NATIONAL INSTITUTE FOR HEALTH AND WELFARE

Erkki Heinonen

Therapists' professional and personal characteristics as predictors of working alliance and outcome in psychotherapy

RESEARCH

123

RESEARCH 123 • 2014

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ACADEMIC DISSERTATION

To be presented with the permission of the Faculty of Behavioural Sciences of the University of Helsinki, for public examination in the Small Hall (Room 4050) of the Main Building of the University of Helsinki, Fabianinkatu 33, Helsinki, on March 22, 2014, at 10 o'clock.

National Institute for Health and Welfare, Helsinki, Finland
and
Institute of Behavioural Sciences, Faculty of Behavioural Sciences,
University of Helsinki, Finland
Helsinki 2014

NATIONAL INSTITUTE
FOR HEALTH AND WELFARE

ISBN 978-952-302-126-6 (printed)
ISSN 1798-0054 (printed)
ISBN 978-952-302-127-3 (online publication)
ISSN 1798-0062 (online publication)
http://urn.fi/URN:ISBN:978-952-302-127-3

Juvenes Print – Finnish University Print Ltd
Tampere, Finland 2014

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MILJÖMÄRKT
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Abstract

Erkki Heinonen, Therapists' professional and personal characteristics as predictors of working alliance and outcome in psychotherapy. National Institute for Health and Welfare. Research 123. 152 pages. Helsinki, Finland 2014.
ISBN 978-952-302-126-6 (printed); ISBN 978-952-302-127-3 (online publication)

Although psychotherapies of different forms and lengths have been found effective for treating depressive and anxiety disorders, some therapists have been shown to be more effective than others in producing positive treatment outcomes. Yet little is known about the characteristics of the more effective therapists. Just as importantly, it is not known whether different therapist qualities are needed in therapies of differing forms and lengths. In contrast, a good working alliance between therapist and patient has been identified as one of the strongest and most consistent predictors of outcome across various therapy forms. The present study investigated therapists' professional and personal characteristics as determinants of the therapists' effectiveness by studying their ability to predict working alliances and therapy outcomes in two short-term and two long-term therapy forms. Additionally, the study explored correspondences between the professional and personal characteristics of therapists endorsing different therapy forms.

In the Helsinki Psychotherapy Study, a total of 367 patients, aged 20-46 years and suffering from depressive or anxiety disorders, were randomly assigned to solution-focused therapy (n = 97), short-term psychodynamic psychotherapy (n = 101), and long-term psychodynamic psychotherapy (n = 128), with 41 patients self-selected to psychoanalysis. Treatments were provided by 71 volunteering psychotherapists who had an average of 17 years of therapy work experience. Working alliance was rated by both patient and therapist at the third therapy session and the 7 months' follow-up point. Treatment outcome was assessed via patients' self-reports of psychiatric symptoms at baseline and 9 times during a 5-year follow-up. The correspondences between therapists' professional and personal characteristics were explored using an international database of over 10 000 therapists representing varied theoretical orientations, career levels, background professions, and nationalities. The therapists' endorsed therapy models and their characteristics in both professional and personal life were assessed similarly via self-report.

The Helsinki Psychotherapy Study results showed therapists' professional and personal characteristics to predict working alliances and treatment outcomes differently in psychotherapies of different forms and lengths. Various experiences of unskillfulness and lack of enjoyment seemed potentially detrimental especially in the two short-term therapies, where a professionally confident, interpersonally active, and engaging manner seemed particularly needed. In comparison, a deliberate, non-intrusive, and considerate relational stance was found more

beneficial in long-term psychodynamic therapy. A further consideration emerged in the comparison of long-term psychodynamic therapy to psychoanalysis, in which the benefits of a professionally restrained but personally highly 'present' relational stance in psychoanalysis was suggested. That such a dynamic between the professional and personal may not be uncommon was suggested by findings from the international therapist database: these findings showed that therapists adjust their professional manner from their personal manner in private life according to the expectations of their treatment models.

Future studies aiming to replicate the present findings might assess therapist characteristics from additional perspectives, such as those of external observers and patients. Insofar as confirmed, results should have implications for improving the quality and flexibility of therapist training programs and supervision, and help in accommodating clinicians' personal qualities with therapy models for optimizing effective training, learning, and therapy practice.

Keywords: psychotherapy, psychotherapists, prediction of effectiveness, working alliance, depressive disorder, anxiety disorder

Tiivistelmä

Erkki Heinonen, Therapists' professional and personal characteristics as predictors of working alliance and outcome in psychotherapy [Terapeuttien ammatilliset ja henkilökohtaiset ominaisuudet ennustajina yhteistyösuhteelle ja vaikuttavuudelle psykoterapiassa]. Terveyden ja hyvinvoinnin laitos. Tutkimus 123. 152 sivua. Helsinki, Finland 2014.
ISBN 978-952-302-126-6 (painettu); ISBN 978-952-302-127-3 (verkkojulkaisu)

Useat erilaiset ja eripituiset psykoterapiat on havaittu vaikuttaviksi hoitomuodoiksi masennus- ja ahdistuneisuushäiriöissä. Osan psykoterapeuteista on kuitenkin osoitettu aikaansaavan myönteisiä hoitotuloksia toisia terapeutteja tehokkaammin. Silti on vain niukalti tietoa, mitkä ovat tuloksekkaampien terapeuttien yksilöllisiä ominaisuuksia. Yhtä olennainen tiedonpuute koskee kysymystä, edellyttävätkö erilaiset ja eripituiset terapiamuodot eri ominaisuuksia terapeutilta. Hyvä yhteistyösuhde terapeutin ja potilaan välillä on puolestaan toistuvasti havaittu yhdeksi vahvimmista hoitotulosten ennustajista eri terapiamuodoissa. Tämä tutkimus selvitti terapeuttien ammatillisia ja henkilökohtaisia ominaisuuksia terapeuttien tuloksellisuuden tekijöinä. Tätä tutkittiin tarkastelemalla terapeuttien ominaisuuksien ennustamiskykyä yhteistyösuhteelle sekä terapian tuloksellisuudelle kahdessa eri lyhytterapian sekä kahdessa eri pitkäkestoisen terapian muodossa. Lisäksi tutkimus selvitti, miten psykoterapeuttien ammatilliset ja henkilökohtaiset ominaisuudet ovat yhteyksissä toisiinsa eri terapiamuotoja edustavilla terapeuteilla.

Helsingin Psykoterapiatutkimuksessa kaikkiaan 367 iältään 20-46-vuotiasta masennus- tai ahdistuneisuushäiriöistä kärsivää potilasta satunnaistettiin ratkaisukeskeiseen terapiaan, (n = 97), lyhyeen psykodynaamiseen psykoterapiaan (n = 101) ja pitkään psykodynaamiseen psykoterapiaan (n = 128), ja 41 potilasta ohjautui omasta aloitteestaan psykoanalyysiin. Terapeutteina toimi 71 vapaaehtoisesti tutkimukseen ilmoittautunutta psykoterapeuttia, joilla oli keskimäärin noin 17 vuotta terapiatyökokemusta. Sekä potilaat että terapeutit arvioivat yhteistyösuhteen laatua kolmannen terapiaistunnon jälkeen sekä seitsemän kuukauden kuluttua terapioiden alkamisesta. Potilaat arvioivat hoidon tuloksellisuutta psykiatrisilla oirekyselyillä ennen terapioiden alkua sekä 9 kertaa 5 vuoden seurannan aikana. Psykoterapeuttien ammatillisten ja henkilökohtaisten ominaisuuksien vastaavuuksia tarkasteltiin yli kymmenentuhannen, eri teoreettista viitekehystä, uravaihetta, taustakoulutusta sekä kansallisuutta edustavan terapeutin käsittävässä kansainvälisessä aineistossa. Terapeuttien edustamat terapiamuodot sekä heidän ammatilliset ja henkilökohtaiset ominaisuutensa arvioitiin terapeuttien täyttämillä kyselyillä.

Helsingin Psykoterapiatutkimuksen tulokset osoittivat psykoterapeuttien ammatillisten ja henkilökohtaisten ominaisuuksien ennustavan yhteistyösuhteita ja hoitotuloksia eri tavoin erilaisissa ja eripituisissa terapioissa. Vähäisemmät

ammatillisen taitavuuden ja mielihyvän kokemukset vaikuttivat haitallisilta eritoten kahdessa lyhytterapiamuodossa; näissä ammatillinen itsevarmuus sekä aktiivinen, tilanteeseen tarttuva vuorovaikutustyyli vaikuttivat erityisen tarpeellisilta. Harkitseva, varovainen ja hienotunteinen vuorovaikutustyyli osoittautui puolestaan hyödyllisemmäksi pitkässä kuin lyhyessä terapiassa. Näitä tuloksia täydensi pitkän psykodynaamisen terapian ja psykoanalyysin vertailussa ilmennyt löydös: tulokset osoittivat ammatillisesti hillityn ja pidättyvän, mutta henkilökohtaisesti 'läsnäolevan' suhteessa olemisen tavan ennustavan hyvää hoitotulosta psykoanalyysissa. Tulokset kansainvälisestä terapeuttiaineistosta viittaavat siihen, että tällainen dynamiikka ammatillisten ja henkilökohtaisten ominaisuuksien välillä ei ole epätavallinen: nämä löydökset osoittivat terapeuttien muokkaavan ammatillista vuorovaikutustyyliään heidän yksityiselämänsä käyttäytymistavasta, pohjautuen heidän terapiamuotojensa asettamiin odotuksiin ja suosituksiin.

Tulokset on syytä toistaa jatkotutkimuksissa, joissa voitaisiin myös arvioida terapeuttien ominaisuuksia muista, esimerkiksi ulkoisten arvioitsijoiden ja potilaiden näkökulmista. Sikäli kuin tulokset varmentuvat, niitä voidaan soveltaa psykoterapeuttien koulutuksen ja työnohjauksen laadun sekä joustavuuden kehittämisessä. Löydökset voisivat auttaa terapeuttien henkilökohtaisten ominaisuuksien ja eri terapiamuotojen yhteensovittamisessa, tuloksellisen terapiakoulutuksen, oppimisen ja terapiatyön edistämiseksi.

Asiasanat: psykoterapia, psykoterapeutit, vaikuttavuuden ennustaminen, yhteistyösuhde, masennushäiriö, ahdistuneisuushäiriö

Contents

List of original papers

I Heinonen, E., Lindfors, O., Härkänen, T., Virtala, E., Jääskeläinen, T., & Knekt, P. (2013). Therapists' professional and personal characteristics as predictors of working alliance in short-term and long-term psychotherapies. *Clinical Psychology & Psychotherapy.* Advance online publication. doi:10.1002/cpp.1852

II Heinonen, E., Lindfors, O., Laaksonen, M. A., & Knekt, P. (2012). Therapists' professional and personal characteristics as predictors of outcome in short- and long-term psychotherapy. *Journal of Affective Disorders*, *138*, 301-312.

III Heinonen, E., Knekt, P., Jääskeläinen, T., & Lindfors, O. (2013). Therapists' professional and personal characteristics as predictors of outcome in long-term psychodynamic psychotherapy and psychoanalysis. *European Psychiatry*. Advance online publication. doi:10.1016/j.eurpsy.2013.07.002

IV Heinonen, E. & Orlinsky, D. E. (2013). Psychotherapists' personal identities, theoretical orientations, and professional relationships: elective affinity and role adjustment as modes of congruence. *Psychotherapy Research, 23*, 718-731.

Abbreviations

APA	American Psychiatric Association
DPCCQ	Development of Psychotherapists Common Core Questionnaire
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th edition
HPS	Helsinki Psychotherapy Study
LPP	Long-term psychodynamic psychotherapy
PA	Psychoanalysis
PST-Q	Personal Style of the Therapist Questionnaire
SCL-90-GSI	Symptom Check List 90, Global Severity Index
SFT	Solution-focused psychotherapy
SPP	Short-term psychodynamic psychotherapy
SPR CRN	Society for Psychotherapy Research Collaborative Research Network
TASC-2	Therapist Attitudes Scales
TCRS	Therapist Characteristics Rating Scale
WAI	Working Alliance Inventory
WHO	World Health Organization

1 INTRODUCTION

The overall effectiveness of both short- and long-term psychotherapies has been generally acknowledged (de Maat, de Jonghe, Schoevers, & Dekker, 2009; de Maat et al., 2013; Lambert, 2013; Lambert & Ogles, 2004; Leichsenring & Rabung, 2011; Sandell, 2012). However, the specific factors underlying therapy effectiveness are still not well-known. Among these factors, the relative importance of patient characteristics (such as diagnosis), specific therapy forms and techniques, and factors common in all therapies has been debated (Lambert & Barley, 2002; Wampold, 2001; Wampold, Hollon, & Hill, 2011). Yet considerably less attention has been given to therapist factors. This is despite the findings that therapists differ in their effectiveness and that these differences may often exceed treatment effects (Wampold, 2001). There is conspicuously little knowledge of what the characteristics of the more effective therapists actually are and whether different therapist qualities are required in therapies of different forms and lengths (Beutler et al., 2004; Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010).

The working alliance between therapist and patient – i.e., a collaborative relationship characterized by positive personal attachment and willingness to work together on mutually endorsed tasks and goals (Bordin, 1994) – has, on the other hand, been consistently identified as one of the strongest predictors of outcome across various therapy forms (Beutler et al., 2004; Horvath & Bedi, 2002; Horvath, Del Re, Flückiger, & Symonds, 2011). While numerous therapist characteristics have been found to be associated with the alliance (Ackerman & Hilsenroth, 2001, 2003), methodological limitations have been pointed out in this area of research. One central limitation involves assessing therapist characteristics and alliance from only a single observer-perspective and thereby making "halo effects" more likely (e.g., a patient who experiences alliance positively will consequently assess his or her therapist's characteristics more positively than otherwise) (Ackerman & Hilsenroth, 2003). Another common limitation involves correlational designs that have assessed alliance and therapist characteristics at only a single point in ongoing therapy and therefore not permitted any conclusions about the direction of effects between these variables (e.g., whether a display of negative therapist characteristics induces a negative working alliance or vice versa) (ibid.). Also, most of the studies have focused on only one form of psychotherapy rather than comparing whether therapist characteristics predict the formation and development of alliance differently in therapies of different form or length. In sum, the beneficial therapist characteristics for working alliance and outcome may be, depending on the characteristic, common for all therapies or beneficial only in therapies of certain form or length (Beutler et al., 2004).

More generally than in terms of specific characteristics, the central domains of beneficial therapist qualities have been contested. While influential proponents of certain therapeutic approaches may arguably emphasize the importance of therapists' various professional qualities, such as technical and relational skillfulness (e.g., Beck, 1976; Greenson, 1985), and while the hypothesized superiority of particular background disciplines has interested some scholars (e.g., psychology versus medicine versus social work) (cf. Beutler et al., 2004), other influential thinkers have suggested that the therapist's personal qualities as an authentic, empathic fellow human being may in fact be the central curative element of therapy (e.g., Rogers, 1957; Wampold, 2001, 2007; see also Frank & Frank, 1991). Hence, research aiming to identify the effective therapist's qualities would ideally look at the predictive ability of both professional and personal characteristics of clinicians. Furthermore, such research should investigate the potential interrelations of these qualities – that is, how therapists' professional selves are intertwined with their private lives and overall characters.

Among the most common psychological disorders treated by psychotherapy are depressive and anxiety disorders, which often run a recurrent and chronic course as well as cause incapacity and subjective distress (WHO, 2000). However, the issue of what the more effective therapists bring into treatments with their patients in treating these disorders has been subjected to very little comparative research looking simultaneously at therapies of differing forms and lengths. Therefore, knowledge of the beneficial professional and personal characteristics of therapists – and their associations – in different therapies could advance understanding of the therapy process and psychological change in the treatment of these disorders. Such knowledge should also have many practical implications for developing specific therapy orientations and selecting applicants for training in different forms of therapy; in influencing the contents and methods of psychotherapist training and supervision for developing characteristics found to be beneficial; and in improving the flexibility of training programs in accommodating trainees' personal qualities for the most effective learning and therapy practice.

The purpose of the present investigation is to study, in a longitudinal design, the ability of therapists' professional and personal characteristics to predict working alliance and outcome in therapies of different forms and lengths in the treatment of depressive and anxiety disorders; and, in a cross-sectional design, to investigate the interrelations of therapists' professional and personal qualities in therapists endorsing different theoretical orientations.

2 REVIEW OF THE LITERATURE

2.1 Definition and classification of therapist characteristics

Recent reviews (Beutler et al., 2004; Beutler, Machado, & Neufeldt, 1994) have classified therapist variables into quadrants, representing two intersecting dimensions (Figure 1). The first dimension makes a distinction between 'therapy-specific' versus 'cross-situational' characteristics of the therapist. Therapy-specific characteristics are employed or have been developed specifically in order to further one's role as a psychotherapist. These include variables such as professional background (e.g., psychologist, psychiatrist, or social worker) and therapeutic philosophy or orientation (e.g., psychodynamic or cognitive-behavioral approach). Cross-situational characteristics, in contrast, reflect enduring qualities that are manifested in the therapist's overall life and are incidental to the therapy process, such as the sex and personality of the therapist. For simplicity, 'therapy-specific' qualities will be referred to as therapists' professional characteristics and 'cross-situational' qualities as therapists' personal characteristics in the present investigation.

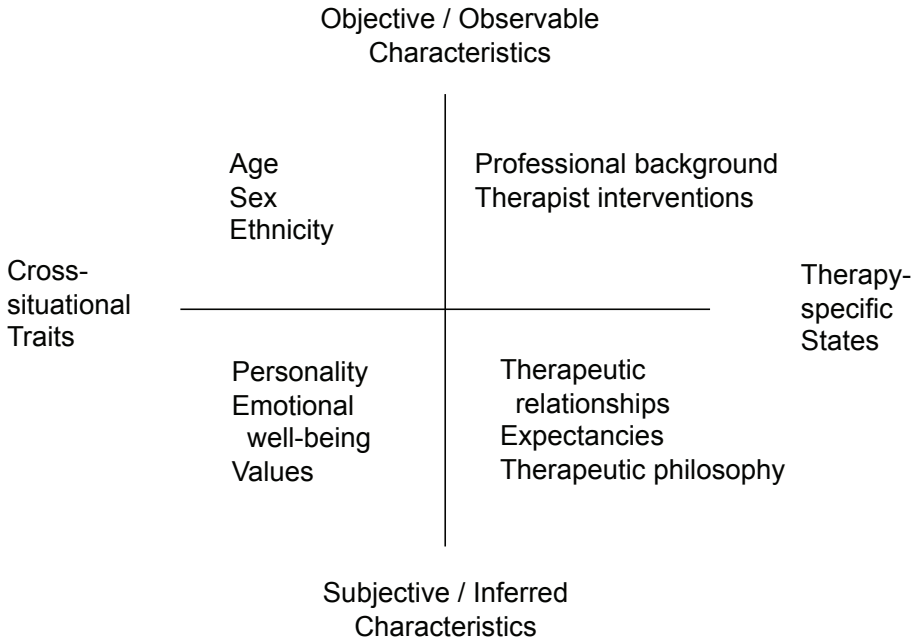


Figure 1. Classification of therapist variables (Beutler et al., 1994, 2004)

The second dimension of Beutler et al. (1994, 2004) establishes an essentially methodological distinction between those characteristics of the therapist that are observable and those that are inferred. Observable therapist variables can be observed and verified directly through means other than simply asking the therapist, e.g., through collateral reports or records of therapy sessions. These consist of characteristics such as sex and age and of therapeutic interventions and techniques used. Inferred qualities – which the present investigation focuses on – comprise hypothetical constructs whose identification relies on inferential processes: the therapist's personality, values, and relationship qualities, such as empathy. Inferred qualities can be identified through therapist self-report measures, for instance.

Finally, independently of the aforementioned dimensions but with relevance to the framing of the present investigation, therapist characteristics can be conceived of and studied as either pre-treatment or process variables. Pre-treatment variables – sometimes termed 'input variables' (Orlinsky, Rønnestad, & Willutzki, 2004) – are the characteristics that therapists and patients bring into the process of therapy, such as their demographics, personality, or theoretical orientation (Hill & Lambert, 2004). In contrast, process variables are the actions, experiences, and relatedness that emerge both between and within the therapy participants once the therapy has begun (Orlinsky et al., 2004).

Of the therapist pre-treatment variables, observable qualities such as sex, professional background (medical doctor, psychologist, social worker, etc.), and amount of training and experience have been studied as predictors of therapy process and outcome. The effects, however, have typically been rather small and inconsistent (reviews: Beutler et al., 2004; Bowman, Scogin, Floyd, & McKendree-Smith, 2001; Crits-Christoph et al., 1991). Therapists' inferred qualities, in contrast, have mostly been studied as process variables – that is, operationalized as related to a specific, initiated therapy relationship with a particular patient (reviews: Beutler et al., 2004; Orlinsky et al., 2004; Teyber & McClure, 2000). Accordingly, they have received scant attention as pre-treatment variables. This means that while inferred characteristics such as personality (Beutler et al., 2004) and relationship dispositions (Lambert & Ogles, 2004) have been viewed as important to psychotherapy outcomes and potentially helpful in explaining the differential effectiveness of therapists, these characteristics have rarely been conceptualized and studied as pre-treatment predictors of working alliance and outcome that antedate the interaction with a particular patient. In other words, although some therapists appear to be consistently more effective than others (Lambert & Barley, 2002), there is little empirical knowledge of the skills, traits, and qualities that these more effective therapists tend to initially bring to bear on each of their therapy processes with patients.

