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Therapists' Emotional Reactions to Patients with Obsessive–Compulsive Disorder: The Role of Therapists' Orientation and Perfectionism

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Abstract

Therapist's emotional response towards patients with obsessive–compulsive disorder (OCD) is under-investigated. This aspect might provide valuable information about therapists' difficulties during sessions and support supervisory practice, since a proportion of OCD patients drop out due to issues related to the therapeutic relationship. In a sample of therapists, we explored the effects of therapists' orientation (cognitive behavioural versus psychodynamic) and perfectionistic traits on their emotional responses towards patients with OCD, controlling for other variables potentially related to emotional response towards patients (i.e., therapists' gender/age and patient's comorbid personality disorders). Ninety-four therapists (74 women and 20 men; mean age = 42.07 ± 10.17 years), of which 47 (50%) had a cognitive behavioural therapy (CBT) and 47 (50%) a psychodynamic orientation matched on gender and age, completed the Therapist Response Questionnaire and Frost Multidimensional Perfectionism Scale. Therapists with a CBT orientation reported less negative emotional responses, i.e., lower overwhelmed/disorganized, hostile/angry, criticised/devalued, parental/protective and special/over-involved emotions towards patients than therapists with a psychodynamic orientation. Therapists with higher perfectionistic traits (i.e., parents' expectations/evaluation) had higher hostile/angry reactions, those with higher concerns over mistakes and doubts about actions had more intense criticised/devalued emotions, while those with stronger concerns with precision, order and organization had lower disengagement responses. The present study is the first investigation which sheds some light on the emotional responses of therapists towards OCD patients. Therapists' CBT orientation and lower perfectionistic traits might be associated with better emotions. Therapists' emotional responses, their psychotherapeutic orientation and levels of perfectionism should be considered during supervisory practice.

Keywords Obsessive–compulsive disorder · Psychotherapy · Perfectionism · Therapist · Therapeutic relationship

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Introduction

Therapists' Emotions Towards Patients: A Key Ingredient of the Therapeutic Relationship

In a therapeutic relationship, the feelings and attitudes that therapists and clients have toward one another and how these are expressed can predict positive outcomes across a range of conditions and theoretical orientations (Fluckiger et al., 2012, 2018; Horvath et al., 2011; Norcross, 2010). This factor can be measured from three distinct perspectives: that of the rater, patient and therapist (Horvath 2000). Therapists' emotions towards patients can be used as a source of valuable information about a patient's intrapsychic and interpersonal functioning for diagnostic and therapeutic purposes (Hayes, 2004). This clinical material can also be analysed during supervisory practice as such reactions may concern the therapist's interpersonal/intrapsychic world (Norcross 2005). According to the contextual model (Wampold and Imel 2015), there are three pathways through which a therapeutic relationship works: (a) a genuine relationship, (b) the creation of expectations through the explanation of symptoms and treatment, and (c) the enactment of health promoting behaviours.

While the therapeutic relationship has been widely studied from the patient's perspective, during the last decade researchers have progressively drawn their attention to therapists' emotional reactions to patients. Betan et al. (2005) reviewed the clinical, theoretical, and empirical literature on therapists' emotions towards patients and explored the feelings self-reported by a large sample of therapists through a practice network approach. Based on factor analyses, the authors identified eight emotional patterns (for a detailed overview of their model see Table 1). The researchers focused on emotions towards patients with personality disorders aggregated at DSM cluster level (Betan et al., 2005). Cluster A was related to criticized feelings, cluster B was associated with overwhelmed, helpless, hostile, and disengaged feelings and sexual attraction, and cluster C was associated with protective feelings (Betan et al.,

Table 1 Classification of therapist's emotional responses to patient (Betan et al., 2005)

Overwhelmed/Disorganized	A desire to avoid or flee the patient and strong negative feelings, including dread, repulsion, and resentment
Helpless/Inadequate	Feelings of inadequacy, incompetence, hopelessness, and anxiety
Positive/Satisfactory	Experience of a positive working alliance and close connection with the patient
Special/Over-involved	A sense of the patient as special relative to other patients and includes "soft signs" of problems in maintaining boundaries, including self-disclosure, ending sessions on time, and feeling guilty, responsible, or overly concerned about the patient
Sexualized	Sexual feelings toward the patient or experiences of sexual tension
Disengaged	Feeling distracted, withdrawn, annoyed, or bored in sessions
Parental/Protective	Wish to protect and nurture the patient in a parental way, above and beyond normal positive feelings toward the patient
Criticised/Devalued	Being unappreciated, dismissed, or devalued by the patient

2005). This approach led to the development of the Therapist Response Questionnaire (TRQ; Betan et al., 2005), a therapist self-report tool aimed to assess emotional response to a specific patient.

