A systematic review on the role of therapist characteristics in the treatment of eating disorders

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ABSTRACT

Treating patients with eating disorders can be challenging for therapists, as it requires the establishment of a strong therapeutic relationship. According to the literature, therapist characteristics may influence intervention outcomes. The aim of this systematic review was to identify and synthesize existing literature on therapist interpersonal characteristics that could affect psychotherapy relationship or outcomes in the context of eating disorder treatment from both patients' and therapists' perspectives. We conducted a systematic search using electronic databases and included both qualitative and quantitative studies from 1980 until July 2023. Out of the 1230 studies screened, 38 papers met the inclusion criteria and were included in the systematic review. The results indicate that patients reported therapist's warmth, empathic understanding, a supportive attitude, expertise in eating disorders, and self-disclosure as positive characteristics. Conversely, a lack of empathy, a judgmental attitude, and insufficient expertise were reported as therapist negative characteristics which could have a detrimental impact on treatment outcome. Few studies have reported therapist's perceptions of their own personal characteristics which could have an impact on treatment. Therapists reported that empathy and supportiveness, optimism, and previous eating disorder experience were positive characteristics. Conversely, clinician anxiety, a judgmental attitude, and a lack of objectivity were reported as negative characteristics that therapists felt could hinder treatment. This systematic review offers initial evidence on the personal characteristics of therapists that may affect the treatment process and outcomes when working with patients with eating disorders.

Key words: eating disorders, therapist characteristics, empathy, expertise, systematic reviews.

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Introduction

Eating disorders (EDs) are severe psychiatric conditions that encompass anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), and other specified feeding and eating disorders (OSFED). These clinical conditions are characterized by a persistent disruption of eating-related behaviors, leading to significant alterations in food consumption. This is accompanied by subsequent severe physical consequences and psychosocial impairments (American Psychiatric Association, 2013). EDs can have a significant impact on physical, psychological, and social functioning, leading to a reduced quality of life and increased healthcare utilization (Ágh *et al*., 2016). The psychopathology of eating disorders is described within a continuum ranging from underconsumption to overconsumption. Maladaptive eating patterns can include extreme or abnormal eating habits, as well as dieting or restrictive behaviors. The global prevalence and impact of eating disorders are constantly increasing, affecting at least 9% of women and 2% of men (Galmiche *et al*., 2019).

In the last two decades, considerable progress has been made in developing effective treatments for ED. Cognitive Behavioral Therapy (CBT), Enhanced Cognitive Behavioral Therapy (CBT-E), and Interpersonal Psychotherapy (IPT) are recommended for the treatment of bulimia nervosa, binge eating disorder, and, to a lesser extent, atypical eating disorders (National Collaborating Centre for Mental Health, 2004). However, meta-analytic evidence showed that any bona fide psychotherapy is equally effective in treating EDs (Grenon *et al*., 2019) and there has been a recent call to improve the accessibility, affordability, and scalability of digital mental health treatments (Lattie *et al*., 2022). This call has gained even greater relevance since the onset of the COVID-19 pandemic, which has led to an increase in the prevalence of eating disorder symptoms (Bonfanti *et al*., 2023; Schneider *et al*., 2023) and significant disruptions in clinical services (Sideli *et al*., 2021).

The treatment of EDs poses a significant challenge for clinicians due to certain intrinsic characteristics that can impact the likelihood of achieving positive treatment outcomes. Patients with EDs tend to underestimate the severity of their symptoms and have low motivation for treatment, which may lead to elevated dropout rates and deteriorating outcomes (Fernàndez-Aranda *et al*., 2021). According to Turner *et al*. (2015), adherence to treatment and the ability to establish a strong working alliance are crucial for a successful treatment of eating disorders. The working alliance, as proposed by Gelso (2014), constitutes one of the three factors that make up the therapeutic relationship, together with the real relationship and the transference/countertransference. Among these three dimensions, the working alliance is the factor that has been most studied in the literature and on which there are more empirical data in the context of the therapeutic relationship (Gelso, 2014; Lo Coco *et al*., 2011). Although there is promising evidence that a positive alliance can enhance the outcomes of psychotherapy for EDs (Werz *et al*., 2022), there is still a need to develop tailored treatments to meet the challenges of eating disorders. In recent years, significant research interest has been given to the examination of common therapeutic factors which may account for a significant portion of treatment outcomes (Wampold, 2015). Several attempts have been made over the years to systematize these common factors, with varying results (*e.g*. Wampold & Owen, 2021). However, there is still a lack of consensus among experts in the field, and a high risk of overlapping within psychological constructs remains.

Personal characteristics of the therapist have long been recognized as a cross-cutting factor in classifications of common factors in psychotherapy which influence treatment outcome (Barkham *et al*., 2017). Since Luborsky and colleagues (1985) early studies on psychotherapy outcomes, it has become clear that there are differences between therapists in terms of the outcome of the patients' treatments. Subsequent studies have reinforced the relevance of the therapist effect, indicating that some therapists achieve more favorable outcomes than others. This therapist effect can account for around 5% of the variance in outcome and is strongly associated with other therapy process constructs, such as the therapeutic alliance (Nissen-Lie *et al*., 2023; Wampold & Owen, 2021). Some recent reviews and meta-analyses have tried to identify and summarize therapist characteristics that may influence treatment outcome and the therapeutic relationship. For example, Lingiardi *et al*. (2018) emphasized the influence of personal characteristics of the therapist, such as attachment, interpersonal styles, and personality traits, on the outcomes of interventions in psychodynamic psychotherapies. Heinonen and Nissen-Lie (2020) identified the therapist socio-emotional traits, such as empathy, warmth, positive regard, communication skills, and the ability to deal with criticism, as stronger predictors of positive outcomes (within the therapist effect). However, few studies have specifically focused on analyzing these therapist factors in the treatment of EDs, despite previous literature suggesting that some personal characteristics of therapists may be crucial in determining therapeutic outcomes in patients with EDs. For example, some studies have identified the therapist's empathy, emotional attunement, and self-awareness as crucial qualities that could improve therapeutic outcomes. In particular, therapists working with people with ED need to be able to understand and address the emotional experiences of their clients. Empathy has been shown to be associated with improved therapeutic outcomes in the treatment of eating disorders (Oyer *et al*., 2016). Moreover, therapists who are emotionally attuned are better able to understand their clients' perspectives, by improving the therapeutic alliance and treatment outcome (Le Grange *et al*., 2007). Self-awareness is also a crucial quality for therapists who work with individuals with eating disorders. It involves understanding one's own thoughts, feelings, and behaviors, which can help therapists avoid projecting their own biases onto clients and provide more effective treatment (Aronson & Anderson, 2010). The therapist's countertransference also seems to play a role in the therapeutic process of treating patients with EDs. Specifically, there is preliminary evidence that therapists may experience greater special/overinvolved countertransference when the patient had higher trauma severity (Groth *et al*., 2020), and that therapist's emotional response may be influenced by patient variables such as sexual abuse or self-harm (Colli *et al*., 2015).