2.2 Review of measures for assessing therapist characteristics

Inferred therapist characteristics such as personality or relationship qualities are, by definition, not directly observable or verifiable. Furthermore, when they are conceptualized and investigated as pre-treatment predictors of working alliance and outcome, data from psychotherapy sessions themselves cannot be used for their assessment. One way of identifying therapists' inferred characteristics prior to the start of treatment is to use self-report measures, which are reviewed below; the other possible method is to conduct interviews, used especially in qualitative studies and with small therapist samples (cf. Rønnestad & Skovholt, 2003, 2012; Skovholt & Rønnestad, 1995).

The most relevant information on therapists would be expected to be gained with measures developed specifically for assessing the therapist profession. However, although therapists have often been surveyed in recent decades with questions specifically linked to facets of psychotherapeutic work, such as their stresses (Deutsch, 1984; Farber & Heifetz, 1981), satisfactions (Farber & Heifetz, 1981), theoretical approaches (e.g., psychodynamic, cognitive-behavioral, humanistic) (Garfield & Kurtz, 1977; Jensen, Bergin, & Greaves, 1990; Norcross, Karpiak, & Lister, 2005; Norcross & Prochaska, 1988), and beliefs about optimal practices in psychotherapy (Mahoney, Norcross, Prochaska, & Missar, 1989), and while systems have been developed for classifying therapist characteristics such as therapist intentions (Hill & O´Grady, 1985) and problems in psychotherapy (Davis et al., 1987), these surveys and systems have rarely been developed into psychometrically examined measures, documented in peer-reviewed journals. Only four such self-report measures were found, described below. The measures considered needed to be independent of the measurement of the treatment process (i.e., not relating to a specific therapy process or a specific patient). Measures excluded also included those that had a strong allegiance to one particular therapy orientation or technique (Gabbard, Howard, & Dunfee, 1986) or were judged to be outdated in their conceptualization (Howard, Orlinsky, & Trattner, 1970). Corresponding to the classification of therapists' inferred characteristics presented earlier (Beutler et al., 1994, 2004), the measures may be classified as assessing the therapists' personality (Keinan, Almagor, & Ben-Porath, 1989; Orlinsky et al., 1999), qualities in therapeutic relationships (Fernández-Alvarez, García, Lo Bianco, & Santoma, 2003; Orlinsky et al., 1999), and therapeutic philosophy (Fernández-Alvarez et al., 2003; Sandell, Carlsson, Schubert, Broberg, Lazar, & Grant, 2004).

The Therapist Characteristics Rating Scale TCRS (Keinan et al., 1989) is a rating scale for assessing therapists' personality characteristics. It was developed with the intent of differentiating therapists drawn to psychoanalytical, behavioural, and eclectic orientations. It consists of three scales for assessing insight-oriented characteristics (such as empathy, cognitive complexity, and self-consciousness), action-oriented characteristics (such as activeness, practicality, and optimism) and

authoritarian characteristics (such as exhibitionism, suspiciousness, and aggressiveness). The scales were developed using data from 64 Israeli therapists and demonstrated internal consistencies of .87, .83 and .78 (Cronbach's alphas), respectively. Poor criterion validity was indicated as a statistically significant association was found only for the action-oriented scale, on which behaviourally oriented therapists scored higher than eclectically and psychoanalytically oriented therapists. The TCRS has not been used in published studies in predicting working alliance or therapy outcome.

The Personal Style of the Therapist PST-Q (Fernández-Alvarez et al., 2003) was constructed to assess the particular set of professional qualities that a given therapist applies in every psychotherapeutic situation. It consists of five scales assessing therapists' tendencies in varied domains: i.e., instructional tendencies (e.g., ways of establishing and regulating the setting of the therapy), expressive tendencies (e.g., ways of ensuring emotional communication with the patient), engaging tendencies (e.g., ways in which the therapist's commitment to his work is manifested), attentive tendencies (e.g., ways of attuning to and gathering information from the patient), and operative tendencies (e.g., ways of preparing to make an impact on the patient in the course of therapy). The PST-Q was developed with data from 189 Argentinean therapists primarily of the cognitive, psychoanalytic, systemic, and integrative-eclectic orientations, with the five scales demonstrating internal consistencies of .69-.80 (Cronbach's alphas). Correlations of test-retest assessments four months apart indicated satisfactory stability of the scales, ranging between .76-.82. Although therapists endorsing different theoretical orientations and years of experience have been found to differ somewhat on the PST-Q dimensions (Castañeiras, García, Lo Bianco, Fernández-Alvarez, 2006), neither the measure's criterion validity nor its predictive ability on the alliance or treatment outcome has been specifically studied.

The Therapist Attitudes Scales TASC-2 (Sandell et al., 2004) assesses therapeutic attitudes. The TASC-2 has nine scales describing therapists' beliefs about what are the curative factors in psychotherapy (e.g., whether patients improve through adjustment to problems, gaining insight, or therapist kindness), assumptions about the nature of psychotherapy and the human mind (e.g., whether psychotherapy is more of an art or a science, whether humans are rational or irrational, whether therapists' attitudes imply belief in possibilities of development, change and understanding versus a more pessimistic fatalism), and their manner of conducting psychotherapy in general (e.g., whether they conduct therapy in a supportive, neutral or self-doubting manner). The TASC-2 was developed with data from a random sample of 227 therapists in Sweden, the nine scales demonstrating internal consistencies of .50-.87 (Cronbach's alphas). Therapeutic attitudes correlated with self-reported theoretical orientations of therapists (psychoanalytic, cognitive, cognitive-behavioral, and eclectic), supporting the criterion validity of the scales, and some of them have been found predictive of outcomes in long-term

psychodynamic therapy and psychoanalysis (Sandell, Lazar, Grant, Carlsson, Schubert, & Broberg, 2006, 2007).

The Development of Psychotherapists Common Core Questionnaire DPCCQ (Orlinsky et al., 1999; Orlinsky & Rønnestad, 2005, 2006) is a questionnaire designed to enable therapists to describe themselves both professionally and personally. Relevant to the present investigation, the DPCCQ assesses therapists' qualities and experiences in therapeutic relationships – such as experienced skills, feelings, difficulties, coping mechanisms, and relational agency and manner – as well as therapists' personality across interpersonal and temperamental domains. These characteristics are measured by 40 scales with internal consistencies of .46-.90. Compared to the TCRS, constructed to differentiate between therapist personalities of three distinct theoretical orientations, and the PST-Q and the TASC-2, assessing essentially the professional attitudes, tendencies, and preferences of therapists, the DPCCQ has arguably a wider scope than any of the other instruments as it has been developed to assess both the professional and the personal characteristics relevant to psychotherapists of all orientations. Also the database used for developing the DPCCQ surpasses the ones used for TCRS, PST-Q, TASC-2, representing over 4000 therapists from over 14 countries and orientations (Orlinsky & Rønnestad, 2005, 2006) and currently extending to over 10 000 therapists from over 30 countries (Orlinsky & Rønnestad, 2011).

All of the four therapist self-report measures also share some short-comings. Discriminant validity, i.e., the expected lack of association with measures of dissimilar constructs, and interrater reliability have not been evaluated for any of the measures. Also, it may be noted that none of the measures have been developed with the specific and unequivocal intent of predicting working alliance or outcome in psychotherapy.

The overall rather small number of measures available for assessing therapist pre-treatment variables is in contrast to the number of measures available for assessing therapist characteristics as treatment process variables, for which at least ten commonly used measures – assessing therapist characteristics such as social influence, techniques, intentions, helpfulness of interventions, nonverbal behaviors, empathy, genuineness, and respect for patient – have been identified and suggested in the prediction of outcome (Hill & Lambert, 2004). The lack of measures up until recently has been a likely contributor to the lack of research on the predictive ability of therapist pre-treatment characteristics on working alliance or therapy outcome, which is reviewed next.

2.3 Review of therapists' professional and personal characteristics as predictors of working alliance and outcome

The association of therapists' inferred characteristics with working alliance and psychotherapy outcome has been studied and reviewed during recent decades (reviews: Ackerman & Hilsenroth, 2001, 2003; Beutler et al., 1994, 2004; Beutler, Crago, & Arizmendi, 1986; Orlinsky, Grawe, & Parks, 1994; Orlinsky et al., 2004; Norcross & Wampold, 2011). However, the conceptual and methodological distinction between therapist pre-treatment versus process variables has rarely been made. This complicates making the distinction between the qualities that therapists initially bring to the treatment, independently of and predating the interaction with a particular patient, and those therapist qualities and actions that are induced by the interaction with a specific patient in a particular therapy process. A review of original quantitative studies on the predictive ability of therapists' pre-treatment characteristics on the working alliance and outcome in the treatment of depressive and anxiety disorders was thus conducted as part of the present investigation. Inclusion and exclusion criteria are presented in Appendix 1; three articles from Germany (Dinger, Strack, Leichsenring, & Schauenburg, 2007; Dinger, Strack, Sachsse, & Schauenburg, 2009; Schauenburg et al., 2010) were included that consisted of inpatients, but were evaluated as essentially comparable to the outpatient populations of the other studies.

2.3.1 Review of therapists' professional and personal characteristics as predictors of working alliance

Corresponding to the classification of therapist variables presented earlier (Figure 1) (Beutler et al., 1994, 2004), therapists' professional pre-treatment characteristics explored as predictors of working alliance could best be subsumed under the rubric of therapists' typical qualities and dispositions in therapeutic relationships (Nissen-Lie, Monsen, & Rønnestad, 2010). Similarly, the investigated personal characteristics of therapists also concern their relationships, albeit in private life: more specifically, therapists' relational tendencies as well as both positive and negative experiences in early parental care and in current adulthood relationships (Dinger et al., 2007, 2009; Hersoug, Høglend, Havik, von der Lippe, & Monsen, 2009; Hersoug, Høglend, Monsen, & Havik, 2001; Hilliard, Henry, & Strupp, 2000; Schauenburg et al, 2010). Hence, in the classification scheme of Beutler et al., these characteristics would be best subsumed under the domains of therapist personality and emotional wellbeing.

2.3.1.1 Therapists' professional characteristics as predictors of working alliance

In an observational study of relatively long-term, nonmanualized and predominantly psychodynamically influenced psychotherapies in standard clinical practice,

therapists' professional experiences of skillfullness and relational style were explored as predictors of patient-rated alliance at the 3rd session (Nissen-Lie et al., 2010) (Table 1). A total of 68 experienced therapists from 16 outpatient clinics across the Norwegian healthcare system provided treatment for 235 patients suffering mostly from anxiety, affective, and co-morbid personality disorders. Contrary to researchers' expectations, patients' experiences of better working alliances at the third session were not predicted by either therapists' global experiences of more effective practice (i.e., skillfullness, efficacy, coping skills, investment in work, and an affirming manner) or less stressful practice (i.e., frequently experienced difficulties, anxiety, boredom, and coping by avoidance of difficult issues). However, therapists' negative personal reaction to patients (i.e., more hostility, empathic deficiency, and frustration with a patient) predicted worse patient-rated alliances. In contrast, therapists' professional self-doubt in their therapeutic capabilities – interpreted by the authors as indicating clinicians' humbleness and sensitivity – predicted better patient-rated alliances. Finally, therapists' greater self-reported advanced relational skills in using their own and the patients' emotional reactions in therapy process predicted worse alliances, when adjusted for a warm interpersonal style and the therapist's experienced difficulties. For better alliances, the authors concluded, therapists should be cautious in using advanced relational skills unless they also simultaneously relate to patients in a warm manner and do not generally experience negative personal reactions to their patients. Put another way, it seems clinicians enamoured of their own skills and feeling justified in their negative sentiments toward patients – as opposed to feeling self-doubt and humility when experiencing difficulties – may face particular trouble in creating good working alliances.

2.3.1.2 Therapists' personal characteristics as predictors of working alliance

Therapists' personal characteristics have been investigated as predictors of both patient- and therapist-rated alliance in several studies. These investigations into clinicians' private lives have focused on both the early development and the later adulthood interpersonal experiences of therapists.

In a U.S. research project that was initiated to study the effect of training in short-term psychodynamic therapy, the parental relationships of relatively early-career therapists were studied in a sample of 16 clinicians who treated 64 patients with predominantly Axis I disorders, with two thirds of the patients also suffering from co-morbid Axis II disorders (Hilliard et al., 2000). Therapists' negative experiences of early parental relations predicted more disaffiliative therapy processes at the 3rd therapy session, i.e., worse therapeutic relationships, as rated from the therapists' own perspective. However, patients' or independent observers' assessments of the relationship at the 3rd session were not affected by therapists' self-rated worse early parental relations.

Two larger-scale, observational studies of long-term or open-ended, principally psychodynamic treatments in Norway also explored therapists' experiences with early caregivers as predictors of alliance (Hersoug et al., 2001, 2009). Additional predictors were therapists' attitudes toward themselves as well as their interpersonal problems in their current life. The predominant patient diagnoses were mood, anxiety, and personality disorders, each diagnosed in at least half the sample consisting of over 200 clients. Treatments were provided in standard clinical practice by over 50 relatively experienced clinicians at 6-7 different sites across the Norwegian healthcare system. In the first study (Hersoug et al., 2001), therapist variables predicted therapists' evaluations of alliance at both the 3rd and the 12th session but only predicted the patients' evaluations at the later, 12th session. Therapists' warmer bonding to their own parents in childhood predicted better alliances as rated by both treatment parties, whereas therapists' current interpersonal problems of relational 'coldness' (such as being too aggressive in private life) predicted worse alliances, both seemingly expectable findings. Ratings of alliance diverged interestingly between the two treatment parties, when practitioners experienced problems regarding interpersonal 'warmth' in private life (i.e., being either overly avoidant, nonassertive, nurturing, or exploitable). These relational problems of clinicians predicted worse therapist-rated alliances, but they did not harm the patients' experiences of alliance. In addition, a more dominant, but less self-controlling style and, most intriguingly, a high self-attacking tendency predicted better patient alliances at the later 12th session, with the last quality also predicting worse therapist-rated alliances both early and later in therapy and thus converging with the aforementioned findings by Hilliard et al. (2000). While little interpretation was provided for these interesting and unexpected findings, they call for further empirical research on therapists' relational qualities in private life to elucidate the meaning and impact of these measured concepts in therapy.

The generally detrimental effect of therapists' interpersonal problems for building a positive working alliance based on mutually endorsed tasks and goals and an empathic bond was supported and strengthened in the second study by Hersoug et al. (2009). Clinicians' interpersonal 'coldness' or 'detachment' in private life, such as being distanced, disconnected, or indifferent, predicted worse patient- and therapist-rated alliances, as rated at the 20th, 60th and 120th sessions – again a seemingly expected finding. In contrast, practitioners' greater perceived care of themselves by their mother in childhood predicted better patient-rated alliances at these same three measurement points. Additionally, the study explored whether these therapist pre-treatment characteristics predicted the improvement or deterioration of alliance during the course of the first 120 therapy sessions. However, no significant results were found.

Conceptually linking and extending these aforementioned investigations of the predictive ability of therapists' childhoods and interpersonal problems, several large-scale studies in Germany (Dinger et al., 2007, 2009; Schauenburg et al., 2010) have

– in conjunction with therapists' relational difficulties – also investigated therapists' attachment relationships, which are typically seen as originating in childhood and extending to adulthood relationships and care-giving behaviors in them. Common with German national practice, the patients in these studies, suffering most often from mood disorders and diversely from other Axis I and Axis II diagnoses, were treated in mostly inpatient settings with various therapeutic modalities, but in all studies with a predominant individual psychodynamic therapy component. Correspondingly with the inpatient setting, the therapies were short-term, lasting on average under 4 months, and the ratio of patients (range of n = 281-1513) to therapists (range of n = 12-31) surpassing other studies. The first of these investigations (Dinger et al., 2007) found no influence of therapists' interpersonal problems on the patient-rated alliance, unlike in the Hersoug et al. (2001, 2009) studies. However, any possible associations may have been attenuated by certain factors: alliance being measured only retrospectively at the end of the overall treatment and, as a related matter, the patients may have had problems, when assessing the alliance, in differentiating their individual psychodynamic therapist from the other hospital staff providing other treatment modalities to them (Dinger et al., 2007). Indeed, a later study in a similar setting but now using weekly alliance assessments (Dinger et al., 2009) showed a higher attachment preoccupation in therapists (i.e., being insecure of emotionally significant others' feelings and consequently tending to cling to and control others in an effort to minimize distance from them) to predict worse patient alliances. Furthermore, an interesting interaction effect with the patients' interpersonal problems was noted. Therapists with lower attachment preoccupation (i.e., who tend more toward dismissiveness and devaluing relationships and who feel more comfortable in distant relationships) had better alliances especially with those patients who reported fewer interpersonal problems. No particular interpretation of this finding was suggested by the authors.

In the study by Schauenburg et al. (2010), the attachment style of psychodynamically oriented therapists was studied again as a predictor of retrospective, patient-rated alliance after an average of 12-week inpatient treatment that utilized both psychodynamic and cognitive-behavioral elements. However, no direct effect on the patient-rated alliance was found for practitioners' attachment styles in private life (i.e., tendencies towards feeling security versus insecurity and dismissiveness versus preoccupation in close personal relationships). However, as in the earlier Dinger et al. (2009) study, an interaction effect was noted, with the finding that a higher attachment security of the therapist facilitated better alliance especially with the more severely impaired patients.

Table 1. Therapists' professional and personal characteristics as predictors of working alliance.

Reference	Diagnosis[1]	Therapy[1]	Sessions, M (SD); range[1]	Frequency of alliance assessment[1]	Patients	Male / Therapists	Therapist age, yrs. M (SD); range	Therapist experience, yrs., M (SD); range	Predictor[1]	Alliance measure[1]	Number of associations[2]
Professional characteristics											
Nissen-Lie et al. (2010)	AFF 50%, ANX 65%, PD 48 %	NR[3] (PDT)	52 (59); 1-364	1 (session 3)	335	NR/68	NR	10 (6.6); 0-28	DPCCQ	Short WAI-P	4/7
Personal characteristics											
Dinger et al. (2007)	AFF 73%, ANX 46%, OCD 9%, PD 65%, ADJ 45%, EAT 24%, SOM 21%, PSY 6%[6]	PDT[4]	either 6 (2.6) or 14 weeks (4.9)[5]	1 (at the end of treat-ment)	1513	16/31	37; 26-54	7; 0-22	IIP	HAQ	0/10
Dinger et al. (2009)	DEP 58%, ANX 22%, OCD 5%, PD 21%, ADJ 9%, EAT 18%, SOM 16%,	PDT[6]	12 weeks (3.0)	Weekly ratings throughout treatment	281	3/12	36; 26-43	3.5; 1 month to 7 yrs.	AAI	IES	2/6
Hersoug et al. (2001)	DEP 33%, DYS 22%, GAD 22%, Other ANX 40%, PD 82%, SOC 28%,	PDT[7]	Open-ended[8]	2 (sessions 3 and 12)	270	21/50	44 (6)	10 (7)	IIP-C SASB PBI	WAI-P WAI-T	10/36
Hersoug et al. (2009)	AFF 50%, ANX 64%, PD 48% SOM 24%, EAT 9%, SUB 3%, Other 5%	PDT[9]	61 (51.1)	8 (sessions 3, 12, 20, 40, 60, 80, 100 and 120)	201	NR/61	NR	9.8 (6.4)	IIP, PBI	Short WAI-P and WAI-T	3/16
Hilliard et al. (2000)	MIXED I 87 % MIXED II 67 %	PDT	21 (6.1); 4-25	1 (session 3)	64	10/16	NR	5.6 (3.0)	SASB Intrex (Early parental relations)	SASB Intrex (Inter-personal Process)	1/3

Schauenburg et al. (2010)	AFF 56%, ANX 36%, OCD 7%, PD 41%, EAT 19%, SOM 17%, PSY 4%	PDT, CBT[10]	12 weeks (5.4)	1 (at the end of treat-ment)	1381	16/31	37.4 (6.5); 26-54	6.6 (4.8); 0.1-21.5	AAI	HAQ	0/2

[1] See Appendix 2.
[2] Significant associations / tested associations.
[3] Therapies not reported in the article, but the study was based on the data from the Norwegian multisite study on process and outcome of psychotherapy (NMSPOP), where therapies have been reported to be mainly within the psychodynamic tradition (Hersoug et al., 2009).
[4] All patients were treated with psychodynamically oriented inpatient psychotherapy and received individual therapy (one to two times per week) as well as complementing therapeutic elements. Most patients also received group therapy (twice a week), and art- and body-oriented therapy was available (Dinger et al., 2007).
[5] Study included both patients in normal inpatient treatment (longer mean duration) as well as patients in a crisis intervention treatment (shorter mean duration) (Dinger et al., 2007).
[6] The main orientation of the clinic was psychodynamic, but behavioral and disorder-specific interventions were included in the treatment (Dinger et al., 2009).
[7] The therapies comprised treatment as usual, mainly within the psychodynamic tradition (Hersoug et al., 2001).
[8] Of the seven sites offering therapy in the study, one clinic had a limit of 40 sessions (Hersoug et al., 2001).
[9] Therapies reported to have been mainly within the psychodynamic tradition.
[10] Patients received multimodal intensive inpatient psychotherapy with cognitive-behavioral as well as psychodynamic elements (Schauenburg et al., 2010).

2.3.2 Review of therapists' professional and personal characteristics as predictors of outcome

Corresponding to the classification of therapist variables presented earlier (Beutler et al., 1994, 2004), therapists' professional characteristics used as predictors of outcome may be categorized under the domains of therapeutic philosophy and expectations (Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Sandell, Blomberg, Lazar, Carlsson, Broberg, & Schubert, 2000; Sandell et al., 2006, 2007). Therapists' personal characteristics used as predictors of outcome have largely been the same as in the studies on alliance which were reviewed in the preceding section. Thus, they could best be subsumed broadly under the domain of personality and emotional wellbeing, considered from such various viewpoints as therapists' attitudes and feelings toward themselves (Hersoug, 2004), their interpersonal problems (Dinger et al., 2007; Schauenburg et al., 2010), and their early experiences of their parents (Hersoug, 2004; Hilliard et al., 2000).

