nielsen, & Wampold, 2016; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Okiishi, Lambert, Nielsen, & Ogles, 2003; Saxon, Barkham, Foster, & Parry, 2017; Zimmermann, Rubel, Page, & Lutz, 2017), and therapist factors account for 5% to 9% of outcome variance in psychotherapy (Baldwin & Imel, 2013; Crits-Christoph et al., 1991). Although this effect seems small in magnitude, a careful comparison with other therapeutic factors in psychotherapy shows that the person of the therapist represents one of the most influential factors in patient outcome, along with other key therapy ingredients, including—most notably—the well-studied therapeutic alliance (Horvath, Del Re, Flückiger, & Symonds, 2011).

To date, the underlying factors of therapist effects remain largely unexplored (Beutler, Machado, & Neufeldt, 1994). Research has mainly investigated some therapy-specific variables, such as therapists' interventions (Diener, Hilsenroth, & Weinberger, 2007; Høglend, 2014), professional characteristics (Okiishi et al., 2003), and the therapeutic relationship (Colli, Tanzilli, Dimaggio, & Lingiardi, 2014). The review of therapist factors of Beutler et al. (2004) noted the dearth of studies on the specific category of personal, cross-situational, and inferred

traits (e.g., the therapist's coping patterns, personality, emotional well-being, values, and cultural attitudes) despite the potential role of these variables.

These considerations seem particularly relevant when applied to psychodynamic and psychoanalytic treatments, which share a careful appreciation of the contribution of the therapist's subjectivity to the therapeutic field (Blagys & Hilsenroth, 2000). Although several meta-analyses have attested to their overall efficacy and effectiveness (Fonagy, 2015; Leichsenring et al., 2015; Shedler, 2010), only few studies have shed light on the role of treatment providers. The Helsinki Psychotherapy Study (Knekt et al., 2012) suggested the importance of therapists' strong and active commitment to involving patients in the therapy process, an interpersonally engaged and extroverted personality, and a less intrusive attitude in predicting faster symptom decrease in both short-term and long-term psychodynamic therapies. Moreover, the Stockholm Outcome of Psychotherapy and Psychoanalysis Project (Sandell et al., 2000, 2007) found that a variety of therapist beliefs and attitudes towards therapeutic matters had a positive effect on outcome at follow-up.

To the best of our knowledge, there has been no systematic review of empirical evidence on the influence of therapists' subjective characteristics on the outcome of psychodynamic treatments, despite the pressing need for these factors to be included in a knowledge base about how effective approaches to a variety of clinical problems should be developed and delivered.

Key Practitioner Message

- Therapists' subjective variables have the potential to influence patient response to psychodynamic psychotherapy.
- Several therapists' subjective characteristics were found to contribute to therapeutic outcomes, but generally, their direct effects are less appreciable—and meaningful in terms of effectiveness—with respect to the interaction effects with other variables.
- An improved knowledge of the role of therapists' subjective characteristics on psychodynamic psychotherapy outcomes could be useful to better understand and guide therapeutic interventions, track in-session processes with their patients, and deal with ruptures in the therapeutic alliance, in order to provide better treatments.
- Methodological weaknesses and heterogeneity across studies highlight the need for further systematic research on this topic.

2 | METHOD

The protocol and methodology of the present review were developed according to the Preferred Reporting Items for Systematic Reviews and Meta-Analysis guidelines (Moher, Liberati, Tetzlaff, & Altman, 2009).

2.1 | Search procedure

For the current review, we used a multistage approach to comprehensively examine the effect of therapists' personal characteristics that have been found in studies of psychodynamic psychotherapies. In the first step, we conducted a systematic database search on PsycINFO, PubMed, ProQuest Psychology Journals, PubPsych, Scopus, and MEDLINE databases, using the search terms: "therapist AND effects," "therapist AND outcome," "differential effects AND therapists," "effective AND therapist," "ineffective AND therapist," "therapist AND variance," "therapist AND variables," "therapist AND psychodynamic," "therapist AND variability," "therapist AND characteristics," "therapist AND factors," "therapist AND influence," and "therapist AND therapeutic process." In order to limit publication bias, we also included grey literature and unpublished dissertations. The resulting full texts were searched and, when available, retrieved from other databases (i.e., ResearchGate and ProQuest Dissertation).

Second, we scoured all references in the meta-analyses on therapist variables in the two most recent editions of *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (Baldwin & Imel, 2013; Beutler et al., 2004) and in other major chapters and theoretical articles of interest (Norcross, 2011; Orlinsky & Rønnestad, 2005; Wampold & Imel, 2015) for additional relevant articles.

In the final step, we examined psychodynamic psychotherapy outcome research reports in the 2016 and 2017 issues of the most relevant peer-reviewed journals (i.e., the *American Journal of Psychiatry*, *Clinical Psychology & Psychotherapy*, *Clinical Psychology Review*, the *Journal of Consulting and Clinical Psychology*, *Psychotherapy*, and *Psychotherapy Research*).

2.2 | Eligibility criteria

Studies were considered eligible for the current review if they presented quantitative statistical analyses of the relationship between therapists' subjective and therapy–nonspecific characteristics (predictor variables) and psychodynamic therapy outcomes. More specifically, the articles had to conform to the following criteria: (a) The abstract had to be available; (b) the full text of the report had to be available in the English language; (c) the study had to report original data; (d) the study had to have been conducted on a clinical population (of previous or current patients); (e) the participants had to have been aged 18 years or older; (f) at least one experimental condition had to have included individual psychodynamic psychotherapy (both short term and long term) as the treatment modality under investigation, with samples larger than 1; and (g) data had to have been relevant to the relationship between therapists' subjective variables (i.e., qualities that are cross-situational and relatively constant across patients; see Beutler et al., 2004), and treatment outcome had to have been reported, in terms of either correlational results or group comparisons.

Studies were excluded if they (a) had not been published in English; (b) pertained to a single case or a case series, or were qualitative, a meta-analysis, a review article, an author reply, a

correction paper, or a conference abstract, only; (c) employed nonclinician therapists (e.g., counsellors, social workers, or psychology students), nonpatient populations (e.g., university students), or a contrived equivalent to the psychotherapy environment or relationship (e.g., clinical vignettes on a "prototypical patient"); (d) did not specify that an individual psychodynamic approach had been employed in at least one experimental condition; (e) only reported data on therapists' characteristics that are inherent to the therapist's role as a psychotherapist (e.g., countertransference, therapeutic style, or theoretical orientation), the therapeutic relationship (e.g., therapists' expectations of patients' outcome, personal therapy, and clinical supervision), or the therapeutic process (e.g., therapists' alliance ratings); or (f) involved participants aged under 18 years. No limits were applied to the date of publication. When a study conveyed insufficient information to determine whether the eligibility criteria had been met, it was excluded from the review.

2.3 | Quality assessment

The quality assessment criteria were selected and adapted from those developed by Barnicot et al. (2012) and Gerber et al. (2011) and were also determined through extensive reading on the appropriate conduct of predictor–outcome analyses.