The therapist's ability to establish a strong therapeutic alliance is crucial to the success of treating EDs. This alliance should be based on trust, mutual respect, and collaboration between the therapist and the client (Mallinckrodt *et al*., 2014). Several therapist characteristics have been identified as important for defining the therapeutic alliance, including empathy, genuineness, respect and unconditional positive regard (Lambert and Barley, 2001). Furthermore, therapists' interpersonal characteristics, such as an engaging and encouraging relational style, have been shown to enhance the development of a positive alliance in short-term therapies, whereas constructive coping techniques have demonstrated more favorable effects on a positive alliance in long-term therapies (Heinonen *et al*., 2014). Conversely, some studies have found that therapists' interpersonal characteristics, such as keeping a distance, being disconnected, or indifferent, could have a negative impact on the working alliance in long-term treatments (Hersoug *et al*., 2009). It is important to note, however, that research investigating the relationship between therapist characteristics and the therapeutic alliance in treating EDs is still in its early stages (Werz *et al*., 2022).

It is also worth noting that previous studies examining both beneficial and adverse experiences of psychotherapy have found that the latter are less commonly reported than positive experiences. Patients may hesitate to express feelings of dissatisfaction regarding therapy or their therapist (Castonguay *et al*., 2010). It is important to note that this research is still in its infancy. However, there is increasing attention to patients' perceptions of negative experiences in psychotherapy (De Smet *et al*., 2019; Hardy *et al*., 2019; Alfonsson *et al*., 2023). According to a qualitative meta-analysis by Smith *et al*. (2014), clients' negative experiences in psychotherapy primarily stem from negative assessments of the therapist's personal qualities and behavior. These include instances where the therapist fails to listen, is judgmental, or devalues the client. Additionally, clients may perceive the

therapist as disconnected from the therapy or the client, which can result in a lack of empathy, distrust, or a lack of interpersonal rapport. A more recent study showed that patients highlighted four areas of therapist variables that could lead to treatment failure: therapists' negative traits (such as being inflexible, unengaged, unemphatic, insecure), unprofessionalism (such as violating personal boundaries, breaking confidentiality, non-transparency), incompetence (such as poor assessment or understanding, poor knowledge, too passive), and mismatch (therapist–patient mismatch) (Alfonsson *et al*., 2023). Although there are few studies that specifically focus on the positive (and negative) personal qualities of therapists in the treatment of EDs, research investigating user satisfaction and the experiences of both patients and therapists during the recovery process has yielded some intriguing findings. For example, in the treatment of patients with AN, positive treatment experiences are associated with therapists who are perceived as impartial, understanding, non-judgmental, warm, reliable, active, flexible, respectful, caring, validating, and loving (Colton & Pistrang, 2004). Patients have expressed gratitude for their therapist's adaptability in tailoring treatment to their specific needs (Fairburn *et al*., 2015). Patients with BED have reported valuing the support provided by their therapists, while also experiencing negative feelings of stigmatization due to their disorder (Wilfley *et al*., 2002). On the other hand, therapists have reported their efforts to establish a warm and supportive treatment environment (Fairburn *et al*., 2015). However, the self-assessment bias of psychotherapists remains an issue. For example, it was found that therapists' bias in assessing their own facilitative interpersonal skills such as emotional expression, warmth, acceptance was higher than those reported by observer ratings (Longley *et al*., 2023).

Although some research suggests the role of therapist characteristics in the treatment of EDs, there is still a lack of a comprehensive view on this relevant topic. The purpose of this systematic review is to identify and synthesize existing literature on therapist interpersonal characteristics and their impact on therapy relationship or outcome for patients with EDs. In addition, it is valuable to analyze therapist characteristics from both the patient and clinician perspective to identify any differences between the two perspectives. These findings may help clinicians and researchers to address current limitations in ED interventions.

Methods

A systematic evaluation of the literature was conducted following the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines (Moher *et al*., 2009) and using the following electronic databases: Embase, Medline, PsychINFO and PsychARTICLE through Ovid.

Three parallel searches were conducted; the first two searches aimed to identify the therapist's characteristics throughout the several types of eating disorders treatments and therapeutic approaches, and the last one wishes to identify the patient's and/or therapist's own satisfaction with the therapist's characteristics reported. In the first search, the following keywords were used: *charact*, *trait*, *effect*, *dimension*, *factor*, *variable*, *influence*, *style*, *personality*, *attitude*, *temperament*, *credibility*. The search was repeated using the following synonyms for therapist: *Psychotherapist*, *Counsel*, *Mentor*, *Facilitator*, *Psychologist*, *Trainee*, *Clinical*. In the second search, the following keywords were used: *warm*, *empath*, *feeling*, *attachment*, *authentic*, *genuine*. Also, in this case the research was repeated using the following therapist synonyms: *Psychotherapist, Counsel, Mentor, Facilitator, Psychologist, Trainee, Clinical.* In the third search, the *satisfaction* keyword was used for *patient* or *client* or *participant* and therapist or *Psychotherapist*, *Counsel, Mentor, Facilitator, Psychologist, Trainee, Clinical.* All three searches were used in combination with the following keywords: *anorexia nervosa*, *bulimia nervosa* and *binge eating disorders*. Both searches were limited to journal articles, published with human subjects and written in the English language between 1980 and January 2023. An updating of the literature was performed last July 2023.

Eligibility criteria

Studies were included in the systematic review if they met the following eligibility criteria: i) a diagnosis of anorexia nervosa and/or bulimia nervosa and/or binge eating according to the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM 5) (American Psychiatric Association, 2013), or the International Classification of Diseases 10th edition (ICD-10) (World Health Organization, 1992), ii) at any stage of life (childhood, adolescence, adulthood), iii) in any therapy setting (Inpatient, outpatient, day-care, private sessions, psychotherapy); iv) from any study design (RCTs, case control studies, correlational studies, longitudinal studies) and lastly v) for both quantitative and qualitative studies. A mandatory criterion was used for all searches, vi) the presence of patient/client and/or therapists (other therapists' definition) personal characteristics related to the treatment process and/or outcomes. The personal characteristics from the included studies were self-reported by therapist or reported by patients/clients. G.A and A.S. conducted the literature search and screened all papers for eligibility for the inclusion criteria. Disagreements were resolved through consensus meetings with G.L.

Study selection

The three literature searches identified 1208 papers in total. 22 studies were added using the reference lists from other studies. 397 duplicates were removed, and 622 papers were excluded because they did not meet the inclusion criteria following screening of titles and abstracts. 173 papers were excluded after reading the full texts. The final eligible papers were 38 (Banasiak *et al*., 2007; Bjork *et al*., 2009; Brown *et al*., 2014; Brown & Nicholson Perry, 2018; Clinton *et al*., 2004; Clinton, 2001; Colton & Pistrang, 2004; Daniel *et al*., 2015; De la Rie *et al*., 2006; De la Rie *et al*., 2008; De Vos *et al*., 2016; Escobar-Koch *et al*. 2010; Fox & Diab, 2013; Gowers *et al*., 2010; Gulliksen *et al*., 2012; Halvorsen & Heyerdahl, 2007; Lose *et al*., 2014; Ma, 2008; Offord *et al*., 2006; Oyer *et al*., 2016; Paulson-Karlsson *et al*., 2006; Pettersen & Rosenvinge 2002; Poulsen *et al*., 2010; Rance *et al*., 2017; Reid *et al*., 2008; Rorty *et al*., 1993; Rosenvinge & Klusmeier, 2000; Sheridan & McArdle, 2015; Smith *et al*. 2016; Stockford *et al*. 2018; Tritt *et al*., 2015; Vanderlinden *et al*., 2007; Warren *et al*., 2013; Wasil *et al*., 2019; Whitney *et al*., 2008; Wright & Hacking 2012; Zaitsoff *et al*. 2015; Zaitsoff *et al*., 2016). A flow-chart of the studies included in the systematic review is presented in Figure 1. Screening was performed by three members of the research team (GA, AS, GL). As most of the included studies were observational and not RCTs, we did not perform a meta-analysis of the association between therapist characteristics and therapy outcome. The increased risk of bias and the high level of heterogeneity between studies would prevent us from establishing a precise estimate of the main effects.