2.3.2.1 Therapists' professional characteristics as predictors of outcome

In a manualized and monitored U.S. multisite, randomized clinical trial comparing pharmacotherapy and two short-term therapies of interpersonal and cognitive-behavioral forms, 28 experienced clinicians treated 239 patients suffering from major depressive disorder (Table 2) (Blatt et al., 1996). As few differences in effectiveness emerged between the three treatment conditions, subsequent analyses focused on therapists' attitudes and beliefs about the etiology and treatment of depression in a comparison of 'the most', 'the least', and 'the moderately' effective therapists in all the three conditions. Effectiveness was measured at the end of the treatment period lasting approximately four months (16-20 sessions) with a composite score that was formed of five common outcome measures covering general psychiatric and, more specifically, depressive symptoms, as well as social and general adjustment. While effectiveness was not related to the treatment condition or the research site, interestingly both 'the least' and 'the most' effective therapists were found to consider psychological factors and adverse environmental experiences as more central to the etiology of depression than the moderately effective therapists. With respect to general attitudes of treating depression, the most effective therapists valued medication significantly less and expected treatment to take longer than the least and the moderately effective therapists (Blatt et al., 1996).

In investigations of considerably longer-term therapies than the aforementioned U.S. trial – albeit similarly centered mainly on Axis I disorders – a series of observational studies in Sweden focused on practitioners' professional attitudes and beliefs, investigating long-term psychodynamic therapy and psychoanalysis (Sandell et al., 2000, 2006, 2007). The large-scale, complex design with panel-wave measurements comprised both patients that were currently in treatment and individuals with up to 3 years after the end of their treatments (range of n = 225–

337), treated by experienced therapists (range of n = 142–167 for those two studies that reported the number of therapists), with outcomes assessed primarily via general psychiatric symptoms. First findings (Sandell et al., 2000) indicated that therapists with classically psychoanalytic attitudes – having less emphasis on supportiveness and facilitating coping strategies and having less warmth and openness in their therapeutic approach – were less effective in delivering long-term psychotherapy than psychoanalysis and less effective than eclectic therapists delivering either kind of treatment, as judged by post-treatment outcomes. A later study (Sandell et al., 2006), not distinguishing between the two treatments this time but scrutinizing therapist variability in effectiveness, investigated the predictive ability of therapists' beliefs about the curative factors in psychotherapy, their assumptions about the nature of psychotherapy and the human mind, and their manner of conducting psychotherapy in general. These further findings indicated that the more effective therapists were characterized by a stronger belief in the curative power of therapist kindness as well as a more neutral relational manner. Therapists with poor outcomes, in contrast, were characterized by a stronger belief in the curative power of successful adjustment, more pessimism towards the human condition and the therapeutic enterprise, as well as low neutrality in professional manner, and a view of therapy more as a set of learnable skills than as artistry.

The same beliefs and attitudes were explored in a subsequent analysis of two groups (Sandell et al., 2007), this time comparing a sample of patients currently in psychodynamic therapy or psychoanalysis to a group of patients that had finished treatment. No qualities predicted symptom change of patients currently undergoing therapy. However, four therapist attitudes predicted significantly greater symptom decrease for those patients who had finished treatment: these were valuation of insight and kindness as curative factors in therapy, viewing therapy work as artistry, and having a self-reported supportive relational manner, as rated by the practitioner.

2.3.2.2 Therapists' personal characteristics as predictors of outcome

In the small-scale U.S. study described earlier (Hilliard et al., 2000), which evaluated the effects of training in short-term psychodynamic therapies, therapists' early parental relationships were explored as determinants of outcome in the treatment of patients with predominantly Axis I disorders. Clinicians' better or worse experiences of their parents did not predict outcome directly, rated either from their patients', outside observers', or the therapists' own viewpoints. Nevertheless, as early parental relations predicted therapists' own ratings of the therapy process, which in turn predicted their ratings of the outcome, the authors hypothesized an indirect link between therapists' early care-giving relationships and outcome.

Therapists' experiences of early parental care were also explored in a Norwegian study originating from the multisite project (cf. Havik et al., 1995) described earlier, but this time using data from only one site (Hersoug, 2004). Patients suffering mainly from mood, anxiety, and personality disorders were treated by 7 experienced

therapists in brief psychodynamic therapy lasting up to 40 sessions, with outcome defined and measured as the proportion of maladaptive defenses utilized after the end of therapy. Therapists' experiences of parental care during their first 16 years of life as well as their attitudes and feelings toward themselves were used as predictors, but none of these had significant direct effects on the decrease of maladaptive defenses.

Similarly, in a German study described previously (Dinger et al., 2007), therapists' interpersonal dispositions to behave in a 'dominant' or 'friendly' manner were explored as predictors of outcome, as measured by global psychiatric symptoms. However, these interpersonal tendencies did not have direct and significant influence on outcome. A negative effect of therapist characteristics on outcome was, however, observed in interaction with patient-rated therapeutic alliance: for those therapists who described themselves as too 'cold' in private life, the positive effect of a good alliance on outcome was stronger than for those therapists who described themselves as too friendly. Likewise, another German study described previously (Schauenburg et al., 2010) also failed to find that therapists' attachment relationship qualities (experiences of security versus insecurity and dismissiveness versus preoccupation in private relationships) have any direct impact on outcome. However, again an interaction was noted: therapists' higher attachment security was associated with better outcome (as earlier with alliances) when dealing with more severely impaired patients.

Table 2. Therapists' professional and personal characteristics as predictors of outcome.

Reference	Diagnosis[1]	Therapy[1]	Sessions, M (SD); range[1]	Follow-up	Patients	Male / Therapists	Therapist age, yrs., M (SD); range	Therapist experience, yrs., M (SD); range	Predictor[1]	Outcome[1]	Number of assocations[2]
Professional characteristics											
Blatt et al. (1996)	DEP 100%	CBT, IPT, IMI-CM[3]	16-20	end of treatment	125	19/27	NR	11	Expectancies and attitudes[4]	Composite of BDI, HDRS, SCL-90-GSI, GAS, SAS	3/13
Sandell et al. (2000)	MIXED I, II NR[5]	LPT, PA	LPT:233 (151) PA:642 (324)	2-3 yrs. after end of treatment[6]	337	NR	NR	NR	Therapeutic attitudes[7]	SCL-90-GSI	6/NR[8]
Sandell et al. (2006)	MIXED I, II NR[5]	LPT, PA, LDT[9]	NR[10]	2-3 yrs. after end of treatment[6]	327	40/167	54 (6.4)	21	TASC-2	SCL-90-GSI	3/9
Sandell et al. (2007)	MIXED I, II NR[5]	LPT, PA, LDT[11]	NR[10]	2-3 yrs. after end of treatment[6]	225	33/142	54 (6.4)	20; 10-35	TASC-2	SCL-90-GSI	6/9
Personal characteristics											
Dinger et al. (2007)	AFF 73%, ANX 46%, PD 65%, ADJ 45%, EAT 24%, SOM 21%, OCD 9%, PSY 6%[6]	PDT[12]	6 (2.6) weeks or 14 weeks (4.9)[13]	end of treatment	1513	16/31	37; 26-54	7; 0-22	IIP	SCL-90-GSI	0/10
Hersoug (2004)	DEP 67% ANX 67%, PD 67%	PDT[14]	35 ($\leq$ 40)	end of treatment	39	1/7	44	10; 4-17	SASB Intrex, PBI	DMRS	0/4

Hilliard et al. (2000)	MIXED I 87 % MIXED II 67 %	PDT	21 (6.1); 4-25	end of treatment	80	10/16	NR	5.6 (3.0)	SASB Intrex (Early parental relations)	GOR, SASB Intrex (Introject at best and worst), SCL-90-GSI	0/6
Schauenburg et al. (2010)	AFF 56%, ANX 36%, OCD 7%, PD 41%, EAT 19%, SOM 17%, PSY 4%	PDT, CBT[15]	12 weeks (5.4)	end of treatment	1381	16/31	37.4 (6.5); 26-54	6.6 (4.8); 0.1-21.5	AAI	GSI, IIP, IS	0/6

[1] See Appendix 2.
[2] Significant associations / tested associations.
[3] IMI-CM = imipramine plus clinical management, used as a standard reference.
[4] 13 attitudes and expectations on the etiology and treatment of depression.
[5] For information on the characteristics of total patient sample in STOPPP, information is provided by Blomberg, Lazar and Sandell (2001): The total sample consisted of 405 patients. Of the psychotherapy patients, 58% were diagnosed with an Axis I disorder and 12% with an Axis II disorder. Of the psychoanalysis patients, 54% were diagnosed with an Axis I disorder and 11% with an Axis II disorder. Exact data on patient diagnoses in studies of the present table (Sandell et al., 2000, 2006, 2007) have not been reported.
[6] Due to study design, follow-up time varied depending on when patients had started their therapy. Maximum follow-up after the end of treatment was 2-3 years (Sandell et al., 2000).
[7] TASC-2 scales (published in a peer-reviewed journal in 2004) not developed at this point yet, but attitudes with names similar to the ones in TASC-2 used as outcome predictors.
[8] Graphs of growth curves, or "decay curves", of psychiatric symptoms reported, but not the method used more specifically. Statistical significance not tested in the analysis of therapist variables as predictors of outcome.
[9] 10 patients were in so-called low-dose therapies (e.g. brief therapy, low-frequency supportive therapy, family therapy, group therapy) (Sandell et al., 2006).
[10] Data analyses included also patients who had not terminated their therapies. For the average number of sessions of terminated treatments in STOPPP, see Sandell et al. (2000) in the present table.
[11] 3 patients were in so-called low-dose therapies (e.g. brief therapy, low-frequency supportive therapy, family therapy, group therapy) (Sandell et al., 2007).
[12] All patients were treated with psychodynamically oriented inpatient psychotherapy and received individual therapy (one to two times per week) as well as complementing therapeutic elements. Most patients also received group therapy (twice a week), and art- and body-oriented therapy was available (Dinger et al., 2007).
[13] Study included both patients in normal inpatient treatment (longer mean duration) as well as patients in a crisis intervention treatment (shorter mean duration) (Dinger et al., 2007).
[14] Most therapists had a psychodynamic orientation (Hersoug, 2004).
[15] Patients received multimodal intensive inpatient psychotherapy with cognitive-behavioral as well as psychodynamic elements (Schauenburg et al., 2010).

2.3.3 Summary of the research on the predictive ability of therapists' professional and personal characteristics on working alliance and outcome

While limited in number, the existing studies on therapists' pre-treatment characteristics as predictors of working alliance and outcome suggest a few tentative conclusions on which to build further research. Most importantly, these studies indicate that both professional and personal characteristics of therapists do seem to matter in making some clinicians better than others. Furthermore, these characteristics seem to encompass qualities relevant to both the task-instrumental and the social-emotional aspects of therapy work (Orlinsky & Howard, 1987): that is, qualities relevant to performing the technical operations in which the patient and the therapist engage in pursuit of outcomes (such as a therapist's skillfullness, difficulties, coping mechanisms, and attitudes and beliefs regarding treatment), as well as the clinician's interpersonal qualities that enable building a positive working relationship in which those technical operations may take place (such as a therapist's professional relational manner, his own attachment style and interpersonal issues, and the accompanying emotions in the therapy process). This seems expectable if the conduct of psychotherapy is understood to be both an expert profession, requiring an acquisition of specific knowledge and skills and, at the same time, an essentially personal relationship, albeit one offered in a professional context and bound by specific ethical boundaries (ibid.).

Despite the theoretical plausibility of the aforementioned research findings, it may be noted that few measures have been developed to actually assess the therapist profession and specifically the pre-treatment characteristics that clinicians bring initially to their therapy work. Consequently, the number of studies looking at therapists' pre-treatment characteristics has been limited. However, based on existing research, certain tentative conclusions may be put forward, which should be corroborated and extended by further investigations.

First, regarding working alliance, a finding emerges that therapists' interpersonal problems, manifested in both early life as well as in current relationships, seem to predict worse therapy alliances (Dinger et al., 2009; Hersoug et al., 2001, 2009; Hilliard et al., 2000). However, whereas certain characteristics such as being too 'cold' have been found harmful for both patient and therapist assessments of the alliance (Hersoug et al., 2001, 2009), the perspectives of therapy participants are nevertheless not equivalent. For example, therapists' problems with being overly avoidant, nonassertive, nurturing or exploitable in private life have predicted worse therapist-rated alliances. Yet they have not seemed to harm the patients' experiences of the alliance (Hersoug et al., 2001; cf. Hilliard et al., 2000). That the perspectives of the participants concerning the alliance or other aspects of the therapy process may diverge is not a surprising finding as such (cf. Bachelor, 2013; Clemence,

Hilsenroth, Ackerman, Strassle, & Handler, 2005; Orlinsky et al., 1994, 2004). However, it does underline the importance of looking at the experiences of both treatment parties when studying the impact of therapist qualities. Even if some of the therapist's self-experienced qualities do not directly predict the patient's experience of the working relationship, they may well influence the clinician's actions and consequently also therapy outcomes experienced by the patient.

Another finding pertinent to the alliance and the distinct observational perspectives concerns the temporal aspect of therapy. While therapists' interpersonal problems may, plausibly as well as demonstrably, prevent therapists from experiencing a good working relationship right from the beginning of therapy, these problems may not emerge as saliently harmful for the patient-rated alliance until later on in the therapy process (Hersoug et al., 2001, 2009; Hilliard et al., 2000). This indicates that ideally studies should assess working alliance not only from the viewpoints of both the therapist and the patient, but also both early and later in the treatment. Finally, regarding the alliance, it may be noted that therapists' professional characteristics have been very rarely studied as its predictors, but at least therapists' self-experienced skillfulness together with their professional interpersonal tendencies (such as a warm relational stance versus a hostile and frustrated relational manner) seem to be related in a complex way to patient-rated alliance (Nissen-Lie et al., 2010); this indicates the need for further study of the impact of therapists' professional qualities on both therapist- and patient-rated alliances.

A similarly complex picture emerges from the research on therapists' professional and personal pre-treatment characteristics as predictors of outcome. In this field of research, the professional characteristics of therapists have been explored more frequently than in the study of alliance. Studies have shown a variety of professional qualities pertaining to clinicians' attitudes and beliefs regarding therapy work to predict the patient-rated outcomes. It seems that therapists with a more psychological focus and patience in expectance of outcomes yield better outcomes in short-term therapies of different forms (Blatt et al., 1996). In long-term therapies, therapists with a creative, kind, and neutral therapeutic attitude and approach have in turn yielded better outcomes (Sandell et al., 2006, 2007). However, distinct long-term therapies may also require differing qualities, as findings also indicate that a classically psychoanalytic attitude and manner has seemed to be especially unbeneficial when conducting long-term psychodynamic therapy instead of psychoanalysis (Sandell et al., 2000). As another interesting finding, it seems that certain professional attitudes may not show their influence during treatment, with their effect becoming only apparent at the very end of treatment (Sandell et al., 2007). This is also intriguing in view of the fact that several of the interpersonal qualities of therapists which predicted alliance from both their own and their patients' viewpoints were not necessarily directly predictive of outcomes (Dinger et al., 2007; Hersoug, 2004; Schauenburg et al., 2010). This

suggests that the relationships between therapists' pre-treatment characteristics, the alliance, the treatment process, and the outcomes of therapy are likely to be complex and manifold. In other words, even though the alliance has been noted to be one of the most robust and consistent predictors of outcome, the therapist qualities that are beneficial to the global alliance may not necessarily and always be the same as those important to outcome and vice versa.

In summary of the research to date on therapists' beneficial pre-treatment qualities, the limits of knowledge are apparent. First and foremost, there are virtually no comparative study designs in existence that would enable investigation of whether the same or different qualities are required in therapies of different forms and lengths. Yet knowledge from such designs could be important for both optimizing therapy outcomes (via e.g., training or supervision of therapists) and elucidating the treatment process in various therapies, as exemplified by the findings of Sandell et al. (2000). As one particular but noteworthy issue, although short-term therapies have been suggested to require different therapist qualities than more long-term treatments (Dewan, Steenbarger, & Greenberg, 2011; Parry, Roth, & Kerr, 2005), both having been found effective for treating mood and anxiety disorders in their own right (Knekt et al., 2008, 2011), no research to date has shown empirical evidence on this issue. Pertaining to the same issue, studies to date have typically ended the evaluation of outcomes at the termination of therapies: thus, comparative designs investigating short- and long-term therapies with a parallel ongoing follow-up would shed light on the longer-term effects of therapist qualities and thus go beyond the present knowledge that ends most often at the conclusion of therapy.

From the second, more conceptual and methodological perspective, several concerns emerge likewise which should be addressed in extending current knowledge. To begin with, given the divergence of the patient and the therapist perspectives, multiple observational viewpoints on the therapy process would clearly seem to be preferable. Second, while such research has to date been scarce, studies should ideally investigate the impact of both the professional and the personal characteristics simultaneously to gain a broader view of the multiple potential determinants of the alliance and outcome. Finally, knowledge of the associations between these professional and personal characteristics, and how they differ between therapists espousing different theoretical orientations and treatment models, might be valuable for developing beneficial therapist qualities in different forms of therapy.

3 AIMS OF THE STUDY

The first aim of the study was to investigate, using a newly developed therapist self-report measure, the ability of therapists' professional and personal characteristics to predict working alliance and outcome in both short- and long-term therapies in the treatment of depressive and anxiety disorders. The second aim was to investigate the correspondence between professional and personal qualities of therapists in an international survey of clinicians representing different professional backgrounds, cohorts, and theoretical orientations. The more specific aims were to investigate:

1. whether therapists' professional and personal characteristics predict working alliance and its development differently in short-term (solution-focused and psychodynamic) versus long-term psychotherapies (psychodynamic and psychoanalysis) during the first seven months of treatment (Study I);

2. whether therapists' professional and personal characteristics predict outcome differently in short-term (solution-focused and psychodynamic) versus long-term (psychodynamic) psychotherapies during a 3-year follow-up (Study II);

3. whether therapists' professional and personal characteristics predict outcome differently in two long-term psychotherapies (psychodynamic therapy versus psychoanalysis) during a 5-year follow-up (Study III); and

4. whether there are correspondences between therapists' professional and personal characteristics and whether these associations differ between therapists preferring different theoretical orientations (Study IV).

4 POPULATION AND METHODS

4.1 Data

4.1.1 Helsinki Psychotherapy Study (Studies I, II, and III)

4.1.1.1 Patients and settings

A total of 506 eligible outpatients were recruited to the Helsinki Psychotherapy Study (HPS) from psychiatric services in the Helsinki region from June 1994 to June 2000 (Knekt & Lindfors, 2004). Eligible patients were 20-45 years of age and had a long-standing disorder causing work dysfunction. They had to meet DSM-IV criteria (APA, 1994) for anxiety or mood disorders. Patients with psychotic disorder, severe personality disorder (DSM-IV cluster A personality disorder and/or lower level borderline personality organization), adjustment disorder, substance abuse or organic disorder were excluded, as were individuals who had undergone psychotherapy within the previous 2 years, psychiatric health employees and persons known to the research team.

Of the 506 patients referred to the HPS, 139 refused to participate. Of the remaining 367 patients, 97 were randomly assigned to solution-focused therapy (SFT), 101 to short-term psychodynamic psychotherapy (SPP), and 128 to long-term psychodynamic psychotherapy (LPP), and 41 were self-selected to psychoanalysis (PA). The predominant patient problems, measured at baseline, were depressive and anxiety disorders, with close to half of the sample also suffering from co-morbidity within these disorders or with personality disorders (Table 3). After baseline examination, psychiatric symptoms and therapeutic working alliance have been evaluated throughout the course of the HPS at 3, 7, 9, 12, 18, 24, 36, 48, and 60 months' follow-up points.

Written informed consent was obtained from the patients after giving them a complete description of the study. The study protocol was approved by the ethics council of the Helsinki University Central Hospital.

4.1.1.2 Treatments

SFT is a brief resource-oriented and goal-focused therapeutic approach which helps clients change by constructing solutions (Johnson & Miller, 1994; Lambert, Okiishi, Finch & Johnson, 1998). The technique includes the search for pre-session change, miracle and scaling questions, exploration of exceptions, use of a one-way mirror and consulting break, positive feedback, and home assignments. The orientation was based on an approach developed by de Shazer and Kim Berg (de Shazer, 1991; de Shazer et al., 1986). The frequency of sessions in SFT was flexible, usually one

session every two or three weeks, up to a maximum of 12 sessions, over no more than 8 months.

SPP is a brief, focal, transference-based therapeutic approach which helps patients by exploring and working through specific intrapsychic and interpersonal conflicts. Short-term psychodynamic psychotherapy is characterized by the exploration of a focus, which can be identified by both the therapist and the patient. This consists of material from current and past interpersonal and intrapsychic conflicts and the application of confrontation, clarification, and interpretation in a process in which the therapist is active in creating the alliance and ensuring the time-limited focus. The orientation was based on approaches described by Malan (1976) and Sifneos (1978). SPP was scheduled for 20 treatment sessions, with one session per week.