The criteria developed for the quality assessment were the following: (1) sample size for the predictors analysis ($N < 30 = 0$; $30 \leq N < 100 = 1$; $N \geq 100 = 2$; not reported = NR); (2) use of a validated and reliable structured measure to evaluate the predictor variable (not used = 0; used = 1); (3) use of a validated and reliable measure to evaluate the outcome variable (not used = 0; used = 1); (4) evidence provided on missing data by showing that (a) participants with missing outcome data did not differ from those with complete data on any of the predictor variables, (b) predictor–outcome relationships remained the same after data missingness was adjusted for, or (c) a sensitivity analysis using multiple imputation demonstrated the same results (information not provided = 0; information provided = 1; data available for entire sample of interest = NA); (5) evidence provided on the outcome distribution and appropriate analyses used (information not provided or inappropriate model used = 0; information provided or appropriate model used = 1); (6) analysis used continuous rather than dichotomized or categorical predictors when appropriate. This method increases statistical power to detect relationships between variables and does not involve the arbitrary division of predictor variables into "high" and "low" categories (continuous predictor variable was dichotomized in the predictor analysis = 0; continuous predictor was entered as a continuous variable in the predictor analysis = 1; predictor was dichotomized or categorical originally = NA); (7) conclusions of the study were justified by the sample, measures, and data analysis, as presented (note: useful to look at conclusions as stated in the study abstract; poor description, execution, or justification of a design element = 0; brief description or either a good description or an appropriate method or criteria but not both = 1; well described, executed, and, where necessary, justified design element = 2); and (8) paper published in a peer-reviewed journal (not published = 0; published = 1).

The quality assessment of each study was independently assessed by the second and fourth authors to ensure interrater reliability. Disagreements on quality scoring were discussed and resolved among all authors, and studies were not excluded on the basis of the quality evaluation.

3 | RESULTS

The identification, selection, screening, and inclusion or exclusion of studies is extensively described in a flow chart (see Figure 1), in which reasons for article rejection are clearly indicated. The initial database search produced 5,933 records, and an additional 139 records were identified through the other sources previously described. After duplicates were removed, the second and fourth authors independently screened all titles and abstracts from the initial search to individuate the studies that were eligible for full-text retrieval. Two thousand six hundred eighty-eight records were excluded because they did not meet the inclusion criteria or did not have a full text available, with interrater agreement of 90%. The remaining 334 articles were retrieved for full-text screening, and 304 were excluded due to not meeting the inclusion criteria, with interrater agreement of 82%. Uncertainties relating to an article's final inclusion in the review ($n = 7$) were resolved by the independent judgement of the first and third authors.

Thirty studies were included in the final review and then qualitatively synthesized. The current review considered broader indices of outcome, including both direct (e.g., symptom reduction) and indirect (e.g., changes in interpersonal problems, defensive functioning, or dropout rates) effects related to patients' mental health. Furthermore, the outcome assessment time points included immediately postsession, at treatment termination, at short-term follow-up (3 to 6 months after termination), at medium-term follow-up (9 to 12 months after termination), and at long-term follow-up (24 months or more after treatment termination).

3.1 | Study characteristics

Table 1 shows the descriptive characteristics of the 30 included studies. All of the studies were published in English between 1987 and 2017, with sample sizes ranging from 2 to 171 clinicians ($M = 28.55$, $SD = 33.87$, $Mdn = 16$). Of the 1,338 therapists who reported their theoretical orientation ($k = 28$), 828 (61.88%) were psychodynamically oriented and the remaining self-identified as primarily cognitive–behavioural (16.07%, $n = 215$), eclectic (10.54%, $n = 141$), humanistic (6.43%, $k = 86$), or other or not declared (5.08%, $n = 68$). In one study (Nissen-Lie, Monsen, Ulleberg, & Rønnestad, 2013), 78.3% of the therapists ($n = 55$) reported a psychoanalytic or psychodynamic orientation, and a sizable proportion also reported themselves to be significantly influenced by other theories, notably humanistic (31%) and cognitive (29.4%) orientations. One study (Samstag et al., 2008) did not specify the sample size of each of the three theoretical orientations reported.

Most of the included studies ($k = 30$) were conducted in the United States (53.4%, $k = 16$), and smaller proportions were conducted

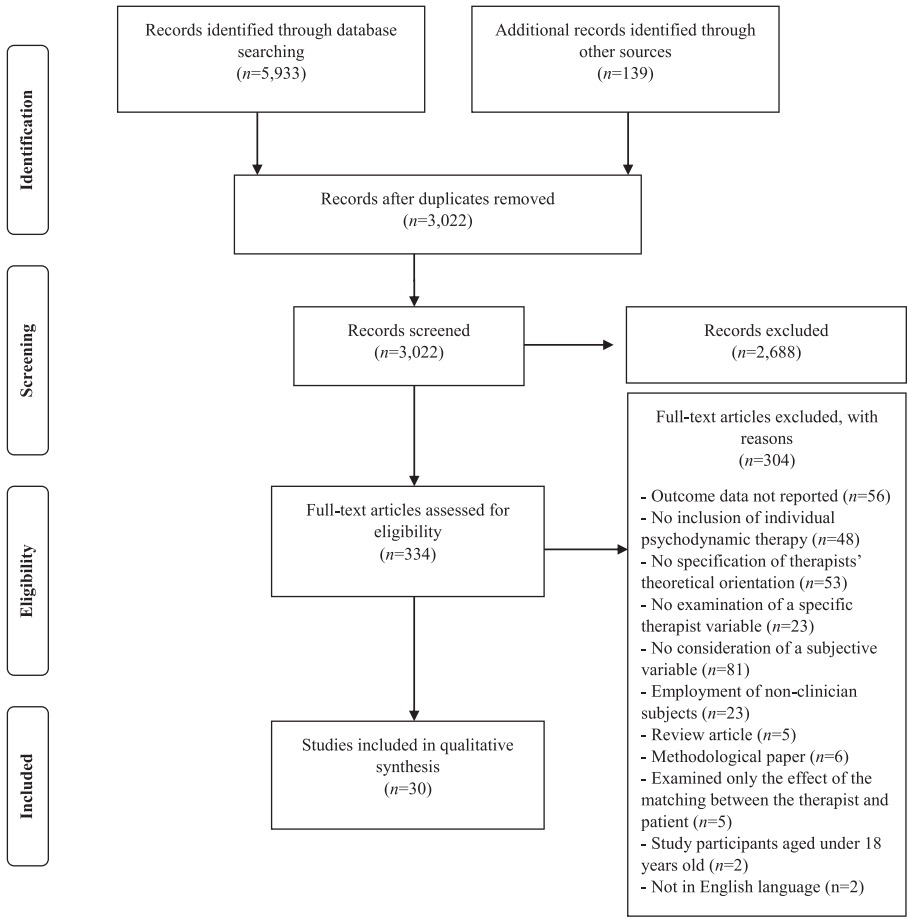

FIGURE 1 Preferred Reporting Items for Systematic Reviews and Meta-Analysis flow chart (see Moher et al., 2009)

in Norway (10%, *k* = 3), Finland (6.68%, *k* = 2), Germany (6.68%, *k* = 2), Israel (6.68%, *k* = 2), Australia (3.33%, *k* = 1), Canada (3.33%, *k* = 1), the Netherlands (3.33%, *k* = 1), Thailand (3.33%, *k* = 1), and the United Kingdom (3.33%, *k* = 1).

The naturalistic setting was most commonly adopted (73.33%, *k* = 22). Of the studies that used this research design, 18 (81.82%) reported an average length of 25.78 sessions (*SD* = 11.78, *Mdn* = 23.5), 1 (4.54%; Talley, Strupp, & Morey, 1990) reported a length ranging from 4 to 25 sessions, 1 (4.54%; Yonatan-Leus, Tishby, Shefler, & Wiseman, 2017) reported a length of 1 year, and 2 (9.10%; Williams & Fauth, 2005; Wongpakaran & Wongpakaran, 2012) did not report treatment duration. Three studies (10%; Anderson, McClintock, Himawan, Song, & Patterson, 2016; Schauenburg et al., 2010; Wiseman & Tishby, 2014) used a longitudinal design with an average length of 18.03 sessions (*SD* = 12.13, *Mdn* = 12.01). Two studies (6.67%; Berghout & Zevalkink, 2011; Frank, Gunderson, & Gomes-Schwartz, 1987) were clinical trials and did not report treatment duration. Two studies (6.67%; Heinonen, Knekt, Jääskeläinen, & Lindfors, 2014; Heinonen, Lindfors, Laaksonen, & Knekt, 2012) used a quasi-experimental design with a 3- and 5-year follow-up from the start of treatment, respectively. In these studies, the average treatment duration ranged from 20 sessions to 3 years (Heinonen et al., 2012) and from 31.3 to 56.3 months (Heinonen et al., 2014). In one study (3.33%; Black, Hardy, Turpin, & Parry, 2005), therapists were surveyed through a postal questionnaire and treatment duration was not reported.