Quality assessment

A quality appraisal for qualitative studies was carried out using the Critical Appraisal Skills Program (CASP) qualitative research checklist by three reviewers (CASP, 2017). A maximum of 10 *Yes* were attributed for each study. A quality appraisal for quantitative studies was carried out using a modified version of the Newcastle-Ottawa Scale (Wells *et al*., 2003). A maximum of 7 points was attributed. Studies were evaluated to be at low risk of bias if the score was 5 to 7, at a moderate risk of bias if the score was 3 or 4, and at high risk of bias if the score was equal or lower than 2 (*Supplementary Table 1*). Quality assessment was conducted by GA, RCB, and AT. Any discrepancies between reviewers were discussed until an agreement was reached, if needed with the consultancy of the senior author (GLC).

Results

The search resulted in a final selection of 38 articles. All studies were evaluated to be at low risk of bias (*Supplementary Table 2*). The eligible articles were divided into two sections: the patient's and therapist's perspectives based on their own personal characteristics considered necessary for the achievement of treatment outcome or for a valid contribution to the EDs treatment process. For each section (patient and therapist), the characteristics of the therapist have been considered as positive or negative and therefore they are treated separately. 30 articles were focused on patient's perspective; 18 out of these 30 studies (60%) reported positive characteristics, whereas 3 studies reported negative characteristics of therapist; 9 articles reported both positive and negative characteristics.

Only 4 articles were focused on the therapist's perspective; 2 studies reported positive characteristics, one study focused on negative characteristics of the therapist, and only 1 article reported both positive and negative characteristics. 4 papers reported both clients' and therapists' perspectives respectively. 17 studies included patients with a diagnosis of anorexia nervosa (AN) or eating disorder not otherwise specified (EDNOS) (Brown *et al*. 2014; Colton & Pistrang, 2004; Fox & Diab, 2013; Gowers *et al*., 2010; Gulliksen *et al*. 2012; Halvorsen & Heyerdahl, 2007; Lose *et al*., 2014; Ma, 2008; Offord *et al*. 2006; Oyer *et al*. 2015; Paulson-Karlsson *et al*. 2006; Rance *et al*. 2017; Smith *et al*. 2014; Stockford *et al*. 2018; Whitney *et al*., 2008; Wright & Hacking, 2012; Zaitsoff *et al*., 2016); 4 studies included patients suffering from bulimia nervosa (BN), (Banasiak *et al*. 2007; Daniel *et al*. 2015; Poulsen *et al*. 2010; Rorty *et al*. 1993); 7 studies included patients with both diagnoses of AN and BN and/or EDNOS, (Bijork *et al*. 2009; De la Rie *et al*. 2008; De Vos *et al*. 2016; Lose *et al*. 2014; Reid *et al*., 2008; Sheridan & McArdle, 2015; Tritt *et al*., 2015; Zaitsoff *et al*. 2015); and 8 studies were focused on the treatment of general eating disorders (Brown *et al*., 2018; Clinton, 2001; Clinton *et al*. 2004; De la Rie *et al*., 2006; Escobar-Koch *et al*. 2010; Pet-

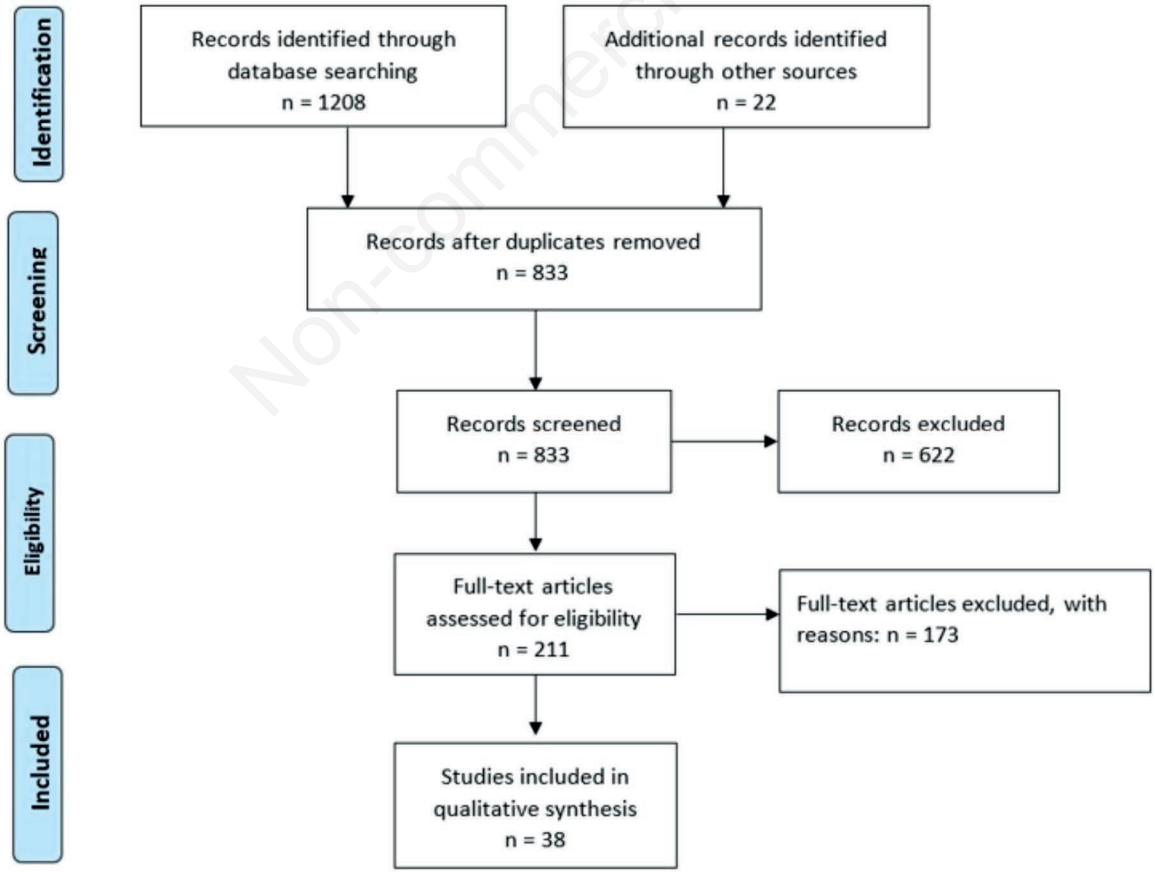

Figure 1. Flowchart of studies included in the present review.

tersen & Rosenvinge, 2002; Rosenvinge & Klusmeier, 2000; Vanderlinden *et al*. 2007; Warren *et al*. 2013; Wasil *et al*., 2019).

The majority of patients included in the systematic review were women, with a mean age range from 14.11 to 39.25 years. Regarding the therapist's perspective, most professionals included from the selected studies were women, with a mean age range from 35.12 to 43.96 years. In the included studies, we found a large variety of clinical intervention directed to EDs, with different psychotherapeutic approaches (*e.g*., individual and group treatment or integrated interventions based on CBT or psychodynamic treatments). 12 out of 32 studies were based on a multidisciplinary intervention directed to both inpatient and outpatient interventions. Finally, in the eligible studies reported there is an accurate definition of the therapist; most studies involved a multidisciplinary clinical staff (composed by several professional identities with a proper expertise on the EDs treatment). Only nine studies involved clinical psychologists or therapists in the treatment of EDs, and in only one study general practitioners/therapists without a specific EDs background were involved in conducting clinical interventions.