LPP is an open-ended, intensive, transference-based therapeutic approach which helps patients by exploring and working through a broad area of intrapsychic and interpersonal conflicts. Long-term psychodynamic psychotherapy is characterized by a framework in which the central elements are exploration of unconscious conflicts, developmental deficits and distortions of intrapsychic structures. Confrontation, clarification, and interpretation are major elements, as well as the therapist's actions in ensuring the alliance and working through the therapeutic relationship to attain conflict resolution and greater self-awareness. Therapy includes both expressive and supportive elements, the use of which depends on patient needs. The orientation follows the clinical principals of long-term psychodynamic psychotherapy (Gabbard, 2004). The frequency of sessions in LPP was 2-3 times a week for approximately 3 years.

PA is an open-ended, highly intensive, transference-based psychodynamic therapeutic approach, which helps patients by analyzing and working through a broad area of intrapsychic and interpersonal conflicts. The therapeutic setting and technique are characterized by facilitating maximum development of transference by the use of a couch and free association for exploring unconscious conflicts, developmental deficits and distortions of intrapsychic structures (Greenson, 1985). The frequency of sessions in PA was 4 times a week for approximately 5 years.

SFT was manualized and adherence monitoring was performed. Psychodynamic psychotherapies and PA were conducted in accordance with clinical practice, where the therapists might modify their interventions according to the patient's needs within the respective framework. Accordingly, no manuals were used and no adherence monitoring was organized.

After assignment to the aforementioned treatment groups, participation was refused by 4 patients assigned to SFT, 3 patients assigned to SPP, 26 assigned to LPP, and 1 assigned to PA (Knekt et al., 2011). Of the 333 patients starting the assigned therapy, a total of 47 patients discontinued the treatment prematurely (11 in SFT, 10 in SPP, 21 in LPP, and 5 in PA). The realized mean length of therapy was

7.5 (SD=3.0), 5.7 (SD=1.3), 31.3 (SD=11.9), and 56.3 (SD=21.3) months in the four treatment groups, respectively.

4.1.1.3 Therapists

Psychotherapeutic societies representing the treatments of interest were informed of the HPS, leading to a total of 112 eligible therapists volunteering for the study between 1994 and 2000. Eligible therapists were required to have at least two years of experience in relevant therapy after completion of their training. The therapist population comprised 71 therapists, after excluding 41 therapists who did not have room for new patients or for some other reason could not attend to clients at the beginning of the study (Table 5). One therapist who gave short-term psychodynamic therapy and did not fill the therapist self-report measure used as a predictor in the present study was excluded. The final therapist population in the present investigation thus comprised 70 therapists of whom 6 therapists gave exclusively solution-focused therapy, 5 short- and 25 long-term psychodynamic psychotherapy only, 4 both short- and long-term psychodynamic psychotherapy, 16 psychoanalysis only, 12 both long-term psychodynamic therapy and psychoanalysis, and 2 both short-term psychodynamic therapy and psychoanalysis. The caseload of the therapists varied between 1 and 24 patients.

All the therapists who provided SFT had been trained for the method and had received a qualification in solution-focused therapy provided by a local institute. All the therapists providing psychodynamic psychotherapy had received and completed standard training in psychoanalytically oriented psychotherapy in one of the accredited psychodynamic or psychoanalytic training institutes in Finland. Likewise, psychoanalysts had received standard training at a psychoanalytic training institute. During their training, the psychodynamic therapists received a minimum of 3 years' training in psychodynamic psychotherapy and analysts a minimum of 4 years' training in psychoanalytic treatment. Those giving short-term psychodynamic therapy received 1-2 additional years of specific short-term focal psychodynamic therapy training. Therapists were relatively experienced, with an overall average of 17 years of general therapy work experience after their first psychotherapy training. In the specific therapy forms given, providers in LPP and PA had the most, 15 years or more, experience in comparison to 9 years in SFT and SPP. None of the psychodynamic or psychoanalytic therapists had any experience of solution-focused therapy or vice versa.

Table 3. Mean (SD) levels of baseline characteristics of the patients and the therapists in the Helsinki Psychotherapy Study.

Characteristic	All	Solution-focused therapy	Short-term psychodynamic psychotherapy	Long-term psychodynamic psychotherapy	Psychoanalysis
Patient characteristics	N = 367	N = 97	N = 101	N = 128	N = 41
Socioeconomic variables					
Age (years)	32.1 (6.8)	33.6 (7.2)	32.1 (7.0)	31.6 (6.6)	30.4 (5.6)
Males (%)	24.8	25.8	25.7	21.1	31.7
Living alone (%)	52.3	56.7	48.5	49.2	61.0
Academic education (%)	28.1	28.9	19.8	28.1	46.3
Psychiatric diagnosis					
Axis I					
Mood disorder only (%)	56.9	53.6	50.5	63.3	61.0
Anxiety disorder only (%)	14.4	13.4	21.8	11.7	7.3
Co-morbidity of mood and anxiety disorders (%)	28.6	33.0	27.7	25.0	31.7
Any Axis II disorder (%)	18.3	18.6	24.8	12.5	19.5
Psychiatric co-morbidity of Axis I and Axis II disorders (%)	43.6	45.4	48.5	36.7	48.8
Previous psychiatric treatment					
Psychotherapy (%)	20.1	20.0	18.8	19.0	26.8
Psychotropic medication (%)	20.4	27.8	21.8	17.6	7.7
Hospitalization (%)	1.4	2.1	0.0	2.4	0.0
Psychiatric symptoms					
Symptom Check List, Global Severity Index, (SCL-90-GSI)	1.29 (0.53)	1.31 (0.50)	1.26 (0.53)	1.27 (0.55)	1.34 (0.52)

Therapist characteristics	N = 71	N = 6	N = 12	N = 41	N = 30
Demographics					
Age (years)	49.4 (6.63)	43.8 (9.0)	48.2 (7.9)	49.7 (5.6)	51.1 (5.7)
Males (%)	31.0	33.3	16.7	24.4	36.7
Training					
Psychologist (%)	71.8	33.3	83.3	80.5	73.3
Psychiatrist (%)	11.3	0.0	0.0	7.3	16.7
Other (%)	16.9	66.7	16.7	12.2	10.0
General therapy experience (years)	16.8 (6.0)	8.7 (4.8)	14.9 (4.4)	18.0 (5.6)	19.3 (5.0)
Specific therapy experience (years)		8.7 (4.8)	8.5 (4.8)	17.6 (5.6)	14.8 (5.4)
Work involvement					
Healing involvement	11.20 (1.34)	11.29 (1.00)	11.47 (1.36)	11.16 (0.98)	11.21 (1.28)
Stressful involvement	3.84 (1.79)	2.99 (0.95)	4.01 (1.45)	3.84 (1.32)	4.02 (1.39)
Personal Identity					
Genial	2.19 (0.14)	1.98 (0.71)	2.36 (0.31)	2.21 (0.32)	2.14 (0.30)
Forceful	1.63 (0.13)	1.51 (0.22)	1.77 (0.37)	1.62 (0.34)	1.66 (0.38)
Reclusive	1.13 (0.23)	1.00 (0.38)	0.87 (0.44)	1.16 (0.52)	1.25 (0.49)

4.1.2 Society for Psychotherapy Research Collaborative Research Network Study (Study IV)

Therapists in the Society for Psychotherapy Research Collaborative Research Network Study (SPR CRN) were recruited between 1991 and 2012 through various means (professional workshops and conferences, professional societies and therapist training programs, individual collegial networks, and telephone directories of providers of counseling or therapy services), leading to a database of approximately 10 000 therapists of different theoretical orientations, career levels, background professions, and nationalities. Therapists representing distinctively differing theoretical orientations were selected for the present study. This selection was based on therapists' self-ratings in the SPR CRN database of how much their current therapeutic approach is guided by various different theoretical frameworks (analytic/psychodynamic, behavioral, cognitive, humanistic, systemic, other), each rated on a six-point scale of influence (0 = 'not all', 5 = 'very much'). Therapists who indicated they had only one saliently influencing (i.e., 4 = 'much' or 5 = 'very much') theoretical orientation and rated all other theoretical influences as less than 'moderate' (< 3), were selected for investigation. As an additional specification, rather than have separate behavioral and cognitive groups, which does not correspond well with contemporary training and practice, a cognitive-behavioral group of therapists was formed in which both behavioral and cognitive scales were rated as salient influences or one of them was salient and the other was rated a 'moderate' influence (3). Finally, an additional comparison group consisted of what were termed 'broad-spectrum integrative-eclectic' therapists, who rated three or more different orientations as salient influences on their current practice. A total of 4088 therapists fulfilled these criteria (Table 4). The two largest groups were broad-spectrum integrative-eclectics and psychoanalytic-dynamic therapists, with well over a 1000 practitioners in each group. Therapists had on average 12 years of general therapy work experience. Therapists came from a total of 37 countries, with the largest groups being from the UK, Norway, Germany, the USA, and Australia.

Table 4. Mean (SD) levels of background characteristics of the therapists in the SPR CRN study.

Therapist characteristics	All	Analytic/ Psychodynamic	Cognitive-Behavioral	Broadly Humanistic	Systemic	Broad-Spectrum Integrative-Eclectic
Demographics	N = 4088	N = 1464	N = 390	N = 391	N = 102	N = 1741
Age (years)	45.8 (10.9)	46.6 (11.0)	41.8 (10.4)	48.2 (10.3)	41.1 (9.7)	45.8 (10.9)
Males (%)	35.9	38.0	42.1	27.4	35.0	34.8
Training						
Psychologist (%)	44.8	38.6	58.5	27.8	45.1	50.8
Psychiatrist, MD (%)	21.9	37.8	11.0	8.7	14.7	14.2
Other (%)	33.3	23.6	30.5	63.5	40.2	35.0
General therapy experience (years)	12.3 (9.3)	12.7 (9.3)	10.7 (8.3)	10.4 (7.9)	8.9 (7.2)	12.8 (9.0)
Nation (%)						
USA	7.7	4.6	9.7	5.1	10.8	10.2
UK	12.8	10.0	32.6	45.0	1.0	4.1
Norway	13.5	11.0	7.7	0.3	5.9	20.3
Germany	13.5	24.1	6.9	10.7	5.9	7.0
Australia	10.1	4.3	2.3	3.3	8.8	18.2
Others[1]	42.6	46.0	40.8	35.5	67.6	40.2
Personal identity						
Genial	2.31 (.42)	2.19 (.41)	2.26 (.40)	2.34 (.43)	2.27 (.47)	2.41 (.40)
Forceful	1.40 (.52)	1.43 (.50)	1.36 (.54)	1.34 (.50)	1.45 (.50)	1.40 (.54)
Reclusive	1.24 (.56)	1.31 (.54)	1.24 (.54)	1.25 (.52)	1.19 (.54)	1.18 (.59)
Practical	1.96 (.55)	1.84 (.55)	2.03 (.56)	1.92 (.55)	2.02 (.55)	2.05 (.53)

[1] Countries with over 1 % representation in total sample: Canada (2.3 %), Greece (1.2 %), Belgium (1.5 %), France (1.4 %), Spain (2.5 %), Italy (1.0 %), Switzerland (2.7 %), Austria (2.0 %), Denmark (1.4 %), Sweden (1.5 %), Chile (1.2 %), Malaysia (1.0 %), New Zealand (2.8 %), South Korea (2.5 %), India (2.9 %), Portugal (4.6 %), Ireland (1.5 %), Finland (1.5 %), Israel (2.4 %).

4.2 Assessment methods

4.2.1 Assessment of therapists' professional and personal characteristics used as predictors of working alliance and outcome in the Helsinki Psychotherapy Study (Studies I, II, and III)

The Development of Psychotherapists Common Core Questionnaire (DPCCQ) was used as the predictor in the Helsinki Psychotherapy Study data. It is a 392-item self-administered questionnaire designed to enable therapists to describe themselves both in their professional (Orlinsky & Rønnestad, 2005) and personal life (Orlinsky & Rønnestad, 2006). The questionnaire covers different domains of therapeutic work: therapists' experience of their current skill levels (12 items), feelings during recent therapy sessions (12 items), various types of difficulty experienced with patients (20 items), coping strategies when encountering difficulties (26 items), and interpersonal style or manner with patients in therapy (17 items). Further, the questionnaire solicits information on the therapists' self-concept in private life, in the domains of their interpersonal style or manner (16 items) and the temperamental and stylistic aspects (13 items) of their personality in close personal relationships. Items are rated on ordinal continuum scales ranging from 0 (never/not at all) to 3 (very much) or 5 (very often), depending on the domain. Within the aforementioned domains, Orlinsky and Rønnestad (2005, 2006) identified distinct characteristics through factor analyses and constructed reliable multiple-item scales for them.

The HPS therapists completed the Finnish translation of the DPCCQ prior to the initiation of the treatments. Indices of professional and personal characteristics were computed with the most recent criteria available at the time of the conduct of Studies I, II, and III (Orlinsky & Rønnestad, 2005, 2006). Principal, pre-determined predictors on the therapeutic work experience dimension consisted of the second-order factor composite scores Healing Involvement and Stressful Involvement, which have been respectively posited as determinants of more and less effective therapy processes (Orlinky & Rønnestad, 2005): Healing Involvement is built up from first-order factors describing therapists' investment in their work (Invested), affirmative manner with patients (Affirming), sense of basic relational and overall skillfulness (Basic Relational Skills, Current Skillfulness), efficacious therapeutic agency (Efficacious), and constructive coping (Constructive Coping Skills) (Figure 2). Stressful Involvement, on the other hand, is characterized by experiences of frequent difficulties (Frequent Difficulties), feelings of anxiety (Anxiety) or boredom (Boredom), and coping by avoidance of issues (Avoidant Coping). The predictive ability of these first-order factors that make up the composite scores was also explored, in order to gain a more detailed picture of the potentially significant therapist characteristics. The same rationale was used in the domain of personal characteristics, investigating both the broad second-order factors as well as their

first-order constituents. In the personal domain, the second-order factor of geniality (Genial) consists of warmth (Warm), openness (Open), and the single item optimism (Optimistic); forcefulness (Forceful) consists of intense (Intense) and task-oriented (Task-Oriented) temperament and assertive (Assertive) interpersonal manner; reclusiveness (Reclusive) consists of aloofness (Aloof), and three single items, skepticism (Skeptical), privateness (Private) and subtleness (Subtle) (Figure 3). The HPS therapists were found to have similar qualities as therapists in the international SPR CRN sample (Orlinsky & Rønnestad, 2005, 2006), showing relatively high Healing Involvement and low Stressful Involvement in their work and, in their personal life, experiencing themselves generally as highly or moderately Genial and Forceful and not all or only moderately Reclusive.

For the analyses in Studies I, II, and III, therapists were classified into 'high', 'middle', and 'low' groups of having more or less of a characteristic, based on therapists' factor scores divided into tertiles ('high' group = highest tertile, 'middle' group = mid-tertile, 'low' group = lowest tertile). However, pre-determined, dichotomous categorical cut-off points existed for the personal identity composite scores which were accordingly utilized (i.e., 'high' group = higher end, 'low' group = lower end) (Orlinsky & Rønnestad, 2006). After Studies I and II, in view of the high number of predictors, the factors having a markedly skewed distribution and thus not being divisible to tertiles, similarly as the single items, were elected to not be considered as predictors in Study III.

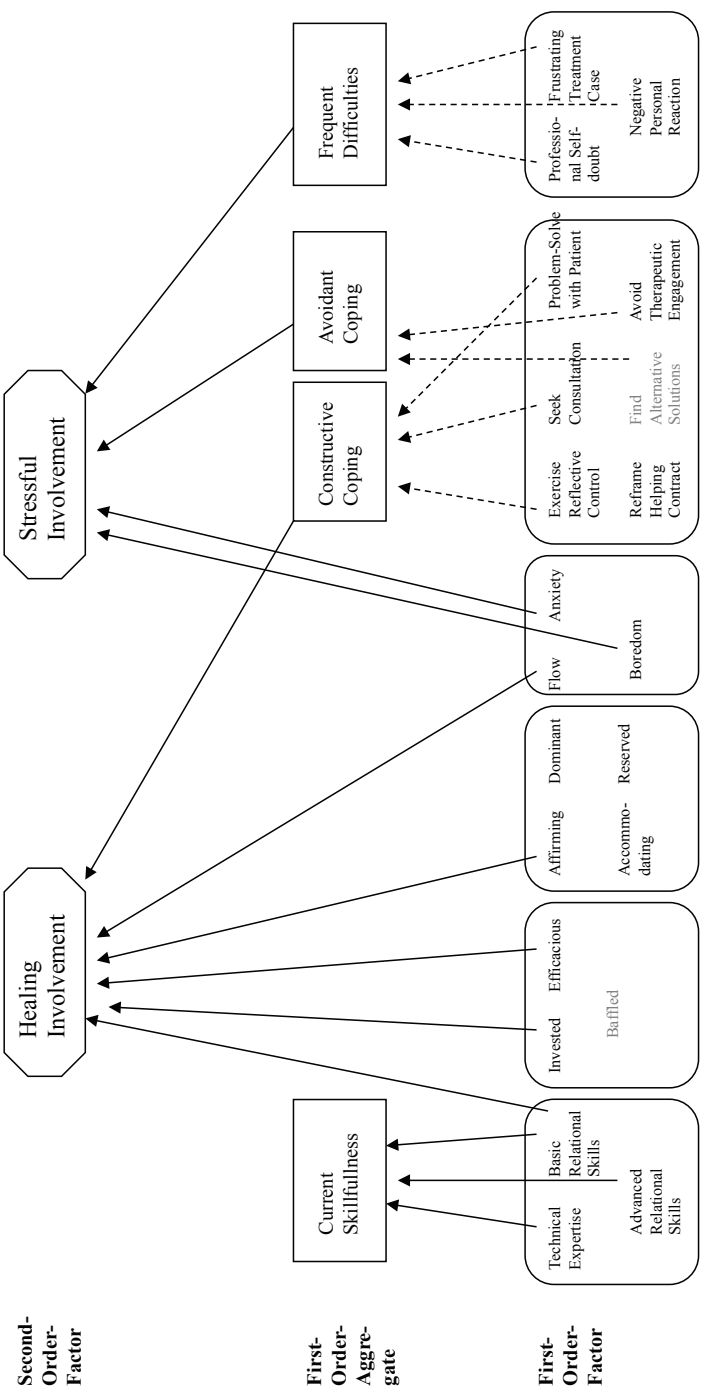


Figure 2. Therapists' professional characteristics in the DPCCQ.

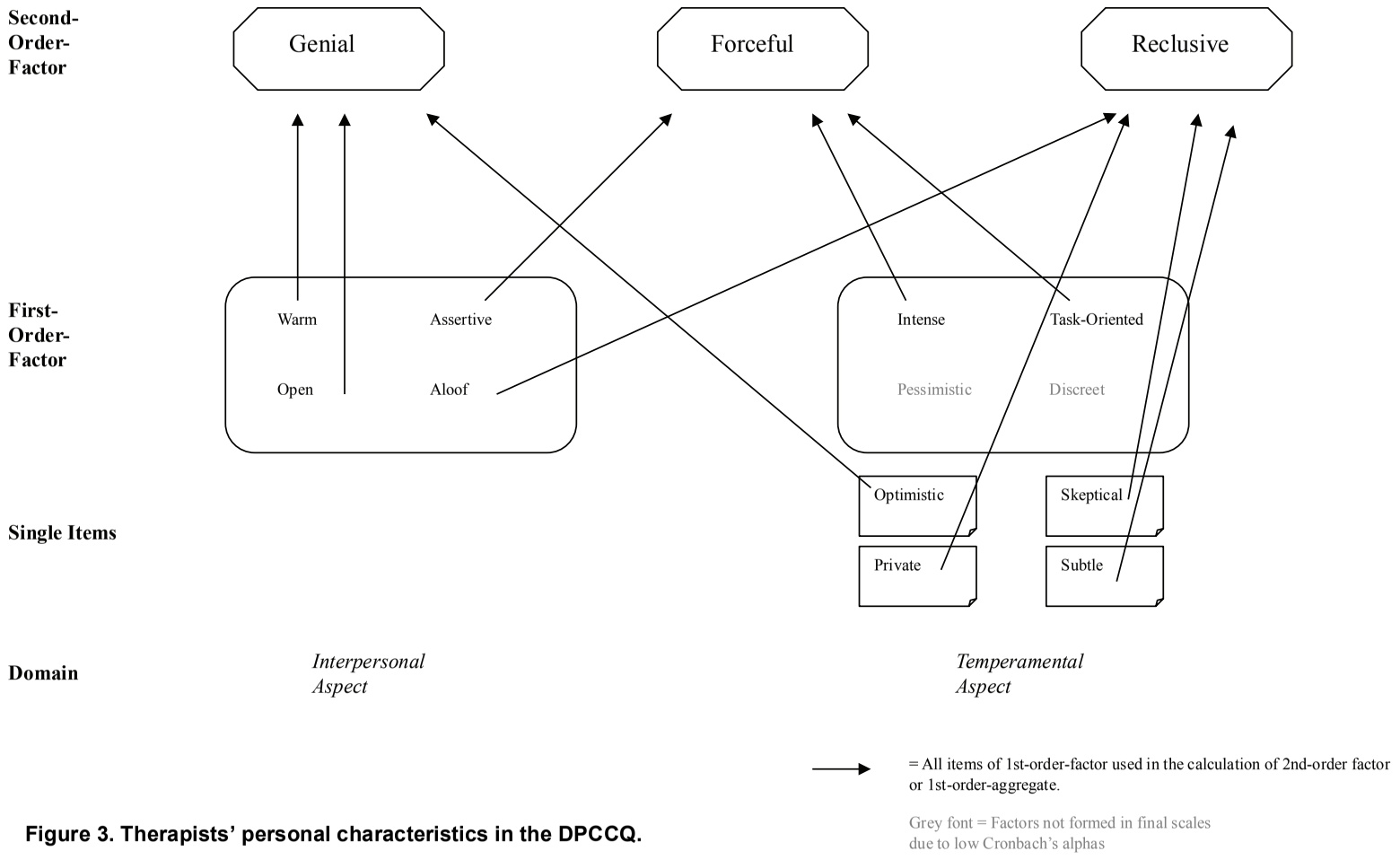


Figure 3. Therapists' personal characteristics in the DPCCQ.