Therapists′ mean age, as reported in the studies (60%, *k* = 18), was 38.72 years (*SD* = 8.38). In one study (3.33%; Bruck, Winston, Aderholt, & Muran, 2006), age ranged from 27 to 59 years, whereas 11 studies (36.67%; Coady, 1991; Frank et al., 1987; Henry, Schacht, & Strupp, 1990; Hilliard, Henry, & Strupp, 2000; Najavits & Strupp, 1994; Nissen-Lie et al., 2013; Reading, 2013; Ryan, Safran, Doran, & Moran, 2012; Schut et al., 2005; Svartberg & Stiles, 1992; Talley et al., 1990) did not report therapists′ mean age. The 1,289 therapists who participated in the study were predominantly female (66.41%, *n* = 856). Only nine studies (30%; Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Anderson et al., 2016; Hilliard et al., 2000; Kaplowitz, Safran, & Muran, 2011; Lawson & Brossart, 2003; Najavits & Strupp, 1994; Talley et al., 1990; Williams & Fauth, 2005; Wiseman & Tishby, 2014; Yonatan-Leus et al., 2017) reported therapists′ ethnicity; of the 225 therapists in these studies, 158 were White/Caucasian (70.22%), 41 were Israeli (18.22%), 6 were Asian American (2.67%), 4 were Black/African American (1.78%), 2 were Native American (0.89%), 2 were Hispanic/Latino (0.89%), and the remaining 12 (5.33%) did not declare their ethnicity.

With regard to therapists′ clinical experience, in 15 studies (50%), the mean duration of experience was 9.80 years (*SD* = 5.95, *Mdn* = 10), whereas in 10 studies (33.33%), it ranged from 1 to 32 years; the remaining 5 studies (16.67%; Anderson et al., 2016; Black et al., 2005; Lafferty, Beutler, & Crago, 1989; Lawson & Brossart, 2003; Schut et al., 2005) did not report this information.

TABLE 1 Characteristics of the included studies

Study	Country	Therapists (*Nt*)	Patients sample (*Np*)	Treatment[a]	Length	Study design	Notes
Anderson et al. (2009)	USA	*N* = 25 F = 9; M = 16 Age M = 43.9 years Clinical experience M = 11.5 years	*N* = 1,141 Diagnosis: NR F = 716; M = 425 Age M = 23.0 years	PDT (*Nt* = 4), CBT (*Nt* = 8), HUM (*Nt* = 8), ECL (*Nt* = 5)	Length M = 9.09 sessions (range = 3–72)	Naturalistic	Subset of the sample from Okiishi et al. (2003)
Anderson et al. (2016)	USA	*N* = 44 F = 32; M = 12 Age M = 24.4 years Clinical experience M = NR	*N* = 117 Diagnosis: NR F = 74; M = 43 Age M = 22.4 years	PDT (4.8%), ECL (38.2%), CBT (26.2%), HUM (7.1%), N/A (2.4%)	Length M = 10.9 sessions (range = 1–60)	Longitudinal	
Banham and Schweitzer (2016)	Australia	*N* = 42 F = 38; M = 4 Age M = 28.7 years Clinical experience M = 0.14 years (in training)	*Np* = 173 Diagnosis: depressive disorder (*DSM-IV-TR*) F = 122; M = 51 Age M = 31.6	CBT (*Nt* = 16), PDT (*Nt* = 11), ECL (*Nt* = 13), NARR (*Nt* = 1), ACT (*Nt* = 1)	Length M = 16.46 sessions (range = 12–43)	Naturalistic	
Berghout and Zevalkink (2011)	the Netherlands	*N* = 53 F = 33; M = 20 Age M = 54.5 years Clinical experience M = 24.3 years	*N* = 97 Diagnosis: NR Gender NR Age M = NR	PA (*Np* = 40), PP (*Np* = 57)	NR	Clinical trial	
Black et al. (2005)	UK	*N* = 491 F = 345; M = 146 Age M = 51.0 years Clinical experience range = 1–10 years	*N* = NR Diagnosis: NR Gender NR Age M = NR	PDT (*Nt* = 171), CBT (*Nt* = 119), ECL (*Nt* = 94), HUM (*Nt* = 73), N/A (*Nt* = 34)	NR	Survey	
Bruck et al. (2006)	USA	*N* = 46 F = 31; M = 15 Age range = 27–59 years Clinical experience range = 1–32 years	*N* = 46 Diagnosis: mixed (*DSM*) F = 26; M = 20 Age M = 39.4	PDT short-term (*Np* = 27), CBT (*Np* = 19)	30 sessions	Naturalistic	
Coady (1991)	Canada	*N* = 10 F = 1; M = 9 Age M = NR Clinical experience = min 4 years	Np = 10 Diagnosis: NR Gender NR Age M = 35.0 years	PDT (short-term)	15 sessions	Naturalistic	Subset from Marziali (1984)
Dinger et al. (2007)	Germany	*N* = 31 F = 15; M = 16 Age M = 37.4 years Clinical experience M = 6.6 years	*Np* = 1513 Diagnosis: mixed (*ICD-10*) F = 1,006; M = 507 Age M = 34.6 years	PDT (inpatient setting)	Length M = 13.6 weeks	Naturalistic	
Frank et al. (1987)	USA	*N* = 81 Gender NR Age M = NR Clinical experience M = 10.0 years	*N* = 143 Diagnosis: schizophrenia (nonchronic; *DSM-III*) Gender NR Age M = NR	PDT-EIO therapy, RAS	NR	Clinical trial	Subset from Stanton et al. (1984)

(Continues)

TABLE 1 (Continued)