By asking large samples of therapists to express their emotions towards one of their patients currently in treatment for a personality disorder, other authors provided further empirical support for the model of Betan et al. (2005) and through confirmatory factor analyses, they demonstrated the discriminant validity of these emotional patterns, showing that some of them were common and others specific to personality disorders (Gazzillo et al., 2015; Tanzilli et al. 2016). However, little is known about therapists' self-reported reactions to patients with conditions other than personality disorders.

The Therapeutic Relationship: A Neglected Dimension in Psychotherapy for OCD

Obsessive–compulsive disorder (OCD) is a disabling condition which affects up 2–3% of the general population (Coluccia et al., 2015; Pozza et al., 2016b, 2020, 2021; Ruscio et al., 2010). It is characterized by intrusive thoughts, mental images, or impulses (i.e., obsessions) and repetitive behaviours (i.e., compulsions) performed to neutralise distress related to obsessions (American Psychiatric Association, 2013; Cervin et al., 2020; Pozza et al., 2017). Cognitive behavioural therapy (CBT) is the first-line psychological treatment recommended in practice guidelines (NICE, 2013; Pozza & Dèttore, 2017). The CBT model assumes that symptoms are reinforced at long-term by the temporary relief provided by compulsions and dysfunctional cognitive styles (e.g., perfectionism and uncertainty intolerance) (Clark, 2003; Obsessive Compulsive Cognitions Working Group, 2005). CBT case formulation assumes that psychotherapy works by exposing the patient to doubts and related distress, helping him/her to accept uncertainty and learn a new thinking style (Clark, 2003). However, among patients completing a standard CBT course, only 40–50% achieve remission while the others show only partial improvement or even non-response (e.g., Farris et al., 2013; Fisher & Wells, 2005; Öst et al., 2015). According to a meta-analysis, 15–30% of the those starting CBT drop out (Ong et al., 2016). CBT components, i.e. exposure with response prevention (ERP) and cognitive restructuring, have comparable effects when either is used as monotherapy (e.g., Olatunji et al., 2013). Trials comparing CBT with other therapies, such as third-wave approaches, failed to demonstrate the superiority of one treatment over another (e.g., Marsden et al., 2018; Twohig et al., 2018).

Recently, other theoretical orientations, including psychodynamic therapy, have received some attention in this field and manualized protocols have been developed and empirically assessed in preliminary research (Chlebowski and Gregory, 2009; King, 2017; Reichsenring and Steinert, 2016, 2017). However, further evidence about the efficacy of psychodynamic therapy is still needed.

In an attempt to better understand the processes involved in psychotherapy for OCD, some authors (Maher et al., 2012; Simpson et al., 2011; Strauss et al. 2018; Vogel et al., 2006; Wheaton et al., 2016) studied common factors such as the therapeutic alliance as it is perceived by the patient (Bordin, 1979). The assessment of

the emotions experienced by the therapist during treatment of patients with OCD might shed some light on the therapeutic relationship and therefore might improve the existing treatment protocols by orienting supervisory practice.

The Therapeutic Relationship and Therapists' Perfectionism

Recent evidence suggests that therapists' perfectionism, i.e. excessively high standards, is associated with clients' retention in treatment and efficacy (Presley et al., 2017). Perfectionism is common among clinical psychologists and is negatively related to both tolerance of ambiguity and satisfaction in conducting psychotherapy (Wittenberg & Norcross, 2001).

Theoretical models and empirical data by factor analyses indicate that perfectionism is a multidimensional construct including Perfectionistic Strivings and Evaluative Concerns (Flett & Hewitt, 2002; Frost et al., 1990). Perfectionistic strivings refer to those facets of perfectionism that relate to perfectionistic personal standards and a self-oriented striving for perfection. They include self-oriented perfectionism (i.e. demanding perfection of oneself) and personal standards (i.e. setting unreasonably high personal standards and goals) (Frost et al., 1990; Hewitt & Flett, 1991). This dimension was found to be related to both negative and positive processes (i.e. adaptive coping) and outcomes (i.e. psychological adjustment) (e.g., Stoeber & Otto, 2006). Conversely, perfectionistic concerns were found to be related to negative outcomes as well as socially prescribed perfectionism (i.e. perceiving others as demanding perfection of oneself), concern over mistakes (i.e. adverse reactions to failures), doubts about actions (i.e. doubts about performance abilities), and self-criticism (the tendency to assume blame and feel self-critical towards the self) (Frost et al., 1990; Hewitt & Flett, 1991).

Rationale and Hypotheses of the Study

While the therapeutic relationship has been investigated according to OCD patients' perceptions, there is no study on the therapist's perspective. This unexplored aspect may provide important information about therapists' difficulties during sessions and OCD patients' interpersonal functioning. This may support supervisory practice and future improvement of psychotherapeutic intervention given the relatively high rates of drop-out. Therapists who are aware of their emotions towards patients may manage the therapeutic relationship more effectively. In addition, knowledge of therapists' characteristics related to negative emotions may suggest matching therapists to patients in the most effective way.