4.2.2 Assessment of therapists' personal identity and professional relational manner in the Society for Psychotherapy Research Collaborative Research Network Study (Study IV)

Therapists' personal identity dimensions evaluated in Study IV consisted of the aforementioned factors of Genial, Forceful, and Reclusive used in the HPS as predictors of working alliance and outcome (Orlinsky & Rønnestad, 2006). However, as a later factor analysis of the personal domain by Orlinsky and Rønnestad (2011) in the more-than-doubled SPR CRN database of over 10 000 therapists revealed an additional fourth factor, termed Practical personal identity (consisting of organized, pragmatic, determined, and energetic self-experience), this was included as an additional dimension to be investigated in Study IV.

The correspondences between therapists' professional and personal qualities were evaluated in terms of their professional manner with patients versus their self-experience in close personal relationships. Comparisons were enabled by a set of 18 overlapping adjectives used in the DPCCQ to assess both therapists' personal identity (in response to the question, "How would you describe yourself as you really are in your close personal relationships?") as well as their experience of their relational manner or style in therapy work (in response to the question, "How would you describe yourself as a therapist – your actual style or manner with clients?"), both on scales from 0 = "not at all" to 3 = "very much". A total of 18 difference scores were calculated by subtracting the rating for manner in professional relationships from the rating for close personal relationships (range +3 to -3).

4.2.3 Assessment of working alliance (Study I)

Working alliance was measured by the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989). Both patients and therapists rated the WAI after the third therapy session and at the 7 months' follow-up point in Study I. WAI assesses the quality of the interaction between therapist and patient. It comprises 36 items in three subscales of 12 items each that measure either therapeutic bonds, goals or tasks. Each item consists of a statement describing the presence of specific interactions along an ordinal continuum from never (score 1) to always (score 7). The total score was calculated by first summing the scores of all items, after reversing 14 negatively worded items.

All alliance ratings were found to be relatively reliable between measurements at the third session and the 7 months' follow-up point, as rated by both patients and therapists, in short- term (reliability coefficients 0.75 and 0.83) and long-term therapy (0.67 and 0.59), respectively.

4.2.4 Assessment of therapy outcome (Studies II and III)

The Symptom Checklist (SCL-90), a 90-item self-report questionnaire for patients (Derogatis, Lipman, & Covi, 1973), was used as a measure of general psychiatric symptoms. Each item consists of a statement describing a symptom. The patients marked one numbered circle for each item along an ordinal continuum from absent (score 0) to extreme (score 4). The Global Severity Index (GSI) was the mean value of all 90 items, ranging from 0 to 4 and describing the severity of symptoms during the past month. In Study II, the analyses were based on assessments at baseline and the 3, 7, 9, 12, 18, 24 and 36 month follow-up points after the start of treatments. In Study III, the analyses were based on assessments at baseline and the 12, 24, 36, 48 and 60 month follow-up points after the start of treatments.

4.3 Statistical methods

4.3.1 Longitudinal study of the predictive ability of therapist characteristics on working alliance and its development (Study I)

In the study on therapists' professional and personal characteristics as predictors of working alliance and its development in short- and long-term psychotherapies, the study design was a longitudinal study with a pre-treatment assessment of therapists and measurement of the alliance at two different time points during treatment. The predictive ability of therapist factor and length of therapy on working alliance and change in working alliance between the 3rd therapy session and 7 months was estimated based on fixed linear models (Cohen & Cohen, 1975) with working alliance or change in working alliance as the dependent variable. Independent variables in the model were the therapist factor considered, therapy group (short- or long-term therapy), the interaction term between the therapist factor and therapy group, and the confounding factors of therapist sex, age, general experience, marital status, profession, and level of training. In the models where change in the working alliance was the dependent variable, the WAI score at the 3rd session was included as an additional independent variable. The therapist factors were categorized by tertile to avoid potential biases resulting from the linearity assumption inherent in the use of continuous variables (Breslow & Day, 1980). Model-adjusted mean levels of WAI (or WAI differences) were estimated in the categories of the therapist factors using predictive means (Lee, 1981). The significance of mean differences and interactions was computed using the F-test. The analyses were conducted using the GLM procedure of SAS version 9.2 (SAS Institute Inc., 2008).

Since the data consisted of patients nested within therapists also multilevel linear modeling was used (Breslow & Clayton, 1993) with the therapist included as a random effect and the observed therapist factors as fixed effects in the models. The residual terms were assumed to follow the t-distribution to handle outlying

observations, allowing more robust regression analysis (Lange, Little, & Taylor, 1989). The analyses were conducted using the GLIMMIX procedure of the SAS version 9.2 (SAS Institute Inc., 2008).

4.3.2 Longitudinal study of the predictive ability of therapist characteristics on outcome with repeated measurements (Studies II and III)

In the studies on therapists' professional and personal characteristics as predictors of outcome in short- and long-term psychotherapy (Study II) and in long-term psychodynamic psychotherapy and psychoanalysis (Study III), the study design was a longitudinal study with a pre-treatment assessment of therapists and repeated measurements of the outcome variable. The statistical analyses were based on linear mixed models (Verbeke & Molenberghs, 1997). The primary analyses were based on the assumption of ignorable dropouts (Härkänen, Knekt, Virtala, & Lindfors, 2005; Knekt et al., 2008) and in secondary analyses, missing values were replaced by multiple imputation. The imputation was based on the Markov chain Monte Carlo methods (Rubin, 1987). Model adjusted outcome means and mean differences were calculated for different measurement points (Lee, 1981). The delta method was used for the calculation of confidence intervals (Migon & Gamerman, 1999) and the statistical significance of the model used was tested with the Wald test.

The dependent variable (outcome variable) in all the analyses was SCL-90-GSI. In the analyses, three models were used: A basic model included as independent variables the main effects of the therapist measure considered, therapy groups compared, and time, their first- and second-order interactions, a correction term (i.e., the first-order interaction of the difference between theoretical and realized date of measurement, time, and the therapist measure), and SCL-90-GSI at baseline. A complete model further included therapist background and professional variables (age, profession, level of training, years of experience), when they satisfied the criteria for confounding (Rothman, Greenland, & Lash, 2008). A third model was created by adding variables describing waiting time from randomization to initiation of treatment and degree of participation (i.e., withdrawal from or discontinuation of treatment) during follow-up as main effects to the complete model and including auxiliary treatment (hospitalization, psychotropic medication, and other psychotherapy) as a time-dependent covariate. The therapist was included as a random effect in part of the models. All three models were based both on the original and the imputed data. The independent variable of main interest (predictor) was the interaction term between the therapist factor, therapy group, and time. Since no major differences were found in this variable during the follow-up between the different models and the imputation did not noticeably alter the results, the results from the basic model were presented.

The significance of the therapist factor in predicting the outcome in the different therapy groups compared was evaluated by testing the statistical significance of the interaction term between the therapist factor and the therapy group throughout the follow-up. The Wald test was used.

For the interpretation of the results, patients were classified into three prognosis groups: short-term therapy (Study II) or long-term psychodynamic therapy (Study III) sufficient, i.e., more beneficial than long-term therapy (Study II) or psychoanalysis (Study III) (= prognosis group 1), long-term therapy (Study II) or psychoanalysis (Study III) more beneficial (= prognosis group 2) and both of the compared treatment groups equally beneficial (Studies II and III) (= prognosis group 3) in the respective comparisons. This was done by assessing the statistical significance of the change in outcome from baseline to the different measurement points for the therapy groups compared and category (low and high) of therapist factor. Therapy was considered to be sufficient for the patients who experienced and maintained a statistically significant reduction in symptoms in comparison with baseline during the follow-up; patients who did not experience such a symptom reduction were not considered to benefit sufficiently from therapy.

To separate prognosis groups 1 and 2 from each other, the statistical significance of the model-adjusted difference in outcome between the therapy groups in the therapist factor categories were measured at the different measurement points. Short-term therapy (Study II) or long-term psychodynamic therapy (Study III) was considered to be sufficient for patients who benefited more from short-term therapy or from long-term psychodynamic therapy (prognosis group 1), whereas long-term therapy (Study II) or psychoanalysis (Study III) was considered more beneficial for patients who in the long run gained more from long-term therapy or psychoanalysis (prognosis group 2) in the respective comparisons.

4.3.3 Cross-sectional study of therapist characteristics (Study IV)

In the study on personal identity and professional relational manner of psychotherapists with clearly different theoretical orientations (Study IV), a cross sectional design was used. The statistical significance of the overall association between therapist's personal identity and theoretical orientation was tested using a multivariate analysis of covariance (MANCOVA). The vector of four personal identity dimensions was used as the dependent variable and the model included as independent variables the theoretical orientation and the potential confounding factors of therapist sex, age, profession, and nationality. Model-adjusted mean levels of the four personal identity dimensions in categories of the theoretical orientation were estimated with covariance analysis based on the linear model using predictive means (Cohen, Cohen, West, & Aiken, 2003; Lee, 1981). The significance of the mean differences between specific orientation groups was tested using the F-test. Bonferroni correction for multiple comparisons was made. Similar multivariate and

separate covariance analyses were carried out for the association between the score for the degree and direction of divergence between the therapist's manner in close personal relationships and in relationships with clients and the therapist's theoretical orientation. The score was calculated for each of the eighteen adjectives that were used in both domains and the vector of these variables was used as the dependent variable in the multivariate analysis.

4.3.4 Statistical programs

Analyses in Studies I, II and III were carried out with SAS software, version 9.2 (SAS Institute Inc., 2008). Analyses in Study IV were carried out with PASW Statistics software, version 18.0.0 (SPSS Inc., 2009).

5 RESULTS

5.1 Therapists' professional and personal characteristics as predictors of working alliance and its development in short- and long-term therapies (Study I)

Although some significant associations were found for patient-rated alliance and its development, therapists' professional and personal characteristics were most strongly predictive of therapist-rated early alliance, assessed at the 3rd session. As for patient-rated alliances (data not shown), therapists' higher Basic Interpersonal Skills were found to predict better patient-rated early alliances in both short- and long-term therapies, and Constructive Coping to suggestively predict better early alliances especially in long-term therapies. Therapists high in Affirming and, suggestively, Invested professional relational manner and agency predicted patient-rated improvement of alliance between the third session and the 7 months' follow-up point in short-term therapies, but in long-term therapies they predicted patient-rated alliance deterioration, along with low Avoidant Coping. Highly Genial personal identity of therapists suggestively predicted better patient-rated early alliances in both short- and long-term therapies, but otherwise no personal characteristics of therapists predicted either patient-rated early alliance or its development.

Turning to therapist-rated alliances (Table 5), better early alliances were predicted in therapies of both lengths, but especially in short-term therapy, by higher Current Skillfullness (for therapists with lowest and highest Current Skillfullness, respectively, WAI = 166 and WAI = 201 in short-term therapy, difference $M_{diff\,S}$ = 21.1 %; in long-term therapy, WAI = 186 and WAI = 201, difference $M_{diff\,L}$ = 8.1 %), Basic Relational Skills ($M_{diff\,S}$ = 20.7 % and $M_{diff\,L}$ = 4.9 %), and Efficacious relational agency ($M_{diff\,S}$ = 12.3 % and $M_{diff\,L}$ = 1.0 %). Worse therapist-rated early alliances were predicted in treatments of both lengths by high Anxiety ($M_{diff\,S}$ = 10.8 % and $M_{diff\,L}$ = 3.7 %), high Boredom ($M_{diff\,S}$ = 9.5 % and $M_{diff\,L}$ = 5.4 %), high Frequent Difficulties ($M_{diff\,S}$ = 8.8 % and $M_{diff\,L}$ = 3.2 %), low Investment ($M_{diff\,S}$ = 7.8 % and $M_{diff\,L}$ = 4.2 %), low Flow ($M_{diff\,S}$ = 8.6 % and $M_{diff\,L}$ = 5.4 %), and high Stressful Involvement ($M_{diff\,S}$ = 4.9 % and $M_{diff\,L}$ = 6.3 %), the last characteristic predictive especially in long-term therapy. Also, several of therapists' personal characteristics predicted better therapist-rated early alliances in treatments of both lengths, i.e., low Forcefulness ($M_{diff\,S}$ = 11.1 % and $M_{diff\,L}$ = 3.8 %), low Reclusiveness ($M_{diff\,S}$ = 3.9 % and $M_{diff\,L}$ = 6.5 %) and high Privateness ($M_{diff\,S}$ = 14.5 % and $M_{diff\,L}$ = 16.2 %). Some characteristics predicted better therapist-rated alliances in short-term therapy but worse alliances in long-term therapy, i.e. high Task-Orientation ($M_{diff\,S}$ = 20.3 % and $M_{diff\,L}$ = 1.6 %) and Skepticism ($M_{diff\,S}$ = 8.8 % and $M_{diff\,L}$ = 9.0 %). Therapists highest in Warmth ($M_{diff\,S}$ = 0.6 % and $M_{diff\,L}$ = 8.2

%) and Openness ($M_{diff\,S}$ = 15.3 % and $M_{diff\,L}$ = 5.0 %) predicted better therapist-rated alliances in long-term therapy, but worse alliances in short-term therapy. No notable findings were found for the prediction of either therapists' professional or personal characteristics on therapists' ratings of development of alliance.

Table 5. Mean values of therapist-rated (WAI-T) working alliance in short- (solution-focused and short-term psychodynamic) and long-term (long-term psychodynamic and psychoanalysis) therapy at the 3rd therapy session according to the levels of therapists' professional and personal characteristics

		Level of therapist factor[1]					
Therapist factor	Therapy	Low	Middle	High	*p* th[2]	*p* l[3]	*p* th x l[4]
PROFESSIONAL CHARACTERISTICS							
Work involvement: Healing	Short	182	209	177	0.002	0.81	0.10
involvement	Long	186	194	185			
Work involvement: Stressful	Short	191	160	182	<0.001	<0.001	0.02
involvement	Long	201	191	189			
Skills: Current skillfullness	Short	166	183	201	<0.001	0.10	0.04
	Long	186	184	201			
Skills: Basic relational skills	Short	174	184	210	<0.001	0.56	0.01
	Long	184	199	193			
Relational agency: Invested[5]	Short	179		193	0.01	0.04	0.41
	Long	192		200			
Relational agency:	Short	171	181	192	0.01	0.01	0.04
Efficacious	Long	194	185	196			
Relational manner: Affirming	Short	192	178	185	0.59	0.24	0.17
	Long	187	194	195			
Feelings: Flow	Short	174	171	189	0.05	0.002	0.14
	Long	184	196	194			
Feelings: Anxiety	Short	195	179	176	0.004	0.06	0.32
	Long	196	190	189			
Feelings: Boredom	Short	196	169	179	0.02	0.20	0.69
	Long	196	181	186			
Coping: Constructive coping	Short	182	202	173	<0.001	0.60	0.03
	Long	187	192	185			
Coping: Avoidant coping	Short	179	187	184	0.41	0.04	0.15
	Long	198	193	184			
Difficulties: Frequent	Short	186	197	171	<0.001	0.07	0.15
difficulties	Long	193	197	187			

PERSONAL CHARACTERISTICS							
Personal identity: Genial[6]	Short	185		183	0.47	0.28	0.15
	Long	184		193			
Personal identity: Forceful[6]	Short	190		171	0.005	0.09	0.13
	Long	191		184			
Personal identity: Reclusive[6]	Short	186		179	0.01	0.03	0.57
	Long	198		186			
Interpersonal: Warm	Short	182	191	181	0.39	0.15	0.02
	Long	184	188	199			
Interpersonal: Assertive	Short	174	182	190	0.36	0.05	0.14
	Long	193	189	190			
Interpersonal: Open	Short	196	200	170	0.04	0.73	0.004
	Long	181	189	190			
Interpersonal: Aloof	Short	181	193	177	0.09	0.32	0.24
	Long	187	192	189			
Temperament: Intense	Short	194	179	183	0.84	0.08	0.16
	Long	188	197	194			
Temperament: Task-oriented[5]	Short	158		190	<0.001	<0.001	<0.001
	Long	193		190			
Temperament: Optimistic[5, 7]	Short	171		187	0.18	0.05	0.13
	Long	190		190			
Temperament: Skeptical[5, 7]	Short	182		198	0.98	0.52	0.01
	Long	194		178			
Temperament: Private[5, 7]	Short	179		205	<0.001	0.009	0.70
	Long	191		222			
Temperament: Subtle[5, 7]	Short	180		184	0.29	0.11	0.92
	Long	187		192			

Note. Adjusted for confounding factors of therapist sex, age, general experience, marital status, profession, and level of training.

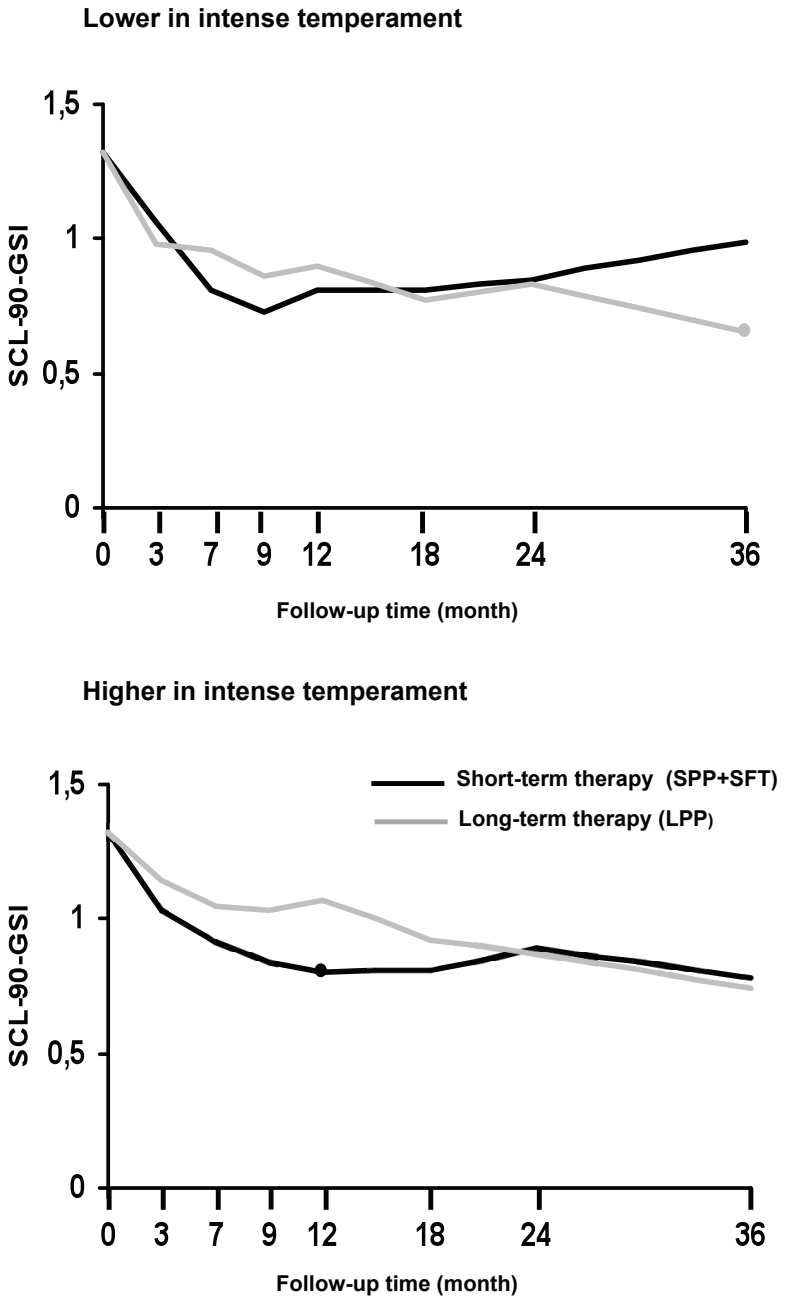
[1] Based on therapist factor scores divided to tertiles. [2] *p* for therapist factor. [3] *p* for length of therapy. [4] *p* for interaction of therapist factor and length of therapy.

[5]Divided by the median, due to skewed distribution or due to being a single item/question.

[6] In consideration of pre-determined categorical cut-off points and skewness of distributions, 'high' vs. 'low' therapists consisted of strongly (≥2 on the 0-3 scale) vs. moderately (1-2) and minimally (<1) genial and forceful therapists, and strongly or moderately vs. minimally reclusive therapists. [7] Single item/question.