Study	Country	Therapists (*Nt*)	Patients sample (*Np*)	Treatment[a]	Length	Study design	Notes
Heinonen et al. (2012)	Finland	*N* = 53 F = 49; M = 20 Age M = 49.2 years Clinical experience M = 15.8 years	*N* = 326 Diagnosis: anxiety or mood disorder (*DSM-IV*) F = 248; M = 78 Age M = 32.3 years	Solution focused (*Np* = 97), PDT short-term (*Np* = 101), PDT long term (*Np* = 128)	Length: solution focused = 12 sessions, PDT short term = 20 sessions, PDT long term = 3 years	Quasi-experimental, follow-up	Part of the HPS (Knekt et al., 2012)
Heinonen et al. (2014)	Finland	*N* = 58 F = 39; M = 19 Age M = 49.9 years Clinical experience M = 18.1 years	*N* = 169 Diagnosis: anxiety or mood disorder (*DSM-IV*) F = 129; M = 40 Age M = 31.3 years	PDT (*Np* = 128), PA (*Np* = 41)	Length M PDT = 31.3 months, PA = 56.3 months	Quasi-experimental, follow-up	Part of the HPS (Knekt et al., 2012)
Henry et al. (1990)	USA	*N* = 14 Gender NR Age M = NR Clinical experience = min 2 years	*N* = 14 Diagnosis: mixed (*DSM-III*) F = 11; M = 3 Age M = 41.0 years	PDT (short term)	25 sessions	Naturalistic	Sample from the Vanderbilt II project (Strupp & Binder, 1984)
Hersoug (2004)	Norway	*N* = 7 F = 6; M = 1 Age M = 44.0 years Clinical experience M = 10.0 years	*N* = 39 Diagnosis: mixed (*DSM-IV*) F = 34; M = 5 Age M = 36.6 years	PDT (short term)	Length M = 35 sessions	Naturalistic	Part of the NMSPOP (Havik et al.,1995)
Hilliard et al. (2000)	USA	*N* = 16 F = 6; M = 10 Age M = NR Clinical experience M = 5.6 years	*N* = 64 Diagnosis: mixed (*DSM-III*) F = 50; M = 14 Age M = 41.0 years	PDT (short term)	Length M = 21.4 sessions	Naturalistic	Part of the Vanderbilt II project (Strupp & Binder, 1984)
Kaplowitz et al. (2011)	USA	*N* = 23 F = 17; M = 6 Age M = 31.9 years Clinical experience = in training (*N* = 18), 1–5 years (*N* = 5)	*N* = 23 Diagnosis: mixed (*DSM-IV*) F = 15; M = 8 Age M = 37.7 years	BRT (*Nt* = 17), CBT (*Nt* = 6)	30 sessions	Naturalistic	
Lafferty et al. (1989)	USA	*N* = 30 F = 11; M = 19 Age M = 29.7 years Clinical experience = NR (in training)	*N* = 60 Diagnosis: mixed, prevalence of anxiety or affective disorders (NR) F = 49; M = 11 Age M = 30.8 years	PDT (59.3%), ECL (29.6%), CC (7.4%), BT (3.7%).	Length M = 17.5 sessions	Naturalistic	

(Continues)

TABLE 1 (Continued)

Study	Country	Therapists (*Nt*)	Patients sample (*Np*)	Treatment[a]	Length	Study design	Notes
Lawson and Brossart (2003)	USA	*N* = 20 F = 14; M = 6 Age M = 32.9 years Clinical experience = NR	*N* = 20 Diagnosis: mixed (NR) F = 13; M = 7 Age M = 29.6 years	PDT (*Nt* = 6), CBT (*Nt* = 10), EXP (*Nt* = 1), ECL (*Nt* = 1)	16 sessions	Naturalistic	
Najavits and Strupp (1994)	USA	*N* = 16 F = 6; M = 10 Age M = NR Clinical experience M = 5.6 years	*N* = 80 Diagnosis: mixed (*DSM*) Gender NR Age range = 24–64 years	TLDP	22 sessions	Naturalistic	Data from the Vanderbilt II project (Strupp & Binder, 1984)
Nissen-Lie et al. (2013)	Norway	*N* = 70 F = 45; M = 25 Age M = NR Clinical experience M = 10.0 years	*N* = 255 Diagnosis: mixed (*DSM-IV*) Gender NR Age M = NR	PDT/PA (78.3%), HUM (31%), CBT (29.4%)	Length M = 51 sessions	Naturalistic	Part of the NMSPOP (Havik et al., 1995)
Reading (2013)	USA	*N* = 43 F = 35; M = 8 Age M = NR Clinical experience = in training (57.7% less than 2 years; 22.3% 2–5 years)	*Np* = 43 Diagnosis: mixed (*DSM-IV*) F = 29; M = 14 Age M = 46.0 years	BRT	30 sessions	Naturalistic	Doctoral dissertation
Ryan et al. (2012)	USA	*N* = 26 F = 18; M = 8 Age M = NR Clinical experience = in training (57.7% less than 2 years; 19.2% 2–5 years)	*N* = 26 Diagnosis: mixed (*DSM-IV*) F = 17; M = 9 Age M = 48.0 years	BRT (*Nt* = 12), CBT (*Nt* = 14)	30 sessions	Naturalistic	
Samstag et al. (2008)	USA	*N* = 38 F = 23; M = 15 Age M = 38.5 Clinical experience M = 7.6 years	*N* = 48 Diagnosis: mixed (*DSM-III-R*) F = 27; M = 21 Age M = 38.9 years	PDT, BRT, CBT (*Nt* = NR)	30 sessions	Naturalistic	
Schauenburg et al. (2010)	Germany	*N* = 31 F = 15; M = 16 Age M = 37.4 Clinical experience M = 6.6 years	*N* = 1,381 Diagnosis: mixed (*ICD-10*) F = 917; M = 464 Age M = 34.6 years	PDT (inpatient setting)	Length M = 12.01 weeks	Longitudinal	Subset from Dinger et al. (2007)
Schut et al. (2005)	USA	*N* = 6 F = 4; M = 2 Age M = NR Clinical experience M = NR	*N* = 14 Diagnosis: avoidant personality disorder (*DSM-III-R*) F = 9; M = 5 Age M = 35.9 years	PDT (SE)	52 sessions	Naturalistic	Therapy adapted for patients with AVPD

(Continues)

TABLE 1 (Continued)

Study	Country	Therapists (*Nt*)	Patients sample (*Np*)	Treatment[a]	Length	Study design	Notes
Svartberg and Stiles (1992)	Norway	*N* = 8 Gender NR Age M = NR Clinical experience M = 5 years	*N* = 15 Diagnosis: mixed (*DSM-III*) F = 9; M = 6 Age M = 30 years	STAPP (PDT)	20 sessions	Naturalistic	
Talley et al. (1990)	USA	*N* = 16 F = 6; M = 10 Age M = NR Clinical experience = min 2 years	*N* = 48 Diagnosis: mixed (*DSM-III*) F = 38; M = 10 Age M = 40 years	TLDP	Length range = 4–25 sessions	Naturalistic	Data from the Vanderbilt II project (Strupp & Binder, 1984)
Williams and Fauth (2005)	USA	*N* = 18 F = 13; M = 5 Age M = 36 years Clinical experience M = 10.1 years	*N* = 18 Diagnosis: NR F = 16; M = 2 Age M = 22 years	CBT (*Nt* = 8), ECL (*Nt* = 2), PDT (*Nt* = 2), HUM (*Nt* = 2), other (*Nt* = 4)	NR	Naturalistic	
Wiseman and Tishby (2014)	Israel	*N* = 27 F = 22; M = 5 Age M = 36 years Clinical experience range = 3–5 years	*N* = 67 Diagnosis: mixed (NR) F = 46; M = 21 Age M = 24.9 years	PDT	32 sessions	Longitudinal	
Wongpakaran and Wongpakaran (2012)	Thailand	*N* = 13 F = 6; M = 7 Age M = 36 years Clinical experience range = 5–20 years	*N* = 121 Diagnosis: mixed (*DSM-IV-TR*) F = 55; M = 66 Age M = 38.1 years	PDT (supportive plus medication)	NR	Naturalistic	
Yonatan-Leus et al. (2017)	Israel	*N* = 20 F = 17; M = 3 Age M = 35.5 years Clinical experience = 73.3% 2–3 years; 20% 5–15 years	*N* = 54 Diagnosis: mixed (NR) F = 36; M = 18 Age M = 24.8 years	PDT	1 year	Retrospective (5 years), naturalistic	Part of the Jerusalem-Haifa study (Wiseman & Tishby, 2014)

Note. NR = not reported; AVPD = avoidant personality disorder; NMSPOP = Norwegian Multisite Study of Process and Outcome in Psychotherapy; HPS = Helsinki Psychotherapy Study; *DSM* = *Diagnostic and Statistical Manual of Mental Disorders*; *ICD-10* = *International Statistical Classification of Diseases and Related Health Problems 10th Revision*.