Of the 38 articles checked for the quality assessment, 21 studies were qualitative researches (Banasiak *et al*., 2007; Colton & Pistrang, 2004; De vos *et al*., 2016; Escobar-Koch *et al*., 2010; Fox & Diab, 2013; Gulliksen *et al*., 2012; Lose *et al*., 2014; Ma, 2008; Oyer *et al*., 2016; Poulsen *et al*., 2010; Offord *et al*., 2006; Rance *et al*., 2017; Reid *et al*., 2008; Rorty *et al*., 1993; Sheridan & McArdle, 2015; Smith *et al*., 2016; Stockford *et al*., 2018; Warren *et al*., 2013; Whitney *et al*., 2008; Wright & Hacking, 2012; Zaitsoff *et al*., 2016), 13 were quantitative researches (Brown *et al*., 2014; Brown & Perry, 2018; Clinton *et al*., 2004; de la Rie *et al*., 2006; Daniel *et al*., 2015; Halvorsen & Heyerdahl, 2007; Paulson-Karlsson *et al*., 2006; Rosenvinge & Kuhlefelt Klusmeier, 2000; Tritt *et al*., 2015; Vanderlinden *et al*., 2007; Zaitsoff *et al*., 2015; Clinton, 2001; Wasil *et al*., 2019), and 4 mixed-method studies (Bjork *et al*., 2009; Gowers *et al*., 2010; de la Rie *et al*., 2008; Pettersen & Rosenvinge, 2002). The majority of studies used interviews or semi structured interviews to collect data. Few studies adopted validated measures to assess therapist characteristics. The nature of the interviews or semi-structured interviews was mainly focused on the assessment of the treatment process. Most of the included studies adopted an inductive nature, avoiding author bias in data collection and allowing to patients the chance to explore the treatment process through broad treatment domains defined a priori by the study authors.

Supplementary Table 1 reports the quality ratings of the included studies. Overall, all studies (21 qualitative research and 17 quantitative research or mixed methods) fully satisfied the criteria for robustness.

In Table 1 and Table 2 are reported the characteristics of the included studies, for clients' and therapists' perceptions, respectively.

Table 1. General characteristics of studies with clients' perspectives (N=34).

Author, year	Country	Type of study	N (% women)	M_{age}	Diagnosis and setting of the client	Type of treatment	Definition of therapist
Banasiak *et al.*, 2007	Australia	Retrospective and qualitative study	36 (100)	29.5	BN, primary care	Guided self-help treatment	Clinical staff
Bjork *et al.*, 2009	Sweden	Longitudinal naturalistic study	82 (97.6)	23.8	AN, BN, EDNOS inpatients, outpatients, day-patients	Individual, family, group psychotherapy	n/a
Clinton, 2001	Sweden	Multicentric and longitudinal study	461 (98.9)	24.5	AN=115; BN=146; BED=64; EDNOS=136 inpatients, outpatients, day-patients	Individual, group, family CBT, PDT	Clinical and medical staff
Clinton *et al.*, 2004	Sweden	Multicentric and longitudinal study	469 (98.5)	25.4	AN=94; BN=175; BED=25; EDNOS=175 inpatient, outpatients, day patients	Individual, group FT, ET	Clinical and medical staff
Colton & Pistrang, 2004	UK	Phenomenological study	19 (100)	15.4	AN inpatients	n/a	Clinical staff
De la Rie *et al.*, 2006	Netherlands	Qualitative study	304 (97.3)	28.7	AN=44; BN=43; EDNOS=69; Former ED=148 outpatients	n/a	Clinical and medical staff
De la Rie *et al.*, 2008	Netherlands	Mixed method	304	16.04	AN, BN and EDNOS	n/a	Clinical and medical staff
De Vos *et al.*, 2016	Netherlands	Qualitative study	205 (98)	27.25	AN=98; EDNOS=72; BN=34 outpatients	Consult with a recovered therapist besides possible therapy from other treatment disciplines	Clinical psychologists
Escobar-Koch *et al.*, 2010	United States & UK	Cross-national study & qualitative and exploratory study	USA 144 (97.2) UK 150 (96.7)	30.1	26.6 ED	n/a	Clinical staff

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Table 1. Continued from previous page.

Author, year	Country	Type of study	N (% women)	M_{age}	Diagnosis and setting of the client	Type of treatment	Definition of therapist
Fox & Diab, 2013	UK	Phenomenological study	6 (100)	27.0	Chronic AN (can) inpatients, outpatients	Psychological therapy (various approaches)	Clinical staff
Gowers *et al.*, 2010	UK	RCT	215 (92.5)	14.11	AN inpatients	CBT therapy	Clinical and medical staff
Gulliksen *et al.*, 2012	Norway	Phenomenological, descriptive, and qualitative study	38 (100)	28.3	AN inpatients and outpatients	n/a	Clinical and medical staff
Halvorsen & Heyerdahl, 2007	Norway	Retrospective study	46 (100)	14.9	AN inpatients or outpatients	CFT	Psychotherapists
Lose *et al.*, 2014	UK	RCT (retrospective and qualitative study)	17 (n/a)	29.5	AN=10; EDNOS-AN= 7	MANTRA	Psychotherapists
Ma, 2008	HongKong	Qualitative study	29 (100)	n/a	AN	FT	Psychotherapists
Offord *et al.*, 2006	UK	Retrospective and qualitative study	7 (100)	n/a	AN inpatients	n/a	Clinical staff
Oyer *et al.*, 2016	Colorado	Phenomenological and qualitative study	8 (87.5)	39.25	AN inpatients, outpatients	n/a	Clinical staff
Paulson-Karlsson *et al.*, 2006	Sweden	Mixed method (TSS with 11 open-ended questions)	32 (100)	15.0	AN outpatients	SFT	Psychotherapists
Poulsen *et al.*, 2010	Copenhagen	Qualitative study	15 (100)	26.1	BN	Individual PDT	Psychotherapists
Pettersen & Rosenvinge, 2002	Norway	Qualitative study	48 (100)	27.6	AN, BN, BED	Professional treatment	n/a
Rance *et al.*, 2017	UK	Retrospective and qualitative study	12 (100)	31.5	AN inpatients or outpatients	CBT, CAT, PDT, IT	Clinical and medical staff
Reid *et al.*, 2008	UK	Qualitative study	20 (95)	n/a	AN and BN outpatients	n/a	Clinical and medical staff
Rorty *et al.*, 1993	USA	Qualitative study	40 (100)	25.65	BN	n/a	Clinical and medical staff
Rosenvinge & Klusmeier, 2000	Norway	Cross-sectional	321 (n/a)	29.3	AN, BN, BED inpatients, outpatient	Individual, group CBT, FT	Clinical staff
Sheridan & McArdle, 2015	Ireland	Qualitative study	14 (100)	23.21	AN and BN inpatients, outpatients	n/a	n/a
Smith *et al.*, 2016	UK	Qualitative study	21 (100)	25.2	AN inpatients	Individual and group CBT therapies, counselling, dietetic management	Clinical staff
Stockford *et al.*, 2018	UK	Phenomenological and qualitative study	6 (100)	36.0	AN inpatients, outpatients	A variety of clinical interventions	Clinical staff
Tritt *et al.*, 2015	USA, Canada, UK	Multicenter and Retrospective study	105 (98.1)	26.2	AN, BN, EDNOS	CBT, FT, DBT, IPT, PDT	Psychotherapists
Vanderlinden *et al.*, 2007	Belgium	Quantitative	132 (97.7)	24.6	AN=56; BN=65; BED=11 inpatients, outpatient	CBT (group format) combined with a FT	Clinical and medical staff
Wasil *et al.*, 2019	USA	Qualitative study	11 (100)	33.09	Patients recovered from an ED at least 1 year prior the study	n/a	Psychotherapists and peers
Whitney *et al.*, 2008	UK	Qualitative study	19 (100)	30.3	AN inpatients	CRT	Psychotherapists
Wright & Hacking, 2012	UK	Phenomenological study	6 (100)	n/a	AN day care patients	n/a	Clinical staff
Zaitsoff *et al.*, 2015	Canada	Qualitative study	34 (100)	16.33	AN=14, BN=4, EDNOS=15 inpatients, outpatients	Individual, group FT; dietician, school counselling	n/a
Zaitsoff *et al.*, 2016	Canada	Qualitative study	21 (100)	16.3	AN=15 and subthreshold AN=6 inpatients, outpatients	Individual, group FT dietitian, school counselling	n/a