5.2 Therapists' professional and personal characteristics as predictors of outcome in short- and long-term therapy during a 3-year follow-up (Study II)

Several professional characteristics (Stressful Involvement, Frequent Difficulties, Anxiety, Constructive Coping, Affirming) and some personal characteristics (Assertive, Warm) did not predict outcomes differently in comparison of short- and long-term therapies (Study II) (data not shown). On the other hand, therapists' several professional experiences appeared to predict poorer outcomes in short-term than in long-term therapy at the end of the 3-year follow-up (low Healing Involvement, low Current Skillfullness, low Basic Relational Skills, low Flow, high Avoidant Coping) (range of SCL-90-GSI 0.80-0.93 and 0.55-0.75 in short- and long-term therapy respectively at the 36-month follow-up), even while some of them (low Healing Involvement, low Current Skillfullness) had initially indicated faster symptom reduction in short-term therapy; of these, also the interaction between therapist characteristic and the therapy group was significant for one characteristic (Flow) and borderline significant ($p = 0.06$) for another (Current Skillfullness) (Table 6). In contrast, a significantly faster, but also lasting symptom reduction for the benefit of patients in short-term therapies was observed when therapists were highly Invested and Efficacious in their professional relational manner and agency (range of SCL-90-GSI 0.82-0.88 and 0.65-0.71 in short- and long-term therapy respectively at the 36-month follow-up). The same kinds of benefits were also observed for several of therapists' personal characteristics (high Intensity, low Subtlety, low Reclusiveness, low Aloofness, low Skepticism) (range of SCL-90-GSI 0.78-0.90 and 0.70-0.76 in short- and long-term therapy respectively at the 36-month follow-up). On the other hand, several other – and some opposites of the above (cf. Figure 4) – personal characteristics (low Intensity, high Subtlety, high Geniality, high Openness, low Optimism, low Forcefulness, low Task-Orientation, high Privateness) predicted more gains in long-term than in short-term therapy at the end of the 3-year follow-up (range of SCL-90-GSI 0.83-0.99 and 0.43-0.66 in short- and long-term therapy respectively at the 36-month follow-up).



- **Statistically significant difference ($p < 0.05$) between short- and long-term therapy.**

Figure 4. Changes in psychiatric symptoms (SCL-90-GSI) according to the therapist's temperament.

Table 6. Mean values of SCL-90-GSI in short- and long-term therapy and mean value differences (95% confidence intervals) between short- and long-term therapy at 7, 12, 24 and 36 month follow-up according to the lower and higher values of therapist professional and personal characteristics.

		Low						High						
Characteristic	Therapy	7	12	24	36	N	Group[5]	7	12	24	36	N	Group[5]	Interaction[6]
PROFESSIONAL CHARACTERISTICS														
Work	Short	0.87	0.74	0.84	0.90	44		0.91	0.83	0.87	0.81	90		
Involvement:	Long	1.04	1.00	0.83	0.68	40		1.10	1.00	0.80	0.71	19		
Healing involvement	S-L[1]	-0.16 (-0.38, 0.05)	-0.26 (-0.47, -0.04)	0.00 (-0.25, 0.25)	0.22 (-0.03, 0.46)		**1**	-0.19 (-0.45, 0.07)	-0.17 (-0.43, 0.09)	0.07 (-0.23, 0.36)	0.10 (-0.19, 0.39)		**3**	0.15
Skills: Current skillfullness	Short	0.89	0.77	0.84	0.93	57		0.95	0.84	0.86	0.81	56		
	Long	1.05	1.00	0.83	0.75	35		0.91	0.88	0.83	0.61	38		
	S-L[1]	-0.17 (-0.38, 0.04)	-0.23 (-0.44, -0.02)	0.00 (-0.24, 0.25)	0.18 (-0.06, 0.42)		**1**	0.04 (-0.17, 0.25)	-0.04 (-0.24, 0.17)	0.02 (-0.22, 0.27)	0.20 (-0.04, 0.44)		**3**	0.06
Skills: Basic relational skills	Short	0.94	1.38	0.88	0.93	7		0.87	0.75	0.82	0.82	35		
	Long	1.07	0.95	0.82	0.72	39		0.85	0.78	0.71	0.61	17		
	S-L[1]	-0.13 (-0.52, 0.26)	0.43 (-0.02, 0.88)	0.06 (-0.42, 0.53)	0.21 (-0.27, 0.69)		**2**	0.02 (-0.27, 0.31)	-0.04 (-0.32, 0.24)	0.11 (-0.23, 0.44)	0.21 (-0.12, 0.54)		**3**	0.11
Relational agency: Invested[2]	Short	0.96	0.87	0.82	0.85	47		0.88	0.81	0.90	0.82	138		
	Long	0.95	0.92	0.86	0.77	32		1.10	0.93	0.82	0.65	55		
	S-L[1]	-0.01 (-0.22, 0.24)	-0.05 (-0.28, 0.18)	-0.04 (-0.30, 0.23)	0.07 (-0.20, 0.35)		**3**	-0.22 (-0.38, -0.06)	-0.12 (-0.28, 0.04)	0.08 (-0.11, 0.26)	0.17 (-0.01, 0.35)		**1**	0.22
Relational agency: Efficacious	Short	0.94	0.73	0.86	0.82	46		0.87	0.82	0.88	0.88	83		
	Long	0.98	0.92	0.79	0.60	38		1.12	0.99	0.85	0.71	30		
	S-L[1]	-0.04 (-0.26, 0.18)	-0.79 (-0.40, 0.03)	0.07 (-0.17, 0.31)	0.22 (-0.02, 0.45)		**3**	-0.25 (-0.46, -0.04)	-0.17 (-0.38, 0.04)	0.02 (-0.22, 0.27)	0.17 (-0.07, 0.41)		**1**	0.62
Feelings: Flow	Short	0.85	0.76	0.80	0.88	61		0.93	0.82	0.95	0.87	22		
	Long	1.03	0.94	0.84	0.65	67		0.99	1.02	0.86	0.76	24		
	S-L[1]	-0.18 (-0.34, -0.01)	-0.17 (-0.34, -0.00)	-0.04 (-0.24, 0.16)	0.24 (0.04, 0.44)		**2**	-0.07 (-0.36, 0.23)	-0.20 (-0.49, 0.10)	0.09 (-0.25, 0.42)	0.11 (-0.24, 0.46)		**3**	0.05
Coping: Avoidant coping	Short	0.94	0.79	0.91	0.89	53		0.86	0.86	0.94	0.80	74		
	Long	1.05	0.98	0.72	0.64	21		1.04	0.86	0.80	0.55	36		
	S-L[1]	-0.11 (-0.37, 0.15)	-0.19 (-0.44, 0.06)	0.19 (-0.09, 0.48)	0.25 (-0.02, 0.53)		**3**	-0.19 (-0.39, 0.02)	-0.00 (-0.20, 0.20)	0.15 (-0.08, 0.37)	0.25 (0.02, 0.47)		**2**	0.25
PERSONAL CHARACTERISTICS														
Personal identity: Genial[3]	Short	0.83	0.76	0.98	0.85	47		0.94	0.86	0.87	0.83	138		
	Long	1.02	0.98	0.82	0.74	26		1.05	0.96	0.86	0.65	72		
	S-L[1]	-0.19 (-0.43, 0.06)	-0.22 (-0.46, 0.02)	0.16 (-0.13, 0.44)	0.11 (-0.17, 0.39)		**3**	-0.11 (-0.26, 0.03)	-0.11 (-0.25, 0.04)	0.01 (-0.15, 0.18)	0.18 (0.02, 0.34)		**2**	0.13
Personal identity: Forceful[3]	Short	0.91	0.84	0.90	0.86	139		0.93	0.81	0.85	0.79	46		
	Long	1.04	0.96	0.86	0.66	74		1.05	1.04	0.81	0.72	24		
	S-L[1]	-0.13 (-0.28, 0.01)	-0.12 (-0.26, 0.02)	0.05 (-0.12, 0.21)	0.20 (0.04, 0.36)		**2**	-0.12 (-0.38, 0.14)	-0.23 (-0.48, 0.02)	0.04 (-0.24, 0.32)	0.07 (-0.20, 0.35)		**3**	0.71

Personal identity:	Short	0.91	0.83	0.83	0.86	119		0.90	0.84	1.00	0.81	66		
Reclusive[3]	Long	1.06	1.02	0.89	0.76	40		1.02	0.93	0.81	0.63	58		
	S-L[1]	-0.15 (-0.33, 0.03)	-0.19 (-0.37, -0.01)	-0.06 (-0.27, 0.15)	0.10 (-0.11, 0.31)		**1**	-0.12 (-0.30, 0.06)	-0.09 (-0.27, 0.09)	0.19 (-0.01, 0.40)	0.18 (-0.03, 0.38)		**3**	0.71
Interpersonal:	Short	0.93	0.85	0.97	0.85	66		0.95	0.84	0.89	0.86	86		
Open	Long	0.89	0.85	0.70	0.62	8		1.08	1.00	0.84	0.64	61		
	S-L[1]	0.04 (-0.32, 0.40)	-0.01 (-0.38, 0.37)	0.27 (-0.16, 0.69)	0.23 (-0.19, 0.65)		**3**	-0.13 (-0.29, 0.04)	-0.16 (-0.32, 0.01)	0.05 (-0.14, 0.24)	0.22 (0.04, 0.41)		**2**	0.87
	Short	0.84	0.80	0.76	0.81	41		0.89	0.79	0.97	0.83	71		
Interpersonal:	Short	0.84	0.80	0.76	0.81	41		0.89	0.79	0.97	0.83	71		
Aloof	Long	1.12	1.11	0.70	0.73	7		1.01	0.90	0.77	0.62	39		
	S-L[1]	-0.28 (-0.73, 0.17)	-0.31 (-0.79, 0.17)	0.07 (-0.47, 0.60)	0.08 (-0.43, 0.59)		**1**	-0.12 (-0.32, 0.08)	-0.12 (-0.32, 0.08)	0.20 (-0.03, 0.42)	0.22 (-0.01, 0.44)		**3**	0.83
Temperament:	Short	0.81	0.81	0.85	0.99	30		0.91	0.80	0.89	0.78	86		
Intense	Long	0.96	0.90	0.83	0.65	30		1.05	1.07	0.87	0.74	38		
	S-L[1]	-0.15 (-0.41, 0.12)	-0.09 (-0.35, 0.16)	0.02 (-0.29, 0.33)	0.34 (0.05, 0.63)		**2**	-0.15 (-0.34, 0.05)	-0.27 (-0.47, -0.08)	0.02 (-0.20, 0.24)	0.04 (-0.18, 0.25)		**1**	0.48
Temperament:	Short	0.97	0.87	0.93	0.89	34		0.90	0.82	0.88	0.83	151		
Task-oriented[2]	Long	1.03	0.95	0.86	0.64	51		1.06	0.98	0.84	0.74	45		
	S-L[1]	-0.06 (-0.29, 0.16)	-0.07 (-0.29, 0.14)	0.08 (-0.18, 0.33)	0.26 (0.00, 0.52)		**2**	-0.15 (-0.32, 0.01)	-0.15 (-0.32, 0.01)	0.04 (-0.15, 0.23)	0.10 (-0.09, 0.28)		**3**	0.85
Temperament:	Short	0.88	0.71	0.92	0.95	28		0.92	0.86	0.89	0.82	157		
Optimistic[2, 4]	Long	0.94	0.90	0.40	0.43	7		1.05	0.96	0.86	0.69	91		
	S-L[1]	-0.08 (-0.49, 0.33)	-0.18 (-0.61, 0.26)	0.50 (-0.26, 1.26)	0.52 (0.00, 1.04)		**2**	-0.13 (-0.26, 0.00)	-0.11 (-0.24, 0.02)	0.04 (-0.11, 0.19)	0.07 (-0.00, 0.29)		**3**	0.14
Temperament:	Short	0.92	0.85	0.89	0.83	172		0.77	0.74	0.87	0.95	13		
Private[2, 4]	Long	1.04	0.96	0.86	0.68	87		1.06	1.02	0.69	0.64	11		
	S-L[1]	-0.12 (-0.25, 0.01)	-0.11 (-0.24, 0.02)	0.03 (-0.12, 0.18)	0.14 (0.00, 0.29)		**3**	-0.29 (-0.71, 0.13)	-0.28 (-0.72, 0.17)	0.19 (-0.31, 0.68)	0.31 (-0.15, 0.77)		**2**	0.83
Temperament:	Short	0.92	0.83	0.88	0.84	177		0.87	0.98	0.96	0.85	8		
Skeptical[2,4]	Long	1.03	0.98	0.83	0.70	77		1.06	0.91	0.90	0.63	20		
	S-L[1]	-0.12 (-0.25, 0.02)	-0.15 (-0.29, -0.02)	0.05 (-0.10, 0.21)	0.15 (-0.01, 0.30)		**1**	-0.19 (-0.60, 0.21)	0.07 (-0.32, 0.47)	0.07 (-0.44, 0.57)	0.22 (-0.26, 0.71)		**3**	0.65
Temperament:	Short	0.85	0.71	0.85	0.90	33		0.92	0.85	0.89	0.82	151		
Subtle[2,4]	Long	0.97	1.11	0.86	0.76	23		1.06	0.95	0.84	0.64	75		
	S-L[1]	-0.12 (-0.39, 0.16)	-0.39 (-0.66, -0.13)	-0.01 (-0.32, 0.31)	0.14 (-0.16, 0.44)		**1**	-0.14 (-0.28, -0.00)	-0.10 (-0.23, 0.04)	0.08 (-0.11, 0.21)	0.18 (0.02, 0.33)		**2**	0.75

[4] p-value < 0.05, underlined symptoms have changed statistically significantly since 0 months symptom status

[1] Mean value difference of SCL-90-GSI between short- and long-term therapy.

[2] Divided by the median, due to skewed distribution or due to being a single item/question.

[3] In consideration of pre-determined categorical cut-off points and skewness of distributions, 'high' vs. 'low'' therapists consisted of strongly (≥2 on the 0-3 scale) vs. moderately (1-2) and minimally (<1) genial and forceful therapists, and strongly or moderately vs. minimally reclusive therapists.

[4] Single item/question.

[5] Prognosis groups. 1 = Therapist characteristic beneficial especially in short-term therapy. 2 = Therapist characteristic beneficial especially in long-term therapy. 3 = Therapist characteristic not differentially beneficial in short- or long-term therapy.

[6] p-value for global test of interaction between therapist factor and therapy length.

Table 7. Mean values of SCL-90-GSI in long-term psychodynamic therapy and psychoanalysis and mean value differences (95% confidence intervals) at 12, 24, 36, 48 and 60 month follow-up according to the lower and higher values of therapist professional and personal characteristics.

		Low							High							
Characteristic	The-rapy	12	24	36	48	60	**N**	Group[3]	12	24	36	48	60	**N**	Group[3]	Inter-action[4]
PROFESSIONAL CHARACTERISTICS																
Work	LPP	1.00	0.80	0.70	0.75	0.79	26	**3**	0.82	0.76	0.56	0.52	0.39	31	**1**	
involvement:	PA	1.13	0.97	0.83	0.83	0.72	14		1.04	0.92	1.16	0.78	0.56	17		
Stressful	LPP-PA[1]	-0.14 (-0.44,0.17)	-0.17 (-0.52,0.17)	-0.13 (-0.50,0.24)	-0.08 (-0.41,0.26)	0.07 (-0.30,0.43)			-0.22 (-0.48,0.04)	-0.16 (-0.47,0.16)	-0.60 (-0.95, -0.26)	-0.25 (-0.56,0.06)	-0.17 (-0.52,0.18)			0.37
involvement																
Skills:	LPP	1.03	0.86	0.77	0.68	0.72	35	**3**	0.89	0.85	0.63	0.57	0.61	38	**1**	
Current	PA	0.95	0.75	0.83	0.64	0.54	10		1.17	1.02	0.93	0.88	0.77	15		
skillfullness	LPP-PA	0.09 (-0.25,0.42)	0.10 (-0.26,0.46)	-0.06 (-0.45,0.33)	0.03 (-0.30,0.37)	0.18 (-0.21,0.57)			-0.28 (-0.56,0.001)	-0.17 (-0.50,0.16)	-0.30 (-0.64,0.04)	-0.32 (-0.62, -0.01)	-0.17 (-0.50,0.17)			0.38
Relational	LPP	1.08	1.00	0.95	0.81	0.90	12	**2**	1.01	0.83	0.73	0.72	0.76	45	**1**	
manner:	PA	0.82	1.00	0.64	0.51	0.27	8		1.25	1.15	1.25	0.93	0.77	15		
Affirming	LPP-PA	0.26 (-0.21,0.74)	0.00 (-0.54,0.55)	0.31 (-0.15,0.77)	0.30 (-0.11,0.71)	0.63 (0.13,1.13)			-0.24 (-0.50,0.02)	-0.32 (-0.62, -0.03)	-0.52 (-0.83, -0.22)	-0.21 (-0.49,0.07)	-0.01 (-0.33,0.31)			0.06
Feelings:	LPP	0.99	0.83	0.74	0.64	0.75	32	**3**	1.03	0.81	0.70	0.70	0.71	35	**1**	
Flow	PA	1.09	0.97	0.91	0.62	0.55	15		1.07	0.91	1.25	0.92	0.81	11		
	LPP-PA	-0.10 (-0.40,0.20)	-0.14 (-0.47,0.18)	-0.17 (-0.51,0.18)	0.02 (-0.29,0.33)	0.20 (-0.17,0.56)			-0.04 (-0.35,0.26)	-0.10 (-0.47,0.27)	-0.55 (-0.91,-0.18)	-0.22 (-0.54,0.10)	-0.10 (-0.47,0.27)			0.44
Feelings:	LPP	1.06	0.80	0.70	0.63	0.71	29	**3**	1.01	0.84	0.58	0.50	0.44	14	**1**	
Boredom	PA	1.05	0.87	1.05	0.74	0.63	12		1.11	0.93	1.03	0.75	0.42	12		0.39
	LPP-PA	0.01 (-0.32,0.35)	-0.07 (-0.44,0.30)	-0.35 (-0.75,0.05)	-0.11 (-0.48,0.25)	0.08 (-0.33,0.49)			-0.10 (-0.48,0.28)	-0.09 (-0.49,0.31)	-0.45 (-0.89,-0.003)	-0.25 (-0.63,0.13)	0.02 (-0.44,0.48)			
Coping:	LPP	1.09	0.96	0.82	0.79	0.83	31	**3**	0.88	0.77	0.59	0.52	0.50	45	**1**	
Constructive	PA	1.03	0.87	0.86	0.62	0.58	10		0.91	0.81	0.92	0.64	0.47	20		
coping skills	LPP-PA	0.06 (-0.27,0.40)	0.09 (-0.29,0.47)	-0.04 (-0.46,0.37)	0.17 (-0.20,0.53)	0.25 (-0.16,0.66)			-0.03 (-0.26,0.20)	-0.04 (-0.31,0.23)	-0.33 (-0.62, -0.04)	-0.12 (-0.37,0.14)	0.03 (-0.26,0.33)			0.76
Difficulties:	LPP	1.01	0.82	0.69	0.69	0.73	32	**3**	0.84	0.78	0.57	0.56	0.47	34	**1**	
Frequent	PA	1.12	0.91	0.90	0.75	0.60	14		0.98	0.87	1.14	0.79	0.61	13		
difficulties	LPP-PA	-0.11 (-0.39,0.17)	-0.08 (-0.43,0.26)	-0.21 (-0.55,0.14)	-0.06 (-0.36,0.24)	0.14 (-0.21,0.48)			-0.14 (-0.42,0.14)	-0.10 (-0.43,0.24)	-0.57 (-0.95, -0.19)	-0.23 (-0.56,0.11)	-0.13 (-0.50,0.23)			0.54
PERSONAL CHARACTERISTICS																
Personal	LPP	0.97	0.80	0.72	0.63	0.60	26	**3**	0.98	0.87	0.69	0.65	0.67	72	**1**	
identity:	PA	1.16	0.93	0.97	0.91	0.82	13		1.01	0.89	0.96	0.65	0.48	25		
Genial[2]	LPP-PA	-0.19 (-0.50,0.12)	-0.13 (-0.50,0.43)	-0.24 (-0.62,0.13)	-0.28 (-0.61,0.05)	-0.22 (-0.62,0.17)			-0.04 (-0.24,0.17)	-0.02 (-0.25,0.21)	-0.27 (-0.52, -0.02)	0.00 (-0.23,0.23)	0.19 (-0.08,0.45)			0.21

Personal	LPP	0.97	0.86	0.69	0.64	0.64	74	**1**	1.05	0.81	0.73	0.67	0.68	24	**3**				
identity:	PA	1.09	0.95	0.95	0.82	0.71	28		1.00	0.78	1.11	0.56	0.35	10					
Forceful[2]	LPP-PA	-0.11 (-0.31,0.09)	-0.09 (-0.31,0.14)	-0.26 (-0.51, -0.01)	-0.19 (-0.40,0.03)	-0.07 (-0.32,0.18)			0.05 (-0.29,0.39)	0.04 (-0.37,0.44)	-0.38 (-0.78,0.03)	0.11 (-0.28,0.50)	0.33 (-0.09,0.74)						0.07
Interpersonal:	LPP	1.05	0.91	0.77	0.74	0.79	36	**3**	0.88	0.82	0.61	0.54	0.53	41	**1**				
Assertive	PA	0.87	0.86	0.80	0.59	0.48	11		1.09	0.89	1.01	0.74	0.44	16					
	LPP-PA	0.18 (-0.13,0.49)	0.05 (-0.30,0.39)	-0.03 (-0.40,0.34)	0.15 (-0.18,0.48)	0.32 (-0.06,0.69)			-0.21 (-0.46,0.05)	-0.07 (-0.37,0.23)	-0.40 (-0.71, -0.09)	-0.20 (-0.48,0.08)	0.09 (-0.23,0.40)						0.18
Interpersonal:	LPP	1.10	0.92	0.81	0.86	0.88	30	**2**	0.90	0.76	0.62	0.50	0.57	39	**1**				
Aloof	PA	0.59	0.40	0.98	0.46	0.32	8		1.09	0.91	1.00	0.76	0.61	18					
	LPP-PA	0.51 (0.15,0.87)	0.51 (0.03,1.00)	-0.17 (-0.72,0.39)	0.40 (0.03,0.78)	0.56 (0.09,1.02)			-0.19 (-0.42, 0.05)	-0.15 (-0.42, 0.13)	-0.38 (-0.70, -0.06)	-0.26 (-0.52, -0.003)	-0.04 -0.35,0.27)						0.02
Temperament	LPP	0.93	0.85	0.66	0.60	0.58	58	**1**	1.01	0.85	0.80	0.74	0.77	27	**3**				
: Intense	PA	1.16	0.99	0.97	0.83	0.72	18		0.91	0.68	0.98	0.67	0.42	14					
	LPP-PA	-0.24 (-0.47, -0.01)	-0.14 (-0.41,0.12)	-0.31 (-0.61, -0.01)	-0.23 (-0.49,0.02)	-0.14 (-0.44,0.16)			0.10 (-0.19,0.38)	0.17 (-0.24,0.59)	-0.19 (-0.54,0.17)	0.08 (-0.25,0.40)	0.36 (-0.01,0.72)					0.26	

[*] p-value < 0.05, underlined symptoms have changed statistically significantly since 0 months symptom status.