[a]*Therapies:* PDT = psychodynamic psychotherapy; HUM = humanistic; ECL = eclectic; NARR = narrative; TLDP = time-limited dynamic psychotherapy (Strupp & Binder, 1984); PA = psychoanalysis; PP = psychoanalytic psychotherapy; ACT = acceptance and commitment therapy; CBT = cognitive-behavior therapy; BRT = brief relational therapy (Safran & Muran, 2000); STAPP = short-term anxiety-provoking psychotherapy (Sifneos, 1979); CC = client-centred psychotherapy; EIO = exploratory insight oriented; RAS = reality-adaptive-supportive therapy; EXP = experiential.

The studied therapists treated a total of 6,125 patients (ranging from 10 to 1,513 patients), with only one study (3.33%; Black et al., 2005) not reporting the number of patients treated. Gender was reported for 5,540 patients (k = 24), of whom 3,692 were female (66.64%). Patients' mean age was 33.98 years (SD = 7.07, Mdn = 34.6), with one study (3.33%; Najavits & Strupp, 1994) reporting ages between 24 and 64 years and four studies (13.34%; Berghout & Zevalkink, 2011; Black et al., 2005; Frank et al., 1987; Nissen-Lie et al., 2013) not reporting this information.

The major diagnostic category that was treated and reported in 18 studies (60%) was mixed disorders, as defined by the *DSM-III*, *DSM-IV*, *DSM-IV-TR*, or the International Statistical Classification of Diseases and Related Health Problems 10th Revision, with the remaining studies focused on the treatment of anxiety or mood disorders (13.34%, k = 4), nonchronic schizophrenia (3.33%, k = 1), and avoidant personality disorder (3.33%, k = 1). Six studies (20%) did not report patient diagnosis.

The therapist variables that were most commonly examined related to interpersonal functioning (26,67%, k = 8), attachment (20%, k = 6), reflective and introspective capacities (16.67%, k = 5), personality traits and characteristics (13.33%, k = 4), self-concept (13.33%, k = 4), values and attitudes (10%, k = 3), early relationships with parents (10%, k = 3), and interpersonal problems (10%, k = 3). As some studies examined more than one variable, the summation of the percentages exceeds 100.

3.2 | Overall quality assessment

The quality assessment showed excellent interrater agreement (87.5%), with 5 studies receiving high quality scores (≥1SD), 19 receiving medium scores (1.24 ≤ SD ≤ 2.00), and 6 receiving low scores (SD ≤ 1). A table explaining the calculation of the quality score for each study is available as Supporting Information (see Table S1). Seventeen authors were contacted in order to clarify information relating to the quality criteria: Eight replied with relevant information, five did not reply, and in the remaining four cases, the e-mail bounced back. A further seven authors were not contacted because contact information was not included in the study. Information gained through contact with study authors is denoted by the superscript c, as shown in Table S1.

3.3 | Review of study findings

To address the aims of this review, the main findings were presented into six major sections according to the specific therapists' variable considered: (a) attachment and early relationships with their parents, (b) interpersonal functioning and problems, (c) reflective and introspective capacities, (d) self-concept, (e) values and attitudes, and (f) and personality traits and characteristics (see Table 2).

3.3.1 | Therapists' attachment and early relationships with parents

Six studies examined the influence of therapists' attachment patterns on therapy outcome. Overall, the findings showed that therapists' attachment has a weak direct effect on patient outcome (Berghout & Zevalkink, 2011; Black et al., 2005; Bruck et al., 2006), but significant interactions with other variables on the patient or therapist level might be able to produce a combined influence on therapy outcomes. For instance, Schauenburg et al. (2010) have found that dimensional therapist attachment security interacts with patients' pretherapy functional and interpersonal impairment to predict symptomatic amelioration and change in interpersonal problems, whereas Wongpakaran and Wongpakaran (2012) demonstrated that therapists' self-reported attachment security was related to a reduction of patients' anxiety and depressive symptoms only when it was associated with a more receptive interpersonal style. Another study found a moderation effect of self-reported therapist avoidant attachment, showing that when treated by low-avoidant therapists, low-avoidant clients were likely to decrease in symptom severity to a greater extent than were high-avoidant clients (Wiseman & Tishby, 2014). These findings are in line with the Degnan, Seymour-Hyde, Harris, and Berry's (2016) review, suggesting that the relationship between therapist attachment and patient outcome might be meaningful but not straightforward (Dozier, Cue, & Barnett, 1994; Mohr, Gelso, & Hill, 2005; Romano, Janzen, & Fitzpatrick, 2009).

The three studies that evaluated the influence of therapists' early parental relationships suggested similar interaction effects. Therapists' better parental care and the quality of their relationships with primary caregivers seemed to impact on the interpersonal process during the treatment session (i.e., their use of exploratory techniques and patients' perception of the working alliance), which in turn predicted therapy outcome (Hersoug, 2004; Hilliard et al., 2000; Lawson & Brossart, 2003). Despite the paucity of studies on this topic, some investigations reported that higher scores on therapists' perceived maternal care were positively associated with both the patient- and therapist-rated working alliance (Hersoug, Høglend, Havik, von der Lippe, & Monsen, 2009; Hersoug, Høglend, Monsen, & Havik, 2001).

3.3.2 | Therapists' interpersonal functioning and problems

Eleven studies examined the impact of therapists' characteristic interpersonal patterns, suggesting that this variable is potentially able to positively or negatively impact on patients' outcome. The five studies that involved the application of a circumplex model of interpersonal behaviour (i.e., the first two surfaces of the Structured Analysis of Social Behavior; Benjamin, 1996) revealed that therapists who showed a more affiliative stance, characterized by nurturing, helping, warmth, and protecting behaviours, as well as involving and mildly persuading attitudes, were more effective in achieving a positive therapeutic outcome (Coady, 1991; Najavits & Strupp, 1994; Svartberg & Stiles, 1992). On the other hand, therapists' less affiliative and more hostile interpersonal behaviours (i.e., belittling, attacking, and rejecting behaviours) were related to poorer outcomes (Samstag et al., 2008). Furthermore, higher levels of therapists' hostility have been found to be associated with a higher number of interpretations, which in turn related to less favourable changes in patients' personality and overall functioning (Schut et al., 2005).

Two additional studies specifically examined the influence of therapists' interpersonal problems and distress. Dinger, Strack, Leichsenring, and Schauenburg (2007) showed a significant interaction effect of therapists' low affiliation: For therapists who described themselves as cold, the positive effect of a good alliance on outcome