CBT, cognitive behavioral therapy; PDT, psychodynamic therapy; ET, expressive therapy; FT, family therapy; CFT, conjoint family therapy; MANTRA, Maudsley model for treatment of adults with anorexia nervosa; SFT, separated family therapy; CAT, cognitive analytic therapy; DBT, dialectical behavioral therapy; IPT, interpersonal therapy; CRT, cognitive remediation therapy.

Client's point of view: positive characteristics

Thirty-four studies reported the positive characteristics related to the therapist identified by clients/patients (Table 3).

Therapist's warmth and empathic understanding

In 26 studies, the emphatic characteristic of the therapist was seen as a positive characteristic in relation to the definition of the therapeutic relationship, in contributing to the recovery process from an Eds (Colton & Pistrang, 2004; De Vos *et al*., 2016; Ma, 2008; Halvorsen and Heyerdahl, 2007; Rorty *et al*., 1993), clients' satisfaction (De la Rie *et al*., 2008; Escobar-Koch *et al*., 2010; Growers *et al*., 2010; Gulliksen *et al*., 2012; Lose *et al*., 2014; Paulson-Karlsson *et al*., 2006; Poulsen *et al*., 2010; Rance *et al*., 2017; Reid *et al*., 2008; Rosenvinge and Klusmeier, 2000), trust in therapist (Fox & Diab, 2013), and adherence/engagement to treatment (Zaitsoff *et al*., 2016).

Table 2. General characteristics of studies with therapists' perspectives (N=8).

Author, year	Country	Type of study	N (% women)	M_{age}	Diagnosis and setting of the client	Type of treatment	Definition of therapist
Brown *et al.*, 2014	UK	Cross-sectional	100 (80)	n/a	AN outpatients	CBT	Clinical and medical staff
Brown & Perry, 2018	Australia	Cross-sectional	100 (95)	36.29	ED	CBT	Psychologists
Daniel *et al.*, 2015	The Netherlands	RCT	12 (75)	n/a	BN	PPT, CBT	Clinical and medical staff
De la Rie *et al.*, 2008	The Netherlands	Quantitative and qualitative study	73 (64.38)	42	AN, BN, EDNOS outpatients	CBT, biomedical therapy, PAT, client-centered therapies STA	Clinical and medical staff
De Vos *et al.*, 2016	The Netherlands	Qualitative study	26 (100)	35.12	AN=98; BN=34; EDNOS=72 outpatients	Consultation with a recovered therapist besides possible therapy from other treatment	Psychologists
Oyer *et al.*, 2016	Colorado	Phenomenological and qualitative study	7 (85.7)	n/a	AN inpatients, outpatients	n/a	Clinical staff
Warren *et al.*, 2013	USA	Qualitative study	139 (96.4)	43.96	ED multiple settings	CBT, PDT, eclectic/integrative and, humanistic thrapies, medication/nutrition interventions	Clinical staff
Wright & Hacking, 2012	UK	Phenomenological study	7 (100)	n/a	AN day care patients	n/a	Clinical staff

Table 3. Positive and negative characteristics of therapists (as reported by eating disorders clients).

Author, year	Positive (+) or negative (-) characteristics	Therapists' personal characteristics reported by clients	Personal characteristics measure	Treatment outcome
Banasiak *et al.*, 2007	+ + - - -	Empathic Supportive Arrogance Criticism/Judgmental Lack of empathy	*Ad hoc* questionnaire, Evaluation of treatment questionnaire	Therapeutic relationship
Bjork *et al.*, 2009	-	Lack of empathy	Treatment Satisfaction scale	Clients' satisfaction drop-out rates
Clinton, 2001	+	Supportive	Treatment Satisfaction scale	Clients' satisfaction
Clinton *et al.*, 2004	+	Supportive	Treatment Satisfaction scale	Client's satisfaction
Colton & Pistrang, 2004	+ +	Empathic Supportive	Semi-structured interviews	Recovery from EDs
De la Rie *et al.*, 2006	+ + - -	Empathic Supportive Lack of expertise Lack of empathy	Questionnaire for eating disorders	Therapeutic relationship Drop-out rates
De la Rie *et al.*, 2008	+ +	Empathic Supportive	Questionnaire for Eating Disorders	Client's satisfaction

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Table 3. Continued from previous page.

Author, year	Positive (+) or negative (-) characteristics	Therapists' personal characteristics reported by clients	Personal characteristics measure	Treatment outcome
De Vos *et al.*, 2016	+	Supportive	*Ad hoc* questionnaire	Hope on EDs recovery
	+	Expertise in EDs		
	+	Authentic		
	+	Empathic		
Escobar-Koch *et al.*, 2010	+	Supportive	*Ad hoc* questionnaire	Client's satisfaction
	+	Empathic		
	+	Expertise in EDs		
Fox & Diab, 2013	+	Expertise in EDs	Interviews	Trust in EDs therapists
	+	Empathic		Exacerbation of feeling of isolation
	-	Pessimism		
	-	Overwhelmed		
Gowers *et al.*, 2010	+	Expertise in EDs	*Ad hoc* questionnaire	Client's satisfaction
	+	Empathic		
	+	Friendly		
Gulliksen *et al.*, 2012	+	Empathic	Interviews	Client's satisfaction
	+	Expertise in EDs		Therapeutic relationship
	+	Humor		
	-	Lack of empathy		
	-	Prejudiced attitude		
	-	Authoritarianism		
	-	Passivity		
	-	Pampering		
Halvorsen & Heyerdahl, 2007	+	Empathic	Perception of therapist(s)	Improvement in EDs symptoms
	+	Expertise in EDs		
Lose *et al.*, 2014	+	Empathic	Semi-structured interviews	Client's satisfaction
	+	Supportive		
	+	Expertise in EDs		
	-	Lack of empathy		
	-	Lack of expertise		
Ma, 2008	+	Empathic	Interviews	Recovery in EDs
	+	Supportive		
	+	Friendly		
Offord *et al.*, 2006	-	Lack of empathy	Semi-structured interviews	Client's satisfaction
	-	Accusational		
	-	Patronising		
Oyer *et al.*, 2016	+	Emotional self-disclosure (crying)	Semi-structured interviews	Therapeutic relationship
	+	Empathic		
	+	Authentic		
	+	Humor		
	+	Expertise in EDs		
	-	Lack of empathy		
	-	Judgmental/invalidating attitude		
Paulson-Karlsson *et al.*, 2006	+	Empathic	Treatment satisfaction scale	Client's satisfaction
	+	Expertise in EDs		
Poulsen *et al.*,2010	+	Empathic	Client experience interview	Client's satisfaction
	+	Supportive		
	+	Expertise in EDs		
Pettersen & Rosenvinge, 2002	+	Empathic	Interviews	Therapeutic relationship
	+	Supportive		
	+	Availability		
Rance *et al.*, 2017	+	Empathic	Semi-structured interviews	Client's satisfaction
	+	Self-disclosure		Therapeutic relationship
	-	Lack of empathy		
	-	Judgmental attitude		
Reid *et al.*, 2008	+	Empathic	Semi-structured interviews	Client's satisfaction
	+	Supportive		
Rorty *et al.*, 1993	+	Empathic	Semi-structured interviews	Recovery in EDs