[1] Mean value difference of SCL-90-GSI between long-term psychodynamic psychotherapy and psychoanalysis.

[2] In consideration of pre-determined categorical cut-off points and skewness of distributions, 'high' vs. 'low' therapists consisted of strongly (≥2 on the 0-3 scale) vs. moderately (1-2) and minimally (<1) genial and forceful therapists.

[3] Prognosis groups. 1 = Therapist characteristic beneficial especially in long-term psychodynamic therapy. 2 = Therapist characteristic beneficial especially in psychoanalysis. 3 = Therapist characteristic not differentially beneficial in long-term psychodynamic psychotherapy or psychoanalysis.

[4] p-value for global test of interaction between therapist factor and therapy length.

5.3 Therapists' professional and personal characteristics as predictors of outcome in long-term psychodynamic therapy and psychoanalysis during a 5-year follow-up (Study III)

Therapists' professional experiences of high Current Skillfullness, high Constructive Coping Skills and high Flow, but also of high Stressful Involvement, high Boredom and high Frequent Difficulties predicted fewer symptoms in long-term psychodynamic therapy than in psychoanalysis around the end of the long-term psychodynamic therapies (at the 4-year follow-up for Current Skillfullness, at the 3-year follow-up for the other characteristics) (range of SCL-90-GSI 0.56-0.70 and 0.86-1.25 in long-term psychodynamic therapy and psychoanalysis respectively) (Table 7). However, these differences were no longer significant at the 5-year follow-up. In contrast, several characteristics reflecting both professional (low Affirming) and personal (high Forcefulness, low Aloofness in close personal relationships) relational manner predicted a lower symptom level in psychoanalysis than in long-term psychodynamic therapy at the end of the 5-year follow-up (range of SCL-90-GSI 0.68-0.90 and 0.27-0.35 in long-term psychodynamic therapy and psychoanalysis respectively at the 60-month follow-up). The interaction between therapist characteristic and the therapy group was significant for one of the qualities (Aloof) and borderline significant for the other two (Affirming, $p = 0.06$; Forceful, $p = 0.07$). Some personal characteristics reflecting relational manner (high Geniality, high Assertiveness, low Intensity) also predicted significantly fewer symptoms in long-term psychodynamic therapy at the 3-year follow-up (range of SCL-90-GSI 0.61-0.69 and 0.96-1.01 in long-term psychodynamic therapy and psychoanalysis respectively at the 36-month follow-up), but these differences were no longer significant at the 5-year follow-up.

5.4 The associations of therapists' professional and personal relational style and their theoretical orientation (Study IV)

In comparisons of therapists with clearly different theoretical orientations, it was found that psychoanalytic-dynamic therapists experienced themselves as significantly less Genial in their close personal relationships than therapists of humanistic orientation and that integrative-eclectic therapists saw themselves as more Genial than all other therapist groups (Table 8). Also, integrative-eclectic therapists experienced themselves as more Forceful than cognitive-behavioral and humanistic therapists. Psychoanalytic-dynamic therapists also experienced themselves, together with humanists, as less Practical than cognitive-behavioral and integrative-eclectic therapists.

In the item-level explorations, therapists in all orientation groups rated themselves as more warm, nurturing, protective, and intuitive in their close personal relationships than when relating with clients, but also as less tolerant, accepting, and subtle (Table 9). Similarly, therapists in all orientation groups rated themselves as more authoritative, demanding, critical, reserved, cold, and determined in their close personal relationships.

The divergence between close personal relationships and professional relationships with patients was greater for analytic-psychodynamic therapists than for some other orientation groups in terms of being more warm, nurturing, friendly, and protective. They also experienced themselves as more authoritative, challenging, directive, demanding, critical, organized, and determined in personal as contrasted to professional relationships, when compared with several other orientation groups.

Compared with certain other orientation groups, cognitive-behavioral therapists experienced themselves in their close personal relationships as less directive, authoritative, and determined and as more intuitive and reserved than they rated themselves when treating clients. Compared with some orientation groups, humanistic therapists experienced themselves as less accepting and as more authoritative, challenging, directive, demanding, critical, and determined in their personal than in their professional relationships. For the relatively small group of systemic therapists, few comparisons reached statistical significance. Integrative therapists tended to follow the general pattern in the direction of divergence but often did so to a significantly smaller degree than many other orientation groups, indicating that relatively speaking they rated themselves as more nearly the same in their personal and professional relationships.

Table 8. Estimated means (95 % confidence intervals) on dimensions of personal identity according to theoretical orientation[a]

Dimension	Ana	CBT	Hum	Sys	I-E	P for difference	Significant between -group differences [b]
Genial	2.21	2.23	2.28	2.25	2.40	<.001	I-E > Ana, CBT, Hum, Sys; Hum > Ana
	(2.19-2.23)	(2.18-2.27)	(2.24-2.32)	(2.17-2.33)	(2.37-2.42)		
Forceful	1.34	1.25	1.28	1.33	1.38	. <.001	I-E > CBT, Hum
	(1.31-1.37)	(1.20-1.31)	(1.23-1.34)	(1.23-1.43)	(1.35-1.41)		
Reclusive	1.21	1.17	1.17	1.10	1.23	.04	-
	(1.18-1.24)	(1.11-1.22)	(1.12-1.23)	(1.00-1.21)	(1.20-1.26)		
Practical	1.83	1.95	1.81	1.97	2.02	<.001	CBT, I-E > Ana, Hum
	(1.80-1.86)	(1.90-2.01)	(1.75-1.87)	(1.86-2.07)	(1.99-2.05)		

[a] Adjusted for sex, age, professional background, and larger national samples (USA, UK, Norway, Germany, Australia).

[b] Post-hoc differences, adjusted for multiple comparisons using Bonferroni correction.

Table 9. Mean differences between self-experience in personal identity versus professional manner according to theoretical orientation[a]

Item	Orientation group Ana	CBT	Hum	Sys	I-E	P for orientation group	R^2 [b]	Direction of divergence [c]	Significant between-group differences [d]
Genial									
Warm	.19	.06	.06	.18	.04	<.001	.010	***pers*** > prof	Ana > CBT, Hum, I-E
Nurturing	.48	.44	.25	.40	.30	<.001	.011	***pers*** > prof	Ana > Hum, I-E; CBT > I-E
Friendly	.23	-.08	.02	.06	.04	<.001	.018	mixed	*pers* Ana > Hum, I-E; *prof* CBT > Ana
Protective	.53	.51	.35	.53	.40	<.001	.006	***pers*** > prof	Ana > Hum, I-E
Tolerant	-.12	-.06	-.17	-.04	-.06	.08	.002	***prof*** > pers	*ns*
Accepting	-.25	-.32	-.41	-.28	-.26	.04	.003	***prof*** > pers	Hum > Ana
Intuitive	.10	.18	.11	.16	.06	.04	.003	***pers*** > prof	CBT > I-E
Forceful									
Authoritative	.22	.03	.37	.18	.10	<.001	.011	***pers*** > prof	Ana, Hum > CBT, I-E
Challenging	.15	-.07	.21	-.08	.00	<.001	.011	mixed	*pers* Ana, Hum > CBT, I-E; *prof* Sys > Hum
Directive	.40	-.28	.32	.12	.10	<.001	.052	mixed	Ana, Hum, Sys, I-E > CBT; Ana, Hum > I-E; Ana > Sys
Demanding	.52	.10	.48	.38	.30	<.001	.020	***pers*** > prof	Ana, Hum > CBT, I-E; I-E > CBT
Critical	.67	.41	.69	.49	.45	<.001	.017	***pers*** > prof	Ana, Hum > CBT, I-E
Reclusive									
Reserved	.07	.34	.22	.18	.15	<.001	.007	***pers*** > prof	CBT > Ana, I-E
Cold	.14	.10	.20	.14	.12	.21	.002	***pers*** > prof	*ns*
Subtle	-.02	-.05	-.05	-.14	-.11	.03	.003	***prof*** > pers	I-E > Ana
Guarded	.08	-.02	.06	-.03	.09	.18	.002	mixed	*ns*
Practical									
Organized	.16	-.10	.06	.05	-.10	<.001	.017	mixed	*pers* Ana > CBT, I-E; *prof* I-E > Hum
Determined	.27	.09	.44	.37	.28	<.001	.007	***pers*** > prof	Ana, Hum, I-E > CBT

[a] Positive values indicate a greater rating on the respective items in personal identity than in professional manner. Adjusted for sex, age, professional background, and larger national samples (USA, UK, Norway, Germany, Australia).
[b] Variance explained by theoretical orientation.
[c] *pers* > prof = greater endorsement in personal than in professional relationships; *prof* > pers = greater endorsement in professional than in personal relationships; *mixed* = direction varying depending on theoretical orientation.
[d] Significant post-hoc differences, adjusted for multiple comparisons using Bonferroni correction. When divergences are in 'mixed' directions, *pers* = personal > professional; *prof* = professional > personal.

6 DISCUSSION

The present investigation indicated that the working alliance and outcome in various types of psychotherapy may be predicted by two seemingly distinct functional groups of therapist characteristics. The first group consisted of therapists' professional characteristics reflecting experiences of skillfulness and enjoyment in therapeutic work versus experiences of unskillfulness and lack of enjoyment. The second group consisted of therapists' experiences of their relational manner in therapy work and personal life. Finally, as a third finding of the present investigation, therapists' relational manner in professional versus personal life was shown to be associated with therapists' preferred theoretical orientations.

6.1 Therapists' experiences of skillfulness and enjoyment in therapeutic work in predicting working alliance and outcome

6.1.1 Prediction on working alliance in short- and long-term psychotherapies

Therapists' experiences of skillfulness and enjoyment in therapy work consistently predicted better early alliances, when the alliance was rated by the therapists themselves. By contrast, therapists' experiences of difficulties, stress, and negative feelings in practice predicted worse early therapist-rated working relationships. The findings persuasively suggest that the alliance – as experienced by the therapist – is not solely determined by the dyadic interaction with a particular patient, but also to a marked extent reflects how therapists experience themselves generally in their professional lives. Based on both empirical and theoretical literature, the finding seems expectable that overall professional stress and difficulties would reflect adversely and feelings of mastery and enjoyment would reflect positively on individual therapy relationships (e.g., Farber, 1983; Farber & Heifetz, 1981, 1982; Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2012; Skovholt & Rønnestad, 1995). As a less obvious, but interesting finding, lower feelings of skillfulness seemed to hinder early therapist alliances particularly in the short-term therapies. It has been suggested that, due to their limited time frame, briefer treatments require even more therapist confidence and optimism to engage the patient, to inspire hope, and to initiate changes (Budman, Friedman, & Hoyt, 1992; Hoyt, 2011). In view of this, it seems understandable that therapists' self-doubt would be demoralizing and detrimental for their experiences of working alliance particularly in briefer treatments.

It was nevertheless noteworthy that therapists appeared capable of containing their difficult self-experiences at work so that they did not predict worse patient-rated alliances. This is interesting especially since earlier research has found that patients' and outside observers' perceptions of therapists as bored, anxious, or unsure are associated with poorer patient-rated alliances (Saunders, 1999; Sexton, Hembre, & Kvarme, 1996). This finding thus further corroborates the fact – noted earlier in the literature review – that the perspectives of the two treatment parties are not equivalent, but differ inherently from one another (Bachelor, 2013; Clemence et al., 2005; Orlinsky et al., 2004). In fact, the only professional characteristic of therapists that significantly predicted patient-rated early alliances were their basic relational skills, which proved beneficial in both short- and long-term therapies. This finding replicated and extended an earlier result from Norway where these skills were found to predict better early patient alliances in relatively long-term therapies (Nissen-Lie et al., 2010). These basic relational abilities – reflecting a composed, responsive personal presence, capacity for empathizing with a wide range of human experiences and an ability to feel and communicate authentic concern for other people – have been posited as the natural talent that beginning therapists bring to their profession, regardless of their specific therapy form or orientation and which have shown the least change over the course of a therapist's career (Orlinsky & Rønnestad, 2005). Consequently, these basic relational skills have been suggested as potentially useful for selecting candidates for therapy training (ibid.), which is in line with our results. Such a hypothesis of "natural talent" was further supported by the better patient-rated alliances found in both lengths of therapies when therapists experienced themselves as more genial (i.e., warm, open, and optimistic) in their personal relationships.

6.1.2 Prediction on outcome of short- and long-term therapies during a 3-year follow-up

As noted above, therapists' experiences of work skillfulness and enjoyment versus unskillfulness and lack of enjoyment seemed to correspondingly predict better versus worse therapist-rated working alliances, but to have little effect on the patient-rated alliances. Interestingly, however, these characteristics also seemed to predict meaningfully the final outcomes of short-term versus long-term therapy during the 3-year follow-up, but this time measured from the patients' perspective.

The finding uniting Studies I and II was that higher basic relational skills – which predicted better early alliances for both therapists and patients – likewise predicted a fast and lasting symptom reduction in both short- and long-term therapies. This finding further supported the hypothesized importance of therapists' basic relational skills (Orlinsky & Rønnestad, 2005). Conversely, characteristics reflecting therapists' lower confidence in their skills as well as lower enjoyment in therapy work (i.e., low Healing Involvement, low Current Skillfullness, low Flow, and high

Avoidant Coping) predicted poorer patient-rated outcomes in short-term than in long-term therapy at the end of the 3-year follow-up. Thus, while therapists' relatively lower confidence and enjoyment did not affect the patient evaluations of the therapeutic alliance during the actual course of the short-term therapies, these characteristics nevertheless seemed to compromise the patient's ability to develop an adaptive and lasting mastery of problems. The results therefore seem to support the suggestion that therapists' confidence and optimism in attainable changes within a short time-frame are a central conducive factor when providing brief treatments (Budman et al., 1992; Hoyt, 2011). In long-term therapy, however, such lack of confidence and enjoyment did not seem to be equally harmful. Previous research has also failed to find associations between therapists' self-doubt and outcome in long-term therapy (Sandell et al., 2006, 2007).

6.1.3 Prediction on outcome of long-term psychodynamic therapy and psychoanalysis during a 5-year follow-up

A yet more complex picture of the role of therapists' professional experiences of skillfulness, enjoyment, and difficulties emerged in the comparison of their predictive ability during a 5-year follow-up of long-term psychodynamic psychotherapy and psychoanalysis. Findings showed that both therapists' experiences of skill and enjoyment (high Current Skillfulness, Constructive Coping Skills, and Flow) as well as their experiences of work stress and difficulties (high Stressful Involvement, Boredom, and Frequent Difficulties) predicted more symptoms in psychoanalyses as compared to long-term psychodynamic psychotherapies at the time when the latter were ending or had ended, and the psychoanalyses were still ongoing.

However, although contradictory, these characteristics are not mutually exclusive and if considered together, they may be seen as largely approximating a therapist's strong personal commitment to therapy work , or, as described by the developers of the DPCCQ (Orlinsky & Rønnestad, 2005), a work experience of 'Challenging Practice': experienced by a practitioner "facing but apparently overcoming difficulties". In fact, one possible interpretation might be that a considerable symptom level would be indicative of a patient's intentional "working through" of problems in ongoing psychoanalysis, in the presence of an equally committed therapist (Wallerstein, 1995). In contrast, in long-term psychodynamic treatments which ended at the 3-year follow-up point, a more appropriate end state would be the patient's more stabilized mastery of problematic issues and lesser experience of symptoms (Busch, 2010). As no differences were observed in the end at the 5-year follow-up, the meaning of these findings is not clear; however, the findings do suggest some further differences between the two long-term treatments that interact with therapist qualities and support closer examination of the processes in both treatments in further studies.

6.2 Therapists' professional and personal relational style in predicting working alliance and outcome

6.2.1 Prediction on working alliance in short- and long-term psychotherapies

Therapists' professional and personal relational manner showed meaningful associations to their ratings of the early alliance in both short- and long-term treatments, just as their experiences of skillfulness and enjoyment in therapy work did. In other words, better working relationships were predicted by professionally more involved qualities (highly Efficacious, highly Invested), but more moderate characteristics in personal relationships (less Forceful and less Reclusive, more Private). These characteristics seem to reflect both a professional commitment as well as a personal propensity to orienting toward and feeling comfortable in a one-on-one collaboration (Guy, 1987). Again, therapists' self-rated characteristics predicted their early alliances clearly and consistently, but had quite little effect on the patients' early alliances.

However, not all relational characteristics were equally beneficial in short- and long-term treatments. It was observed that therapists who were highly warm and open experienced the best early alliances if they conducted long-term therapy. These characteristics thus seem beneficial to establishing a therapeutically intimate long-term relationship, as opposed to more detached therapist characteristics (Hersoug et al., 2009). In contrast, being highly task-oriented and skeptical predicted better alliances especially in short-term therapy. These characteristics, in turn, possibly facilitate a right frame of mind to begin a working relationship that recognizes, in line with the patient's expectations, the limited time at hand and practical concerns and possibilities in briefer treatments (Valkonen, Hänninen, & Lindfors, 2011).

Patient-rated improvement of alliance was also predicted by certain therapist characteristics. In the course of the 7 months' follow-up, highly invested and affirming therapist qualities predicted improvement of patient alliances especially in the short-term therapies. The findings thus seemed to corroborate the benefits of active and engaging qualities especially in briefer treatments (Saunders, Howard, & Orlinsky, 1989; Sexton et al., 1996). However, in long-term therapies these therapist qualities actually predicted alliance deterioration. This may perhaps be due to involving patients either too deeply or prematurely in the intensive exploration of problematic experiences (as in the case of higher investment) or leading to premature closure (as in the case of higher affirming manner) (Busch, Rudden, & Shapiro, 2004). This may also explain the unexpected finding that alliance deterioration was predicted by a low amount of avoidant coping especially in the long-term therapies.

The results are intriguing when considered together with the earlier, likewise surprising finding from long-term therapies which showed that therapists' greater

self-rated advanced relational skills actually predicted worse patient-rated alliances, when in the context of therapists' frequent negative personal reactions to patients (Nissen-Lie et al., 2010). Taken together, the findings suggest that particularly long-term psychodynamic and psychoanalytic therapy processes may be vulnerable to therapists' misevaluated or overly active manner and interventions in the early stages of treatment, a hazard recognized early in psychoanalytic thought (Freud, 1913). From a pragmatic point of view, the findings suggest the importance of further studies monitoring therapists' overly active negative interventions and behaviors that may unintentionally lead to alliance ruptures as experienced by the patients (cf., Hilsenroth, Cromer, & Ackerman, 2012; Owen, Hilsenroth, & Rodolfa, 2013).

6.2.2 Prediction on outcome of short- and long-term therapies during a 3-year follow-up

In the prediction of outcome in short- versus long-term therapy, certain commonalities seemed to be observable between therapists' professional and personal relational qualities which were specifically beneficial in one of the two treatment lengths.

First, professional characteristics reflecting a more active professional manner (highly Invested and highly Efficacious) were predictive of a faster symptom reduction in short-term therapies. Mirroring this, the same result was also observed when therapists were more engaging and extroverted in their personal life (highly Intense, low in Subtlety, Reclusiveness, Aloofness, and Skepticism). The findings thus not only fit the notion that brief treatments require a more active, engaging, and optimistic therapist than long-term psychodynamic or psychoanalytic therapies (Budman et al., 1992; Dewan et al., 2011; Hoyt, 2011; Parry et al., 2005), but they also further support the suggestion that the professional skills of effective therapists may be intertwined with their personal qualities (Strupp & Anderson, 1997).

In contrast to the benefits found in short-term therapies, greater gains during the 3-year follow-up were predicted in long-term psychodynamic therapy when the therapists' personal manner was more considerate, cautious, and non-intrusive (highly Genial and Open; low in Forcefulness, Intensity, Task-Orientedness, and Optimism; and highly Private and Subtle). These are also therapist qualities generally associated with the more deliberate pace of long-term therapies as compared to briefer treatments (Gabbard, 2004; Hoyt, 2011). However, the present investigation, to the best of our knowledge, is the first one to explore this issue in a comparative setting of short- and long-term psychotherapies.

6.2.3 Prediction on outcome of long-term psychodynamic therapy and psychoanalysis during a 5-year follow-up

The findings on the predictive ability of therapists' professional and personal relational manner in short- versus long-term therapy were interestingly further complemented with the comparison of outcomes in long-term psychodynamic therapy versus psychoanalysis during a 5-year follow-up. The end results of the two long-term treatments differed noticeably and systematically at the 5-year follow-up as predicted by several, both professional and personal relational qualities.