TABLE 2 Therapist subjective variables and therapeutic outcome

Study	Therapist variable	Predictor variable measure(s)[a]	Outcome measure(s)[b]	Predictor analyses	Main findings
Anderson et al. (2009)	Interpersonal functioning	FIS performance task, SIS	OQ-45	Hierarchical linear model	Therapists' age accounted for variation in outcomes. (Older therapists produced superior outcomes.) However, when therapists' social skills and FIS were examined, age no longer predicted outcome. There were larger rates of improvement in clients whose therapists had higher levels of facilitative interpersonal skills.
Anderson et al. (2016)	Interpersonal functioning	FIS performance task, SIS	OQ-45	Two- and three-level hierarchical linear model	Therapists' FIS, measured upon entry into graduate training, predicted patient outcomes during their second, third, and fourth years of training. Clients of higher FIS therapists experienced greater symptom reduction than did clients of lower FIS therapists.
Banham and Schweitzer (2016)	Reflective and introspective capacities	NPCS	OQ-45.2	Independent sample *t* tests	Therapists in the better outcome group evidenced greater use of observational language to elicit an internal and reflexive narrative process model. Therapists in the poorest outcome group were able to engage their clients in a reflexive narrative process, but they tended to do so through the use of questioning.
Berghout and Zevalkink (2011)	Attachment, values, and attitudes	ASQ, TASC-2	General distress, introversion, and disadaptation or disorganization	Pearson's correlations and analysis of covariance	Therapists' self-reported attachment security was prevalent, but this variable did not correlate with patient outcomes. In the Psychoanalysis group, a higher level of therapists' adjustment and kindness was associated with better patient outcomes.
Black et al. (2005)	Attachment, personality traits, and characteristics	ASQ, EPQ	PCL	Pearson's correlations and multiple regression analysis	Higher insecure attachment scores in therapists correlated with more problems in therapy. More specifically, one dimension of insecure attachment (need for approval) and neuroticism predicted more problems in therapy, especially in the group of psychodynamic therapists.
Bruck et al. (2006)	Attachment and self-concept	INTREX SASB, RSQ	SCL-90-R, IIP, GAS, SEQ	Paired *t* tests and Pearson's correlations	Affiliative introjects were significantly correlated with session depth and smoothness, patients' symptomatic improvements, and interpersonal problems. Secure attachment was related to session depth and changes in patients' interpersonal problems, whereas dismissing style was negatively associated with patients' interpersonal problems.
Coady (1991)	Interpersonal functioning	SASB	DSI, Beck's MS, SAS	Analysis of variance (2 groups × 3 sessions), Kolmogorov–Smirnov test, and Mann–Whitney *U* test	Therapists in the good outcome group showed more helping and protecting behaviours overall and in single sessions (3, 5, and 15 of 20 sessions), whereas those in the poor outcome group were more disaffiliative only in session 3.
Dinger et al. (2007)	Interpersonal problems	IIP	SCL-90-R	Multilevel regression analysis (hierarchical linear model)	Interpersonal dimensions (dominance and affiliation) did not directly influence patient outcomes. However, there was an interaction effect of therapists' affiliation in the positive relationship between alliance and outcome: Good alliance was more helpful when the therapist described himself or herself as cold and not too friendly.
Frank et al. (1987)	Values and attitudes	RI, TOQ	None—patient's therapy continuance (vs. dropout)	Pearson's correlations and stepwise multiple regression	Patients remained in treatment longest with therapists who showed openness, belief in the value of limiting regressions, and adherence to a theoretically based model of useful treatment intervention.
Heinonen et al. (2012)	Personality traits and characteristics	DPCCQ	GSI of the SCL-90-R	Linear mixed model and ITT analyses	Active, engaging, and extroverted therapists produced faster symptom reduction in short-term PDT than in long-term PDT. More cautious, nonintrusive therapists generated greater benefits in long-term therapy during the 3-year follow-up. Therapists' lower confidence and enjoyment in therapeutic work predicted poorer outcomes in short-term therapy in the long run.

(Continues)

TABLE 2 (Continued)

Study	Therapist variable	Predictor variable measure(s)[a]	Outcome measure(s)[b]	Predictor analyses	Main findings
Heinonen et al. (2014)	Personality traits and characteristics	DPCCQ	GSI of the SCL-90-R	Linear mixed model	Personally more forceful and less aloof therapists predicted fewer symptoms in PA than in long-term PDT at the end of the 5-year follow-up. A faster symptom reduction in long-term PDT was predicted by a more moderate relational style.
Henry et al. (1990)	Self-concept	INTREX SASB	SCL-90-R	Independent sample *t* tests, analysis of variance	Therapists in the poor outcome group were typified by interpersonal behaviours that were ignoring or neglecting and belittling or blaming. Therapists with disaffiliative introjects tended to engage in a much higher level of problematic interpersonal processes that were associated with poor outcomes.
Hersoug (2004)	Early relationships with parents and self-concept	PBI and SASB	DMRS and DSQ	Pearson′s correlations and hierarchical multiple regression	Personal characteristics were not separately predictive of patients′ changes in defensive functioning over the course of therapy. However, the combination of therapists′ personal characteristics and their proportion of interpretation contributed to a significant reduction in patients′ maladaptive defensive functioning.
Hilliard et al. (2000)	Early relationships with parents	INTREX SASB	GSI of the SCL-90-R and GOR	Pearson′s correlations and multiple regression	Therapists′ representations of early parental relationships had a direct effect on the therapy process, which in turn influenced patients′ symptom reduction and overall therapy outcome.
Kaplowitz et al. (2011)	Reflective and introspective capacities	MSCEIT V.2	SCL-90-R, TCQ, and IIP	Multilevel analysis, logistic regression, and Pearson′s correlations	Higher therapist EIQ positively influenced outcome with regard to therapist ratings of patients′ interpersonal problems and target complaints. Higher emotion-management abilities were associated with greater improvements in patient-rated symptomatology and lower dropout rates.
Lafferty et al. (1989)	Values and attitudes	RI and RVS	GSI of the SCL-90-R	Stepwise multiple regression	Less effective therapists had lower levels of empathic understanding, rated themselves as more directive, and valued comfort and stimulation significantly more and intellectual goals significantly less than did more effective therapists.
Lawson and Brossart (2003)	Early relationships with parents	PAFS-Q	GAS and TCQ	Multiple regression	Relationships with parents had a small direct effect on outcome. Both healthy (i.e., intimacy and individuation) and less healthy (i.e., fusion and triangulation) relationship patterns contributed to patient perceptions of a positive working alliance, which in turn predicted therapy outcome.
Najavits and Strupp (1994)	Interpersonal functioning	SASB and RI	SCL-90-R, GAS, and GOR	Analysis of variance	More effective therapists displayed more affiliative behaviours fewer negative behaviours and more self-criticism than did less effective therapists.
Nissen-Lie et al. (2013)	Interpersonal functioning	DPCCQ	GAF, GSI of the SCL-90-R, and IIP	Multilevel modelling	Therapists′ differences explained 4% of patients′ changes in symptom distress, 21% of their changes in interpersonal problems, and 28% of their growth in overall functioning. Negative personal reactions had a negative effect on patients′ interpersonal problems and distress. Advanced relational skills seemed to impede growth in patients′ global and interpersonal functioning.
Reading (2013)	Reflective and introspective capacities	RFS, TRI-M	SEQ, SCL-90-R, and IIP-32	Pearson′s correlations and multiple regression	There was a predictive relationship between therapists′ reflective functioning and patient reports of session depth. A moderate correlation between reflective functioning and patients′ symptom reduction and a strong correlation with residual gain scores from termination to 6-month follow-up for both patient reports of interpersonal problems and symptoms was also found.
Ryan et al. (2012)	Reflective and introspective capacities	KIMS	SCL-90-R and IIP-32	Pearson′s correlations	Total mindfulness scores were significantly correlated with patients′ improvement in overall interpersonal functioning, but not with symptom amelioration.
Samstag et al. (2008)	Interpersonal functioning	SASB	SCL-90-R and IIP-64	Pearson′s correlations and analysis of variance	The poor outcome dyads showed more hostile interpersonal behaviours, but this variable was not related to therapy dropout. Affiliative behaviours did not differ between good or poor outcome groups.