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Table 3. Continued from previous page.

Author, year	Positive (+) or negative (-) characteristics	Therapists' personal characteristics reported by clients	Personal characteristics measure	Treatment outcome
Rosenvinge & Kuhlefelt Klusmeier, 2000	+ +	Empathic Expertise in EDs	*Ad hoc* questionnaire	Client's satisfaction
Sheridan & McArdle, 2015	+ + -	Empathic Expertise in EDs Lack of empathy	Semi-structured interviews	Therapeutic relationship
Smith *et al.* 2014	+ + -	Supportive Empathic Judgmental attitude	Semi-structured interviews	Therapeutic relationship Recovery process
Stockford *et al.*, 2018	- -	Judgmental attitude Lack of empathy	Semi-structured interviews	Recovery process (low self-esteem)
Tritt *et al.*, 2015	+ +	Emotional self-disclosure (crying) Self-disclosure (crying)	*Ad hoc* questionnaire	Adherence to treatment Recovery process
Vanderlinden *et al.*, 2007	+ +	Supportive Expertise in EDs	EDs questionnaire	
Wasil *et al.*, 2019	+	Self-disclosure	Semi-structured interviews	Recovery process
Whitney *et al.*, 2008	+ + +	Empathic Supportive Expertise in EDs	Feedback letter	Therapeutic relationship
Wright & Hacking, 2012	+ + + +	Empathic Authentic Maternalism Optimism	Semi-structured schedule	Therapeutic relationship
Zaitsoff *et al.*, 2015	+ +	Empathic Self-disclousure	Interviews	Therapeutic relationship
Zaitsoff *et al.*, 2016	+ +	Empathic Supportive	Semi-structured interviews	Therapeutic relationship Engagement in treatment

EDs, eating disorders.

Supportive attitude

In 17 studies, the supportive attitude of the therapist, *i.e.* the ability to be a helpful source of support and encouragement for the patient, particularly during the most difficult phases of treatment, was seen as a positive characteristic in relation to therapeutic relationship definition (Banasiak *et al*., 2007; De la Rie *et al*., 2006; Pettersen & Rosenvinge, 2002; Smith *et al*., 2016; Whitney *et al*., 2008; Zaitsoff *et al*., 2016) and the contribution to the recovery process from an Eds (Colton & Pistrang, 2004; De Vos *et al*., 2016; Ma, 2008; Vanderlinden *et al*., 2007), and clients' satisfaction (Clinton *et al*., 2001; 2004; De la Rie *et al*., 2008; Escobar-Koch *et al*., 2010; Lose *et al*., 2014; Poulsen *et al*., 2010; Reid *et al*., 2008).

Therapist's expertise in eating disorders

In 13 studies the therapist's expertise in EDs, *i.e.* the ability to convey clinical expertise and knowledge about key issues related to EDs (*e.g.*: nutrition, medical issues), was seen as a positive characteristic in relation to the definition of the therapeutic relationship (Oyer *et al*., 2016; Sheridan & McArdle, 2015; Whitney *et al*., 2008), in contributing to the recovery process from an EDs (De Vos *et al*., 2016; Halvorsen & Heyerdahl, 2007; Vanderlinden *et al*., 2007), clients' satisfaction (Escobar-Koch *et al*., 2010; Gowers *et al*., 2010; Gulliksen *et al*., 2012; Paulson-Karlsson *et al*., 2006; Poulsen *et al*., 2010; Rosenvinge & Klusmeier, 2000) and trust in therapist (Fox & Diab, 2013).

Self-disclosure

In 6 studies, therapists' self-disclosure, defined as the willingness to share some aspects of themselves and their emotional inner experiences with the patient, was seen as a positive characteristic in relation to the therapeutic relationship (Oyer *et al*., 2016, Zaitsoff *et al*., 2015), clients' satisfaction (Lose *et al*., 2014; Rance *et al*., 2017), or in relation to the recovery process from an EDs (Wasil *et al*., 2019) and to higher adherence/engagement to treatment (Tritt *et al*., 2015).

Others positive characteristics

In 3 studies the authenticity of the therapist, which is seen as the ability to respond intuitively to the patient's needs beyond the standard treatment protocols, was positively related to the definition of the therapeutic relationship (Oyer *et al*., 2016; Wright & Hacking, 2012) and to the recovery from an Eds (De Vos *et al*., 2016). In 2 studies the therapist' friendly attitude was considered as a positive characteristic in relation to the recovery process from an EDs (Ma, 2008) and clients' satisfaction (Gowers *et al*., 2010). In only 1 study (Oyer *et al*., 2016) the therapist' sense of humor was considered a positive characteristic in relation to the definition of the therapeutic relationship, and the therapist's vitality (Gulliksen *et al*., 2012) was related to client satisfaction. Finally, the therapist' availability (Pettersen & Rosenvinge, 2002), optimism (Wright & Hacking, 2012), and maternalistic attitudes (Wright & Hacking, 2012, referring to the role of protecting, feeding and nur-

turing) were considered positively associated to the definition of the therapeutic relationship.

Client's point of view: negative characteristics.

Thirteen studies reported the therapists' negative characteristics identified by clients/patients during their EDs treatments (Table 3).

Therapist's lack of warmth and empathic understanding

In 10 studies the therapist's lack of warmth and empathic understanding was considered as an unhelpful and negative characteristic and associated with a poor therapeutic relationship (Banasiak *et al*., 2007; Gulliksen *et al*., 2012; Oyer *et al*., 2016; Rance *et al*., 2017), client's dissatisfaction (Bjork *et al*., 2009; Lose *et al*., 2014; Offord *et al*., 2006), drop-out rates (De la Rie *et al*., 2006; Sheridan & McArdle, 2015) and a worsening in the recovery process (Stockford *et al*., 2018).

Therapist's judgmental attitude

In 6 studies the therapist's judgmental attitude was considered negative and associated to a poor therapeutic relationship (Banasiak *et al*., 2007; Gulliksen *et al*., 2012 Oyer *et al*., 2016; Rance *et al*., 2017), and in a worsening in the recovery process (Smith *et al*., 2016; Stockford *et al*., 2018).