It was observed that patients in psychoanalysis had less symptoms than ones in long-term psychodynamic therapy when therapists experienced themselves in professional manner as less affirming and in personal life as less aloof and more forceful. That being less Affirming (i.e., less 'accepting', 'friendly', 'tolerant', and 'warm') in professional manner predicted a relatively high symptom level especially in long-term psychodynamic therapy supported the earlier findings of Sandell et al. (2000) that therapists low on 'kindness' and 'supportiveness' were especially unbeneficial in such treatment. Our findings thus support Sandell et al.'s (2000) conclusion that "the classically psychoanalytic stance, with less emphasis on support, coping strategies, warmth and openness, may be functional with analysands but much less so with patients in psychotherapy".

However, our findings also seemed to challenge the benefits of a pervasively "neutral" therapist in psychoanalysis. The other two qualities that proved especially beneficial in psychoanalysis – high Forcefulness (i.e., highly 'assertive', 'authoritative', 'demanding', 'directive', 'challenging', 'critical', 'pragmatic', 'organized', 'demonstrative', 'determined', 'energetic', 'intuitive', 'intense') and low Aloofness (i.e., low on 'cold', 'guarded', and 'reserved') in close personal relationships (Orlinsky & Rønnestad, 2006) – clearly do not embody the stereotypical 'detached' psychoanalyst which, in fact, was arguably not advocated by Freud (Lipton, 1967; Stolorow, 1990). It has been suggested instead that Freud merely advocated that analysts should confine their personal characteristics to the service of building the working alliance or a positive transference in a realistic sense (Lipton, 1967).

Taken together, the findings thus suggest a complex pattern in which patients do best in psychoanalysis when their analysts are restrained in showing affirmation professionally but are personally highly 'present' (i.e., Forceful and not Aloof) (cf. Schachter & Kächele, 2007). This suggested the question of how therapists' professional and personal characteristics may be associated with each other and their preferred treatment frameworks, which was addressed in the final study using an international therapist database.

6.3 The associations of therapists' professional and personal relational style and their theoretical orientation

The final, cross-sectional study of therapists' professional and personal characteristics found that therapists who prefer clearly different theoretical orientations also differ from each other in their personal identity, conceptualized in terms of their relational manner in close personal relationships. Most relevantly to the present investigation, psychoanalytic-dynamic therapists experienced themselves as less genial than humanistic and integrative-eclectic therapists and, together with humanistic therapists, also as less practical than cognitive-behavioral and integrative-eclectic therapists. Theoretically, the findings are understandable given that a genial personal disposition would fit more naturally with the warm, open, and empathic professional relational manner recommended for therapists in humanistic thought (Bohart & Watson, 2011; Rogers, 1957), in contrast to the more neutral and restrained stance suggested by analytical-psychodynamic approaches (Gabbard, 2004). Also, a practical approach to relationships seems to fit more naturally with the problem-solving ethos of cognitive-behavioral therapy (e.g., Beck, 1976; Dienes, Torres-Harding, Reinecke, Freeman, & Sauer, 2011) than with the observing and interpretive focus of psychodynamic-analytic approaches (Wolitzky, 2011) or the emphasis on facilitating client experiencing and emotional expression in humanistic approaches (e.g., Bohart & Watson, 2011; Gendlin, 1978; Rogers, 1957). While to our knowledge this is the first study to explicitly investigate the associations between theoretical orientations and therapists' experiences in close personal relationships, the results are also congruent with the few earlier empirical studies on the associations of therapists' personal qualities in these orientations (Keinan et al., 1989; Murdock, Banta, Stromseth, Viene, & Brown, 1998; Tremblay, Herron, & Schultz, 1986). Thus, while the cross-sectional data does not allow conclusions about the direction of effects, it nevertheless seems a possibility that therapists may be drawn in professional life to practice within theoretical frameworks that are congruent with their relational manner in personal life (Arthur, 2001; Guy, 1987; Topolinski & Hertel, 2007).

Additionally, therapists also seemed to mold their professional manner to the kind of relationship suggested by their theoretical approach, and conversely to relax these expectations in their personal relationships. Thus, in contrast to the stereotypical image of the neutral psychoanalyst observing clients' associations with "evenly hovering attention" (Freud, 1912; Wolitzky, 2011), psychodynamic practitioners experienced themselves in their private life as more warm, friendly, nurturing, and organized than they did in their professional work, when compared to therapists of certain other orientations. In sum, therapists at work seem either to 'tone up' the qualities recommended by their theoretical orientations or 'tone down' personal qualities that are viewed as detrimental in those frameworks. Whether there is an optimal 'fit' between these professional and personal characteristics for therapy

effectiveness – also in therapies not explored in the present investigation – could thus be explored in future studies, as well as how divergences between therapists' professional and personal manner evolve during training in different therapy frameworks.

6.4 Methodological considerations

6.4.1 Methodological considerations of the Helsinki Psychotherapy Study

Several strengths in the present investigation stem from the design and methods of the Helsinki Psychotherapy Study. First, the sample size was large enough to detect relevant effects. Second, the long follow-up, the low attrition rate, and the possibility to adjust for auxiliary treatment provided validity for the observed effects of the treatments. Third, the frequent outcome assessments allowed following the patterns of change thoroughly from the initiation of the therapies to the end of the lengthiest treatments. Fourth, psychiatric symptoms have been recognized as a sensitive indicator of outcome; the instrument used (SCL-90-GSI) covers depressive, anxiety, and interpersonal phenomena relevant to the patient population studied; and the used measure is among the most common and recommended outcome instruments, thus supporting the validity and comparability of the results to other investigations (Holi, Sammallahti, & Aalberg, 1998; Hill & Lambert, 2004; Sandell et al., 2000). Fifth, the alliance measure is also the most frequently used in extant research (Horvath et al., 2011), and multiple perspectives on the treatment process were provided via having both the therapists and the patients rate the alliance. Sixth, treatment providers were assessed with an instrument developed specifically for assessing the therapist profession: this enabled assessing clinician characteristics relevant to therapy work, neglected by more generic measures used in many earlier studies. Seventh, therapists' self-reports offered a way of assessing a variety of qualities that are primarily experiential and not similarly accessible by other methods such as using external observers or patient evaluations (Hill & Lambert, 2004). Eighth, the pre-treatment assessment of therapist characteristics allowed their measurement independently of the effect of patient and therapy interaction, thus enabling a more valid assessment of what the therapist as an individual brings into the therapy from its very beginning. Finally, since the present investigation focused on the effectiveness of treatment given in normal clinical practice, the psychodynamic therapies were not manualized.

There are, however, certain difficulties in the interpretation of the results. First, despite the adjustment for potential confounding factors (i.e., sex, age, experience, marital status, profession, and level of training), further residual confounding cannot be fully excluded. Second, while investigating separately the prediction of the first-

and second-order factors gives a comprehensive picture of the potentially important therapist qualities, these characteristics cannot be examined truly in isolation from each other, as they likely are intertwined with each other in complex ways in actual therapy practice. However, given the lack of articulated theoretical models to date that would specify the relative relationships and importance of the numerous DPCCQ domains and qualities for the therapy process (Orlinsky & Rønnestad, 2005, 2006); the still nascent and limited empirical literature on this topic (Hartmann, Zeeck, & Orlinsky, 2011; Nissen-Lie et al., 2010; Zeeck et al., 2012); the overall scarce knowledge of what are the beneficial therapist characteristics in any therapies (Baldwin & Imel, 2013; Beutler et al., 2004); and consequently the explorative nature of our study, our strategy was intentionally chosen to gain as comprehensive as possible a view of the potentially important therapist characteristics. Third, the withdrawal from treatment after randomization and discontinuation of therapy may be a potential source of bias. However, no notable differences were found between the different models that adjusted for the compliance of study treatment. Fourth, since it would have been unethical to deny the use of auxiliary treatment during the 3-year and 5-year follow-ups, use of psychiatric medication, therapy, or psychiatric hospitalization may have caused bias in the data. Although adjustment for auxiliary treatment did not notably alter the results in the complementary analyses, the potential associations of therapist characteristics with the use of auxiliary treatment as well as drop-out from therapy are questions that could be investigated in further research. Fifth, as the first two studies compared two combined long-term and/or short-term therapies, they do not permit conclusions about the effects of therapist characteristics in each individual form of therapy. Nevertheless, given equal treatment outcomes between the two short-term and the two long-term therapies during the respective follow-ups in question, as well as the need to achieve adequate statistical power, combining the treatments was seen to be warranted (Knekt et al., 2011). For further assurance, in conjunction with Study II the two short-term treatments – which differ significantly in their theoretical fundamentals – were also investigated separately, but did not evidence different outcomes as a function of the DPCCQ therapist qualities (data not shown). Sixth, as the study focused on treatment of depressive and anxiety disorders, the findings might not be generalizable to other patient groups excluded from the present study (e.g., patients with severe personality disorders or substance abuse disorders). Seventh, the generalizability to other clinical settings is tempered by both the fact that the therapists were relatively experienced and the low patient-to-therapist ratio. While random effects modeling of our data showed negligible between-therapists differences in the patient-rated alliance and outcome measures (data not shown), larger between-therapist effects could emerge for study in other settings and samples with greater therapist diversity and patient-to-therapist ratios (cf. Baldwin & Imel, 2013; Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Okiishi, Lambert, Nielsen, & Ogles, 2003). Finally, as it has been shown that

the outcomes of psychoanalysis may not appear even after the end of therapies but only some time after termination (Blomberg, Lazar, & Sandell, 2001; Sandell et al., 2000), even longer follow-ups are needed to ascertain the development and persistence of outcomes.

6.4.2 Methodological considerations of the Society for Psychotherapy Research Collaborative Research Network study

The SPR CRN study has several methodological strengths but also limitations. First, the large and varied SPR CRN database provided sufficient statistical power to detect relatively small real effects and allowed exploration of associations between theoretical orientation and personal characteristics while adjusting for multiple situational and socio-demographic variables such as nationality, profession, age, and sex. Second, the factor structure of the DPCCQ has been replicated in diverse subpopulations (Orlinsky & Rønnestad, 2005, 2006, 2011) and thus seems suitable for assessing therapists from various countries and backgrounds, supporting the generality of the Study IV's findings and also those of the Helsinki Psychotherapy Study. Finally, as there was considerable overlap in the DPCCQ scale contents used in assessing therapists' professional and personal relational manner, direct comparisons could be made by computing difference scores between the two – rather than relying on correlations between separate and hence not strictly comparable measurement instruments of therapists' professional and personal qualities.

The limitations of the study are intertwined with its strengths. First, given the heterogeneous nature of the SPR CRN database, confounding with other variables can never be fully eliminated so as to conclusively extract the association between two specific variables, despite the adjustment for multiple background factors in the study. A second limitation is the cross-sectional nature of the data, which does not permit conclusions to be drawn about the direction of potential influence between therapists' theoretical orientations and personal and professional relational manner. The findings therefore do not show whether or how much therapists' choices of orientations reflect a sense of congruity with their personal self-concept, or whether training and practice within a given theoretical framework may actually influence how therapists experience themselves in their personal relationships (Guy, 1987). Finally, a question of further interest is how observations of therapists by other persons, such as the therapist's friends, family, or supervisors, would correlate with the therapist's self-experience. Nevertheless, even should they differ, they would not negate the validity of those reports as reflections of the therapist's self-image (cf. Vazire, 2010).

6.5 Conclusions and directions for future research

In summary, both the professional and the personal characteristics of therapists seem to predict working alliance and outcome differently in psychotherapies of different forms and lengths. Various experiences of unskillfulness and lack of enjoyment seemed potentially detrimental especially in the short-term therapies, where a professionally confident and relationally active and engaging stand seemed particularly needed. While more deliberate, non-intrusive, and considerate relational characteristics seemed especially beneficial in long-term psychodynamic therapy, a further consideration emerged in its comparison to psychoanalysis: here, the potential benefits of a professionally restrained, but personally highly 'present' psychoanalyst were suggested. As therapists were also found to differ in their professional *vis-à-vis* their personal relational manner in private life as a function of their theoretical orientation, the findings suggest that therapists' professional and private selves may be in a more or less self-conscious relation to each other in therapy practice.

Since the particular issues studied here have not been investigated before, the results should be replicated before any firm conclusions can be drawn. Future studies aiming to replicate the present findings might also do well to assess the therapist characteristics from multiple observational viewpoints, as the therapists' self-perception may well differ from how others perceive them. In terms of therapist development, a longitudinal design of therapist training programs could examine the interrelated evolution of therapists' professional characteristics, theoretical approaches, and personal characteristics. Together with more research on how therapy relationships and outcomes are affected by these professional and personal qualities – in conjunction with relevant, e.g. psychiatric and interpersonal patient qualities – these lines of research should have implications both for improving the flexibility of training programs in accommodating candidates' personal qualities and in optimizing effective training, learning, and therapy practice.

7 ACKNOWLEDGMENTS

This study was carried out in the Helsinki Psychotherapy Study (HPS) at the National Institute for Health and Welfare (THL) during 2008-2013, funded initially by the Social Insurance Institution (KELA). The HPS was initiated in the early 1990s and has continued to the present day. It has involved close to 400 patients, over 70 therapists, and approximately a hundred researchers or planners. The opportunity to participate in the work of the HPS is very gratefully acknowledged. It has been a privilege to work in such a highly skilled and committed research environment, along with the excellent research facilities provided by THL. Moreover, the work of the people in the HPS-group throughout numerous years, as well as the sustained commitment of the patients and therapists to participate in the study, are what made this thesis possible.

There are a great number of people to whom I owe thanks for initiating and completing this work. My greatest indebtedness goes, without dispute, to Professor Paul Knekt, PHD, my primary supervisor and the director of the HPS, who suggested the theme of this thesis. His unwavering support and encouragement, vast expertise in epidemiology, health research and statistics, as well as his invariably timely and concise feedback were of paramount importance throughout this process. Equally, his scientific rigor, meticulous attention to detail, creativeness, and enthusiasm for research have served as a prized and inspiring model for a young scholar. Second, I want to very sincerely thank my second supervisor, psychoanalyst, Professor Johannes Lehtonen, MD, PhD. His broad scholarly empirical and theoretical understanding of psychotherapy as well as clinical perceptiveness was greatly valued and enabled the refinement of the dissertation summary. Third, I am greatly indebted to psychoanalyst, LicPsych Olavi Lindfors. His contribution as the development manager of the HPS, a thoroughly knowledgeable clinician-researcher, continued collaborator on research articles, as well as a source of encouragement is gratefully acknowledged.

The broader experience, knowledge and commitment at THL are something without which this work could not have been done. Adjunct Professor Tommi Härkänen, PhD, offered his statistical expertise at various stages of the dissertation infallibly concisely, efficiently, and amiably. Senior Systems Analyst Esa Virtala was available for valuable advice and help in organizing the database and programming the study analyses. Likewise, Researcher Harri Rissanen gave helpful advice in computing, data management, and many practical matters at various stages of the study, and IT-Systems Analyst Talvikki Leinonen provided IT support. I am very grateful to publications coordinator Sanna Koivumäki for her always quick and ready help in preparing this work for press - as well as maker-up Anita Pesola at Juvenes Print for the final touches. I am also very thankful to my fellow doctoral

and/or master's degree student colleagues who have worked in the HPS throughout these years – Tuija Jääskeläinen, MSc, Laura Sares-Jäske, MSc, and Peija Haaramo, MSocSc – for important and always reliable practical help in carrying out data analyses and lunch company. In particular, however, I owe to my fellow doctoral student colleague (in psychology) and PhD (in biometry), Maarit Laaksonen, who with Professor Paul Knekt developed the approach for the study of patients' psychotherapy suitability which also become essential in this research on therapist characteristics. Thanks also belong to the numerous other fellow THL researchers for providing a friendly working environment.

I also thank the official reviewers of this dissertation, Adjunct Professors Ilpo Lahti, MD, PhD, and Annamari Tuulio-Henriksson, PhD, who kindly read the manuscript and provided many insightful comments. I am also thankful to Professor Juhani Julkunen, PhD, for serving as the official overseer of this work at the Institute of Behavioral Sciences, Faculty of Behavioral Sciences, University of Helsinki.

I also thank the Fulbright Center and Professor David E. Orlinsky for being able to visit the University of Chicago as a part of this dissertation work. Thank you, David – and all of BN – most of all, for your friendship.

Financial support from the Social Insurance Institution was essential for the collection of the data and the grant from the Academy of Finland (nr. 138876) further supported the HPS. For financial support of the thesis I thank the Finnish Cultural Foundation, the Fulbright Center, and the Psychiatry Research Foundation. In particular, I am thankful to the Emil Aaltonen Foundation for their sustained support at important stages of this research. I am also very grateful to the Finnish Psychological Association, the Helsinki Psychologists' Association, and the Society for Psychotherapy Research for providing travel support for scientific conferences. I also gratefully acknowledge the American Psychological Association, Division 29 of Psychotherapy, for the Jeffrey E. Barnett Research Paper Award; the Society for the Exploration of Psychotherapy Integration for the SEPI Dissertation Award; and the European Psychiatric Association for the EPA Research Prize, in their kind recognitions of this work while it was still in progress.

The seventy-one therapists of the Helsinki Psychotherapy Study are to what this study owes most of all, however: for participating in the study, and providing information on an intimately professional and personal topic; and to these therapists this work is gratefully dedicated.

Finally, I want to thank family, friends, and close ones for their support and encouragement throughout this work and all these years.

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9 APPENDICES

Appendix 1. Criteria for selection of published original studies on working alliance and outcome.

1. Original quantitative studies
2. Published in 1980-2011
3. Predictor variable: therapists' inferred pre-treatment characteristics
    a. Excluded: therapist-patient similarity as predictor
4. Dependent variable: study included a direct measure of working alliance or outcome (thus excluding dropout and premature termination)
5. Study design: randomized trial or cohort study
6. Psychotherapy: at least one of the therapies studied in the article is short or long individual psychotherapy
7. Strength of association or significance reported
8. Diagnosis: main diagnosis of interest is Axis I
9. Number of patients in smallest study group: > 10
10. Patients: outpatients
11. Patients' age: adult patients
12. Number of therapists: more than five therapists
13. Professional psychotherapists (not trainees)

Appendix 2. Abbreviations for Tables 1 and 2.

DIAGNOSIS
ADJ % = Proportion of adjustment disorders
AFF % = Proportion of affective disorders
ANX % = Proportion of anxiety disorders
DEP % = Proportion of depressive disorders
DYS % = Proportion of dysthymia
EAT % = Proportion of eating disorders
GAD % = Proportion of generalized anxiety
MIXED I % = Proportion of Axis I disorders (proportion of depressive and anxiety disorders cannot be separated)
MIXED I NR = Variety of Axis I disorders, but proportions not reported (may include some patients without diagnosis)
MIXED II % = Proportion of Axis II disorders
MIXED NR = Variety of different diagnosis, but Axis I and Axis II diagnosis cannot be separated
OCD % = Proportion of obsessive-compulsive disorders
PD % = Proportion of personality disorders
PSY % = Proportion of psychotic disorders
SOC % = Proportion of social phobia
SOM % = Proportion of somatoform disorders
SUB % = Proportion of substance use disorders

NUMBER OF PATIENTS
As the number of patients in the original articles was reported at several different phases of the study (i.e. patients admitted, patients who began treatment, patients who finished treatment), the author chose to report the number of patients used in the analysis on which the final analyses and results were based.

THERAPIST AGE
Mean age and age range were reported, if this knowledge was available, otherwise the level of information given was used.

SESSIONS
The mean number and range of therapy sessions was reported, if this knowledge was available, otherwise the level of information given was used.

THERAPIST EXPERIENCE
The mean and range of therapy experience (in years) was reported, if this knowledge was available, otherwise the level of information given was used.

TREATMENTS
PT = Not specified individual psychotherapy
LPT = Not specified long-term individual psychotherapy
CBT = Cognitive-behavioural therapy
IMI-CM = Imipramine and clinical management
IPT = Interpersonal psychotherapy
PDT = Psychodynamic therapy
PA = Psychoanalysis
LDT = Low-dose therapies (brief therapy, low-frequency supportive therapy, family therapy, group therapy) (Sandell et al., 2000, 2006, 2007)

PREDICTOR
The respective measurement areas of instruments, according to classification of therapists' inferred characteristics (Beutler et al., 1994, 2004), are noted in parentheses.

AAI = Adult Attachment Interview (Personal characteristics: emotional well-being)
IIP = Inventory of Interpersonal Problems (Personal characteristics: emotional well-being)
Neuroticism (EPI) = Neuroticism scale of Eysenck Personality Inventory (Personal characteristics: emotional well-being)
PBI = Parental Bonding Instrument (Personal characteristics: emotional well-being)
RVS = Rokeach Value Survey (Personal characteristics: values)
SASB Intrex = Structural Analysis of Social Behaviour (Personal characteristics: emotional well-being)
TASC-2 = Therapist Attitudes Scales (Professional characteristics: therapeutic philosophy)

Two studies (Blatt et al., 1994; Sandell et al., 2000) did not report usage of a specific therapist assessment instrument.

ALLIANCE MEASURE
HAQ = Helping Alliance Questionnaire
IES = Inpatient Experience Scale
SASB INTREX = Structural Analysis of Social Behavior Questionnaire
WAI = Working Alliance Inventory (WAI-P: patient-rated form, WAI-T = therapist-rated form)

OUTCOME MEASURE

The respective measurement areas of instruments are noted in parentheses.

BDI = Beck Depression Inventory (Depressive symptoms)

DMRS = Defense Mechanism Rating Scales (Defenses)

GAS = Global Assessment Scale (Global benefits of therapy)

GOR = Global Outcome Rating (Global benefits of therapy)

HDRS = Hamilton Depression Rating Scale (Depressive symptoms)

IS = Impairment Score

SAS = Social Adjustment Scale (Social functioning)

SASB Intrex = Structural Analysis of Social Behaviour (Self-concept)

SCL-90-GSI = Symptom Check List, General Symptom Index (Global psychiatric symptoms)