(Continues)

TABLE 2 (Continued)

Study	Therapist variable	Predictor variable measure(s)[a]	Outcome measure(s)[b]	Predictor analyses	Main findings
Schauenburg et al. (2010)	Attachment	AAI	SCL-90-R, IIP, and IS	Multilevel regression	Attachment dimensional scores did not directly predict patients' symptom reduction or changes in interpersonal problems, but higher attachment security was associated with better outcomes when patients had high initial symptomatic impairment.
Schut et al. (2005)	Interpersonal functioning	SASB	GAF, IIP, and WISPI	Partial correlations	Therapist disaffiliativeness during interpretations was related to less favourable outcomes in patients' global functioning, but not in their interpersonal and personality functioning (despite the trend towards significance). Affiliative behaviours were not associated with any of the outcome variables.
Svartberg and Stiles (1992)	Interpersonal functioning	SASB	GSI of the SCL-90-R, SAS, and DAS	Hierarchical multiple regression	Positive interpersonal behaviours (i.e., friendly and autonomy-enhancing behaviours) in early sessions predicted short-term patient changes in symptomatology and dysfunctional patterns.
Talley et al. (1990)	Self-concept	INTREX SASB	GOR, SCL-90-R, and GAS	Analysis of variance, partial correlations	Therapist self-concept (introjects) influenced symptomatic change only in patients with high scores on the affiliation dimension.
Williams and Fauth (2005)	Reflective and introspective capacities	ISSA	SIS and HRS	Analysis of covariance and multiple regression analysis	Therapists reported a moderate level of in-session self-awareness. The more self-aware the therapists reported feeling in sessions, the higher the helpfulness ratings they received from their clients and the more positive emotions they experienced towards their clients.
Wiseman and Tishby (2014)	Attachment	ERC	OQ-45	Hierarchical three-level model (hierarchical linear model)	Attachment was a moderator between client attachment and symptomatic change. When treated by low-avoidant therapists. Low-avoidant clients were likely to decrease symptoms to a greater extent than were high-avoidant clients treated by low-avoidant therapists.
Wongpakaran and Wongpakaran (2012)	Attachment and interpersonal problems	ERC and IIP	PDQ	Analysis of variance, multivariate analysis of variance, and Pearson's correlations	Secure attachment, only if combined with submissive interpersonal style (passive and more receptive than proactive) was significantly related to a reduction in anxiety symptoms.
Yonatan-Leus et al. (2017)	Personality traits and characteristics	HEXACO-H, HSQ, and Playfulness Scale	OQ-45	Hierarchical three-level model (hierarchical linear model)	Therapists' aggressive humour style was a significant predictor of patients' symptom change over time, whereas therapists' honesty scores were negatively correlated with symptom change.

[a]FIS = Facilitative Interpersonal Skills performance task (Anderson, Patterson, & Weis, 2007); SSI = Social Skills Inventory (Riggio, 1986); NPCS = Narrative Process Coding System; ASQ = Attachment Styles Questionnaire (Feeney, Noller, & Hanrahan, 1994); TASC-2 = Therapeutic Attitudes Scales-2 (Sandell et al., 2004); EPQ = Eysenck Personality Questionnaire (Eysenck & Eysenck, 1969); INTREX = Introject Questionnaire (Benjamin, 1983); RSQ = Relationship Scale Questionnaire (Griffin & Bartholomew, 1994); SASB = Structural Analysis of Social Behavior (Benjamin, 1996); IIP = Inventory of Interpersonal Problems (Horowitz, Alden, Wiggins, & Pincus, 2000); RI = Relationship Inventory (Barrett-Lennard, 1962); TOQ = Therapy Opinion Questionnaire (Frosch et al., 1983); DPCCQ = Development of Psychotherapists Common Core Questionnaire (Orlinsky & Rønnestad, 2005); PBI = Parental Bonding Instrument (Parker, Tuplin, & Brown, 1979); MSCEIT V.2 = Mayer et al. (2002); RVS = Rokeach Value Survey (Rokeach, 1973); PAFS-Q = Personal Authority in the Family System Questionnaire (Bray, Williamson, & Malone, 1984); RFS = Reflective Functioning Scale (Fonagy, Steele, Steele, & Target, 1998); TRI-M = Therapist Interview at Midphase; KIMS = Kentucky Inventory of Mindfulness Skills (Baer et al., 2004); AAI = Adult Attachment Interview (Main et al., 2002); ISSA = In-Session Self-Awareness Scale; ERC = Experiences in Close Relationships Scale (Brennan, Clark, & Shaver,1998); HEXACO = Honesty–Humility, Emotionality, Extraversion, Agreeableness, Conscientiousness, Openness to Experience (Lee & Ashton, 2004); HSQ = Humor Style Questionnaire (Martin, Puhlik-Doris, Larsen, Gray, & Weir, 2003); Playfulness Scale (Schaefer & Greenberg, 1997).

[b]OQ-45 = Outcome Questionnaire-45 (Lambert, Umphress, Hansen, & Burlingame, 1994); PCL = Therapist Problem Checklist; SCL-90-R = Symptom Checklist-90-R (Derogatis, 1983); GAS = Global Assessment Scale (Endicott, Sitzer, Fleiss, & Cohen, 1976); SEQ = Session Evaluation Questionnaire (Stiles et al., 1994); DSI = Derogatis Symptom Index (Derogatis, 1983); BMS = Beck's Mood Scale (Beck, Ward, Mendelsen, Mock, & Erlbaugh, 1961); DMRS = Defense Mechanisms Rating Scale (Perry, 1990); DSQ = Defense Style Questionnaire (Bond, Gardner, Christian, & Sigal, 1983); TCQ = Target Complaints Questionnaire (Battle et al., 1966); GAF = Global Assessment of Functioning (APA, 1994); IS = Impairment Score (Schepank, 1995); DAS = Dysfunctional Attitude Scale (Weissman & Beck, 1978); SIS = Session Impacts Scale (Elliott & Wexler, 1994); HRS = Helpfulness Rating Scale (Elliott, 1985); PDW = Psychological Distress Questionnaire (Wongpakaran & Wongpakaran, 2012).

was stronger than for therapists who described themselves as too friendly. Moreover, Wongpakaran and Wongpakaran (2012) found that the level of therapists' self-rated interpersonal difficulties interacted with attachment style in predicting low levels of patients' anxiety and depression at treatment termination. Three other studies that considered psychodynamic therapists' interpersonal skills and capacities showed that facilitative interpersonal skills (such as verbal fluency, emotional expression, warmth or positive regard, and empathy) predicted better outcomes in short-term therapies (e.g., fewer than eight sessions), whereas in longer term therapies, this effect was very weak (Anderson et al., 2009, 2016; Nissen-Lie et al., 2013).

These findings challenge the stereotypical representation of a "detached" and restrained psychoanalyst, highlighting that more effective psychodynamic therapists showed encouraging, friendly, helping, warm, and engaging interpersonal behaviours (Ackerman & Hilsenroth, 2003; Roos & Werbart, 2013). However, our results also showed that a more cautious and nonintrusive therapist stance could be beneficial to treatment outcome (Sandell et al., 2000, 2007). Moreover, excessive self-disclosing behaviours were found to be negatively related to alliance (Ackerman & Hilsenroth, 2001; Coady & Marziali, 1994).

3.3.3 | Therapists' reflective and introspective capacities

Despite the high heterogeneity of the predictor variables, five studies converged in suggesting that therapists' overall reflective and introspective abilities might have a positive impact on therapy outcome. Only Reading's (2013) dissertation considered mentalization—or reflective functioning (RF) as conceptualized by Fonagy, Steele, Steele, Moran, and Higgitt (1991)—showing that therapists' RF predicted higher session depth and was moderately related to therapy outcome. According to this finding, therapists' higher capacity to understand and use the internal and interpersonal processes that drove behaviours during specific conversational episodes in therapy sessions seemed to promote better patients' outcomes (Banham & Schweitzer, 2016), and therapists' emotional intelligence and higher ability to manage emotions predicted lower patients' interpersonal problems and dropout rates (Kaplowitz et al., 2011). Moreover, therapists' global mindfulness was found to be significantly related to residual gain scores from intake to termination for patient-rated interpersonal problems and distress (Ryan et al., 2012), and higher therapists' self-awareness was related to more positive client ratings of the therapy usefulness (Williams & Fauth, 2005).