Therapist's lack of expertise

In 2 studies the therapist's lack of expertise was considered as an unhelpful/negative characteristic associated to drop-out rates (De la Rie *et al*., 2006) and client's dissatisfaction (Lose *et al*., 2014) respectively.

Other negative characteristics

The therapist's arrogance, authoritarianism, passivity and pampering were negatively associate to therapeutic relationship definition (Banasiak *et al*., 2007; Gulliksen *et al*., 2012). Therapist's pessimism and overwhelmed tendency were considered as an unhelpful and negative characteristic causing a feeling of isolation in patients (Fox & Diab, 2006). Finally, Offord and colleagues (2006) found that the therapist's accusating and patronising attitudes were considered as unhelpful and negative characteristics associated with client's dissatisfaction.

Therapist's point of view: positive characteristics

Seven studies reported the positive characteristics identified by therapists in their experiences of EDs treatments conduction (Table 4).

Two studies found that the therapist's empathic characteristic and supportive attitude were positively associate to the therapeutic relationship definition and a sense of hope towards recovery (De la Rie *et al*., 2008; De Vos *et al*., 2016).

In two studies the presence of happy and enthusiastic feelings and optimism were considered positive characteristics in relation to client attachment security and treatment fidelity (Daniel *et al*., 2015; Brown *et al*., 2018), whilst the therapist's authenticity was positively associated to a sense of hope towards recovery (De Vos et a., 2016). Finally, therapists reported that their expertise on EDs treatment was considered a positive characteristic in relation to the client's sense of hope towards recovery (De Vos et a., 2016). Therapist's self-disclosure and the capacity to be transparent with the clientswere seen as positive characteristics in relation to the therapeutic relationship (Oyer *et al*., 2016; Wright & Hacking, 2012). Finally, in the study of Warren *et al*., (2013) the therapist's personal history of eating disorders was considered positively associated with increased empathy.

Therapist's perspective: negative characteristics

Only three studies reported the negative characteristics iden-

Table 4. Positive and negative characteristics of therapists (as reported by therapists).

Author, year	Positive (+) or negative (-) characteristics	Therapists' personal characteristics reported by clients	Personal characteristics measure	Treatment outcome
Brown *et al.*, 2014	-	Clinician anxiety	*Ad hoc* questionnaire	Lack of hope in the therapeutic relationship; no improvement in EDs symptoms
Daniel *et al.*, 2015	+ -	Happy/Enthusiastic feelings Negative/unpleasant feelings	Feeling word checklists	Client attachment security Therapeutic relationship
Brown & Perry, 2018	+ +	Self-efficacy Optimism	Personal efficacy beliefs Eating disorder scale Therapeutic optimism eating disorder scale	Treatment fidelity
De la Rie *et al.*, 2008	+ +	Supportive Empathic	*Ad hoc* questionnaire	Therapeutic relationship
De Vos *et al.*, 2016	+ + +	Empathic Authenticity Expertise	*Ad hoc* questionnaire	Hope on recovery
Oyer *et al.*, 2016	+ -	Self-disclosure Lack of objectivity	Semi-structured interviews	Therapeutic relationship
Warren *et al.*, 2013	+	Personal history of eating disorders	*Ad hoc* questionnaire	Increasing empathy
Wright & Hacking, 2012	+	Transparent	Semi-structured schedule	Therapeutic relationship

EDs, eating disorders.

tified by therapists in their experiences of EDs treatments conduction (Table 4). In two of these studies authors reported negative or unpleasant feelings and emotions and the lack of experience in EDs related to the absence of improvement in EDs (Brown *et al*., 2014; Daniel *et al*., 2015). In only one study (Oyer *et al*., 2016) the lack of objectivity was considered a negative characteristic in relation to poor therapeutic relationship.

Discussion

This systematic review is the first to synthesize the existing literature on therapists' personal characteristics and their impact on specific treatment aspects for patients with eating disorders. A total of 38 studies were reviewed, reporting both qualitative and quantitative data on positive and negative views from patients and/or therapists. The studies included in the review take into consideration a wide variety of treatments, including theoretical orientations, settings, clinical practitioners (such as psychologists, psychotherapists, psychiatrists, and clinical staff), and patients' diagnostic criteria (AN, BN, EDNOS, or EDs). The results of the review indicate that therapists' personal characteristics, such as empathic and supportive attitudes, authenticity, tendency to self-disclose, and level of expertise in ED treatment, are considered by both patients and therapists to be positive determinants in the treatment of EDs. These characteristics have an impact on therapy outcome and the quality of the therapeutic relationship. Our findings on empathy, supportive attitude, and authenticity/transparency align with the results of the APA Task Force on Evidence-Based Relationships and Responsiveness, which identified these relational qualities of the therapist as effective factors in the development of the therapeutic relationship and as central components of change (Norcross, 2018). Previous meta-analyses (Elliott *et al*., 2018; Farber *et al*., 2018; Kolden *et al*., 2018) have indicated that therapist attributes, such as empathy, positive regard, and genuineness, are essential prerequisites for successful treatment. Our findings underline their relevance in the treatment of EDs. Some studies have confirmed the importance of therapists' self-disclosure as a positive characteristic that can be important in fostering the therapy relationship and positively influencing the recovery process of individuals with eating disorders (see Patmore, 2020). Our findings seem to be in line with previous research literature, which has emphasized how the therapist's willingness to share some aspects of themselves and their inner experiences with the patient can play a constructive role in fostering the therapeutic relationship, promoting patient disclosure, and alleviating feelings of shame and eating symptoms (Simonds & Spokes, 2017).

Our findings suggest that patients' perceptions of their therapist's expertise in the specific area of EDs may be associated with more positive perceptions of the therapeutic relationship, greater hope for recovery, greater client satisfaction, and greater trust in the therapist. These findings regarding patients' perceptions of treatment credibility are consistent with recent literature which has highlighted its correlation with more positive treatment outcomes (Costantino *et al*., 2019). Therapists should consider patients' perceptions of their own expertise in EDs as a 'non-specific' belief factor that could affect the quality of treatment and explore this aspect in clinical interventions and professional training. Furthermore, patients reported that they perceived the positive attributes of the therapist, such as a friendly attitude, sense of humor, optimism, availability, and caring behavior, as beneficial aspects of therapy. Humor and optimism are often considered beneficial in psychotherapy as they can help to establish a non-defensive clinical relationship, foster a sense of belonging, promote adherence to treatment, and facilitate the implementation of novel intervention strategies to achieve optimal outcomes (Bergmann, 2013; Edward *et al*., 2014).

It is common knowledge that patients with eating disorders may exhibit resistance and non-cooperation, especially during the initial stages of treatment. They may also struggle to accept their condition and may feel pressured into treatment by family members or significant others (Paulson-Karlsson *et al*., 2006). Therefore, it is important to establish a trusting and welcome setting to cultivate an effective therapeutic relationship. Bordin (1979) highlighted the crucial significance of establishing a bond when constructing the therapeutic relationship, a concept that can be understood as 'being with' (Solomon, 1972). Additionally, it is essential to establish the goals and tasks of therapy. When working with people with EDs, the negotiation of these two aspects inevitably involves elements of care and nurturing. From this perspective, the availability and care of the therapist can play an important role in therapy (Wright, 2015). As noted by Clarkson (2003), the therapist takes on a supportive role during the negotiation process, becoming a 'safe other' for the patient with EDs, ensuring a sense of protection and security. This promotes hope in recovery and a way out of eating disorders, similar to how parental care promotes independence (Wright, 2015).