Despite promising findings, conclusions should be drawn with caution. For instance, some case studies suggest that patients who worked with a high-RF therapist were more likely to develop the capacity to consider mental states, whereas the low-RF therapist produced a poorer outcome (Diamond, Stovall-McClough, Clarkin, & Levy, 2003). Moreover, despite the inclusion of mindfulness interventions in widespread nonpsychodynamic approaches (such as dialectical behaviour therapy), the effect of therapists' pretraining mindfulness is virtually unknown. Regarding therapists' emotional intelligence, some investigations have suggested the importance of therapists' use of emotional and affective information in the therapeutic encounter (Diener et al., 2007).

3.3.4 | Therapists' self-concept

Four studies considered the effects of psychodynamic therapists' introject or self-concept, which corresponds to a relatively stable repertoire of methods for treating the self that have been learned from early interpersonal relationships (i.e., the third surface of the Structured Analysis of Social Behavior; Benjamin, 1996). Overall, these studies suggest that therapists with a greater hostility towards themselves were more vulnerable to engaging in blaming, ignoring, and separating sequences with patients during sessions, or to use more interpretations, leading to poorer treatment outcomes (Henry et al., 1990; Hersoug, 2004). On the other hand, therapists' more affiliative introjects were related to patient-rated session depth, presenting symptomatic impairment and interpersonal problems (25). Likewise, therapists' positive introjects interacted with patients' self-concept, which positively affected treatment outcome (Talley et al., 1990).

These results are in line with previous studies in which therapists with higher scores on hostile introjects have been found to be more likely to exchange countertherapeutic verbal messages in therapy and to achieve no change or negative outcomes (Henry, Schacht, Strupp, Butler, & Binder, 1993a; Henry, Strupp, Butler, Schacht, & Binder, 1993b). Moreover, more affiliative introjects seemed to affect therapists' ability to connect emotionally with clients (Dunkle & Friedlander, 1996). Despite these findings, the relative decline in research on this subject prevents us from achieving an understanding of the effect of this variable in psychodynamic therapies.

3.3.5 | Therapists' values and attitudes

The three studies that examined therapists' attitudes and value systems suggested a weak effect of these variables on therapy outcome. Therapists' attitudes towards curative factors were found to be related to better outcomes at the end of long-term psychoanalysis (Berghout & Zevalkink, 2011) and to treatment continuation in a shorter form of psychodynamic therapy applied to schizophrenic patients (Frank et al., 1987). More subjective therapist attitudes, such as intellectual and reflective stances, seemed to slightly affect treatment outcomes (Lafferty et al., 1989).

Although substantial evidence on values and psychotherapy was accumulated in the 1970s and 1980s (e.g., Arizmendi, Beutler, Shanfield, Crago, & Hagaman, 1985; Kelly, 1990), this line of research has lost popularity over the past three decades. In line with our findings, recent outcome studies are very scarce, and even when significant effects have been obtained, these have typically been small (Beutler et al., 2004).

3.3.6 | Therapists' personality traits and characteristics

Four studies investigated general personality characteristics or traits, with highly heterogeneous results. Two studies considered the influence of therapists' personal qualities, as defined by the therapists' temperamental and stylistic aspects of their personality in close personal relationships. The results showed that in short-term psychodynamic treatment, clinicians with interpersonally engaged and extroverted personalities produced faster symptom reduction, whereas patients in long-term therapies benefited more from less intrusive therapists (Heinonen et al., 2012). In a 5-year follow-up, the same authors found that therapists who experienced themselves as less cold

or detached, as well as more assertive, tended to achieve greater patients' symptom reduction (Heinonen et al., 2014).

The other two studies considered a theory-based conceptualization of personality. Therapists' neuroticism was found to be significantly related to more reported problems in therapy (Black et al., 2005), whereas a recent study by Yonatan-Leus et al. (2017) showed that therapists with high honesty scores (i.e., the H factor in the HEXACO model) tended to achieve poorer outcomes. Other general personality traits did not show significant effects.

Of note, these studies seem to conceptualize this variable more as general attributes rather than measure a broad spectrum of personality traits and styles in a systematic and complex way. Some evidence suggest that psychodynamic therapists are personally more prone to traits of "neuroticism" than are clinicians of other approaches (Arthur, 2001; Boswell, Castonguay, & Pincus, 2009), as well as more intuitive, open to experience, and prone to rely on analytic-rational information processing (Topolinski & Hertel, 2007; Tremblay, Herron, & Schultz, 1986). One additional contribution found that client–therapist personality congruence was associated with the bond component of working alliance (Taber, Leibert, & Agaskar, 2011). However, despite these promising results, this variable seems still to be "an unresolved problem" (Rosenzweig, 1936).

4 | DISCUSSION

Findings of the present review support the conclusion that therapists' subjective characteristics impact on patients' responses to psychodynamic therapies, suggesting a potential interaction effect in their relationship with other variables of the patient (e.g., symptomatic impairment), therapist (e.g., age, interpersonal style, and interventions), or therapeutic relationship (e.g., therapeutic alliance) and with treatment outcomes.

Among the predictor variables included in the current review, only therapists' characteristic interpersonal patterns showed the strongest evidence of a direct effect on the psychotherapy outcome. This finding suggests that the therapists' capacity to create a positive interpersonal connection with a patient might help to create a warm, accepting, and supportive therapeutic climate that may increase the opportunity for greater therapeutic changes. Of note, therapists' attachment styles, their interpersonal history with caregivers, and their self-concept seemed to affect the therapeutic encounter that in turn influences treatment outcome. Furthermore, the high variability between studies on therapists' overall reflective or introspective abilities and personality characteristics suggested the need for more systematic research in these areas, whereas therapists' values and attitudes showed small effects on therapeutic outcome.

In this research field, disentangling the impact of a specific aspect is challenging. For instance, Schaffer (1982) differentiated therapists' contribution into three conceptual and overlapping dimensions: the techniques they employ, their "skilfulness" or competence, and their personal qualities. For this reason, a deep examination of the contribution of therapists' subjective characteristics can help elucidate the complex interactions between relational and technical factors related to therapy outcome in the context of psychodynamic therapies. Another important implication is that therapists' improved knowledge of the role of their own subjective characteristics could be useful to better understand their actions in therapy, guide therapeutic interventions, track in-session processes with their patients, and deal with ruptures in the therapeutic alliance, in order to provide better treatments. Moreover, this information would be particularly relevant in the supervisory relationship, which is one of the most important components in psychodynamic therapists' professional development and a research variable related to treatment outcome (Holt et al., 2015; Sarnat, 2016).

However, some limitations of the present review should be addressed. The high variability between studies in predictor-measuring instruments, outcome measures, time points, and treatment lengths requires caution in drawing conclusions. Moreover, several studies considered other treatment approaches in addition to psychodynamic therapies, which may have led to confounding results. The participants' selection criteria significantly differed between studies, showing high heterogeneity in variables such as clinical experience and gender. This limitation also involved the patient samples, which generally presented mixed diagnoses on the basis of different taxonomies.

At the same time, there are many questions left to consider. First, future studies should use appropriately sized samples of psychodynamic clinicians, reliable assessment tools, and more homogeneous samples of patients. Second, some variables included in this review have not yet been adequately studied. For example, most clinicians would endorse the view that the therapist's personality can play a significant role in therapy outcome (Arthur, 2001; Taber et al., 2011). Finally, it is critical that we do not lose sight of the equally important contribution of the patient in developing the therapeutic relationship and achieving better therapeutic outcomes. It seems that the most promising strategy for future research may be to examine the interplay between patients' and therapists' subjective characteristics that impact on the effectiveness of psychodynamic psychotherapy.

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SUPPORTING INFORMATION

Additional Supporting Information may be found online in the supporting information tab for this article.

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