Conversely, therapists also acknowledge that enthusiasm, self-efficacy, and a prior history of EDs can be positive personal characteristics from the patients' view. This aligns with recent studies which aimed to understand how healed individuals can contribute to patient change. There is some evidence that people with previous experiences of EDs can help patients feel understood and improve clinical outcomes and treatment attendance (Albano *et al*., 2021). The literature suggests that enthusiasm and self-efficacy have a positive effect on treatment. Enthusiasm is linked to the clinician's investment in the therapeutic relationship, which strengthens it (Ackerman & Hilsenroth, 2003). Self-efficacy is related to the potential to promote behavioral change in the patient, and to increase the chances of recovery by observing a functional model (Brown & Nicholson Perry, 2018).

Regarding the perception of negative therapist characteristics, our study found that the negative personal qualities reported by patients were arrogance, a judgmental attitude, lack of empathy, lack of expertise, pessimism, prejudice, authoritarianism, passivity, pampering, accusation, and patronizing. The results suggest that the mentioned characteristics could have an adverse effect on the establishment of a genuine therapeutic relationship, which is linked to treatment outcome (Lo Coco *et al*., 2011; Gelso *et al*., 2018) in psychotherapy. Our findings seem in line with previous research on clients' negative experiences during treatment, showing that therapist errors/behaviors are connected with obstructive aspects of the therapy relationship (Vybíral *et al*., 2023). However, the relationship between negative client ratings of therapist qualities and therapy outcomes remains unclear, and further research is needed to establish this potential relationship.

Regarding therapists' perceptions, our findings indicate that clinician anxiety, negative emotions, and a lack of objectivity were identified as adverse factors that could affect patient outcomes. Clinicians often experience emotions such as anxiety, lack of objectivity, or more generally negative feelings, including stress, hostility, and anger when working with individuals with EDs. These difficulties are often linked to the intrinsic characteristics and behaviors of ED patients. While patients with ED may expect a high level of responsiveness from clinicians, especially in the

early stages of treatment, they may not necessarily trust them. This ambivalence may lead to a dichotomy between attention-seeking and devaluing attitudes; for clinicians, this can lead to patients being perceived as manipulative, subversive and obstructive (Palmer, 2000), resulting in frustration and negative emotions (Kaplan & Garfinkel, 1999). Negative feelings experienced by clinicians towards patients with EDs may significantly affect treatment outcomes (Thompson-Brenner *et al*., 2012). Considering these factors, it is crucial for clinicians who work with ED patients to engage in regular supervision and consultation (Warren *et al*., 2009). However, there is a lack of research on the quality, quantity, or nature of supervision activities in ED treatment, especially in addressing clinician emotions.

This systematic review examined the factors that influence the psychotherapeutic relationship in the treatment of eating disorders. The current findings suggest that personal characteristics play a central role in the process of change (Constantino *et al*., 2019; Elliott *et al*., 2018; Delgadillo *et al*., 2020). Finally, a noteworthy finding that requires further investigation is that although most positive characteristics were recognized by both patients and therapists, the negative characteristics varied between the two perspectives. Patients and therapists often differ in their evaluation of treatment effectiveness and the factors they consider significant in therapy (Compare *et al*., 2016; Werbart *et al*., 2022). Furthermore, research indicates that this difference is even more noticeable when treatments are unsuccessful (Gold & Striker, 2011). This difference may explain why, unlike positive traits, there is a greater divergence in the opinions of clinicians and patients regarding which personal characteristic of therapists have a negative impact on treatment. Similarly, the literature on therapists' self-assessment bias (Longley *et al*., 2023) suggested that therapists tend to overestimate their skills in relation to their professional role and that this may be seen as an unconscious attempt to maintain motivation, particularly when working with difficult patients, such as EDs (Walfish *et al*., 2012). Overall, this study supports the findings by Heinonen and Nissen-Lie (2020) which showed that the socio-emotional qualities of the therapist, such as empathy, warmth, and positive regard, contribute to improved treatment outcome. Our results add the importance of addressing these factors in the psychological treatment of patients with EDs.

This review has several strengths. Firstly, it enriches the existing literature on therapists' personal characteristics and their impact on specific aspects of the treatment of patients with eating disorders. Secondly, it brings together two distinct streams of literature on psychotherapy, one focusing on the patient perspective and the other on the therapist perspective. Another strength is the good quality of the included studies, none of which were coded as high risk of bias. However, this review has some significative limitations. Firstly, the limited number of included studies did not allow to draw firm conclusions on the role of therapy characteristics in the treatment of specific disorders such as AN or BN. Secondly, the included studies varied in therapeutic approach and patient characteristics, which may account for the heterogeneity in results. Several eligible studies analyzed therapist characteristics and treatment outcomes using non-standardized or ad hoc questionnaires or analyzed patient narratives. This qualitative approach may raise some concerns about our ability to establish correlations between the therapist characteristics and the outcomes reported in the studies. Moreover, the field is dominated by a lack of consensus on the relevance of therapist characteristics and further studies are needed to explore patients' and clinicians' views of therapist characteristics that can impact on the therapeutic relationship and treatment outcome through an exploratory approach. This qualitative approach may allow the development of more appropriate tools to identify and measure the influence that these characteristics have on the therapeutic process and outcome in the treatment of EDs. Finally, there are very few studies in the literature which have investigated personal characteristics perceived negatively by clinicians. This could potentially affect the generalizability of the results obtained from this review.

The clinical implications of this systematic review are noteworthy. Therapists who work with patients with eating disorders should be aware of the personal factors that can affect both the therapeutic relationship and treatment outcomes. Therapists should prioritize in establishing a warm and bonding therapeutic relationship with their patients. They should also be capable of discussing treatment goals and tasks in an accepting and non-judgmental manner. Additionally, our findings suggest the importance of customizing interventions to the personal and interpersonal characteristics of both members in the therapy dyad. Personalizing interventions by promoting interpersonal factors may be associated with a reduction in a fundamental disease-maintenance factor in ED, *i.e.* interpersonal distress (Brugnera *et al*., 2018; Lo Coco *et al*., 2012). Personalization can also serve as a potential predictor of treatment adherence and the development of a stronger therapeutic relationship. However, there is a lack of evidence regarding which interpersonal characteristics of therapists should be considered when developing patient-tailored interventions for EDs. These results highlight the significance of comprehensive training and ongoing supervision for clinicians working with ED patients. Measures like establishing clearer boundaries, providing emotional management training for therapists, increasing awareness of factors that will contribute to the patient's goals, and implementing mentalizing and metacommunication abilities can aid clinicians in effectively handling negative patient experiences and preventing them from negatively affecting the therapeutic relationship.

Conclusions

The studies included in this systematic review highlight the importance of the therapist's personal qualities as a critical factor in treating patients with eating disorders. This systematic review offers initial evidence on the therapist's personal characteristics which may affect the treatment process. The findings support the importance of socio-emotional characteristics, as highlighted by Heinonen & Nissen-Lie (2020), which are also relevant in the context of ED treatments. However, this review has also revealed a gap in the research on how negative characteristics may affect treatment from the clinician's perspective, as well as the high variability in the methods and research designs used. This indicates a strong need for further research to gain a better understanding of how therapist personal characteristics can impact the therapeutic process and contribute to positive changes in patients during therapy.

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Online supplementary material:

Supplementary Table 1. Quality assessment of included qualitative studies.

Supplementary Table 2. Quality assessment of included cohort studies and mixed methods.