The advancement in the development of different theoretical approaches to psychotherapy for OCD (i.e. psychodynamic approaches) suggests the importance of assessing whether the therapeutic relationship is perceived differently by therapists with different theoretical orientations. In the CBT literature, the emphasis has been traditionally on implementing empirically supported interventions, whilst the importance of therapists reflecting upon their own emotional

reactions and/or traits has featured little until recently (Haarhoff, 2006). Indeed, the focus of CBT interventions is traditionally directed at reducing symptoms and it is based upon therapeutic techniques which work by directing targeting symptoms instead of using the therapeutic relationship (including the emotional reactions experienced by the therapists towards the patients) (Pozza & Dèttore, 2020). At the opposite end, the psychodynamic approach emphasizes not only that the psychotherapist's emotional reaction is an inescapable aspect of every psychotherapy session, but also that these reactions should be used to help the patient and promote change (Jones & Pulos, 1993).

Hypothesis A Therapists' orientation (CBT versus psychodynamic) might be associated with different emotions towards patients. According to the contextual model (Wampold 2015), one of the ingredients of a good therapeutic relationship is the creation of expectations through explanation of disorder and treatment. Currently, CBT is the most effective approach for OCD, and CBT case formulation shared by the therapist and patient through a collaborative approach may help therapists manage the relationship better (Clark, 2003). Therapists with CBT skills may have a comprehensive understanding of the vicious cycles maintaining symptoms and can more effectively manage patient behaviours interfering with the therapeutic relationship (i.e. reassurance seeking). CBT formulation and skills may allow therapists to be aware of behaviours which can negatively impact the relationship. Considering all these points, we compared therapists' emotional reactions to OCD patients across two theoretical orientations, hypothesizing that CBT orientation is related to less negative emotional reactions than the psychodynamic one.

Hypothesis B Previous evidence shows that therapist perfectionism is associated with a negative therapeutic relationship. Higher therapist perfectionism, including high standards and expectations, might create high expectations in the therapist regarding patient improvement/progress. Perfectionism and intolerance of uncertainty are a vulnerability/maintenance factor of OCD (Egan et al. 2011; Gentes and Ruscio, 2011; Pozza et al. 2019). During sessions, patient's perfectionism may entrap a therapist with high perfectionism. Considering all these points, we hypothesized that high therapist's perfectionism dimensions may be related to negative emotions towards patients regardless of theoretical orientation.

Role of Therapists' Socio-Demographics and Patients' Comorbid Personality Disorders

We checked for other variables potentially related to emotional response, including the therapist's gender and age and the patient's comorbid personality disorders. Since there is no univocal evidence suggesting the role of such variables in the emotional reactions of therapists towards patients with OCD, we had no specific hypotheses regarding their role.

Method

Participants and Procedure

A sample of therapists identified through the Italian regional rosters of licensed psychotherapists and public or private mental health centres was recruited through e-mail messages providing a detailed overview of the study's rationale, aims and instruments. Therapists were included if they were licensed psychotherapists with CBT or psychodynamic training and orientation and if they provided written informed consent to participate. Therapists were directed to select a patient among their list of patients currently in treatment. To minimize selection biases, therapists were asked to check their calendars to identify the last patient they had met during the previous week who met the study criteria. Each therapist provided data about only one patient. Patient had to meet the following criteria: (1) primary current diagnosis of OCD, (2) aged at least 16, (3) currently in CBT or psychodynamic therapy for OCD after at least five individual sessions, (4) absence of lifetime psychosis/bipolar disorders, (5) absence of alcohol/substance/drug addiction, (6) absence of current suicidal ideation, (7) absence of neurological disorders, (8) absence of mental retardation. Psychotherapeutic treatment had to consist of weekly individual outpatient sessions according to a CBT or psychodynamic manual. Comorbid personality disorders or other psychological conditions and concurrent psychopharmacotherapy were not considered exclusion criteria since comorbid personality disorders are quite common in this clinical population (e.g., Dèttore & Pozza, 2014) and concurrent psychopharmacological treatment is relatively frequent in clinical practice for OCD patients (Brakoulias et al., 2016).

Participation was voluntary and uncompensated. The study was approved by the Institutional Ethics Committee. The study used a cross-sectional design where each therapist completed the measures at only one time-point. Two groups were created: CBT therapists and psychodynamic therapists were included according to a matching design where each CBT therapist was matched by age and gender to a psychodynamic therapist.

Measures

Therapists completed the following self-report questionnaires. To minimize their recognizing the questionnaires, the acronyms of the measures were omitted.

Therapists' Emotional Response to Patients

The Therapist Response Questionnaire (TRQ; Betan et al., 2005) is a clinician report of 79 items that assess a wide spectrum of thoughts, feelings, and behaviours expressed by the therapist toward one specific patient (e.g. "I feel bored in sessions with him/her"). Items are written in a straightforward manner, without jargon and near to clinical experience, so that the instrument can be used comparably by

therapists of any orientation. Therapists assess each item on a 5-point Likert scale ("Not true" = 1, "Very true" = 5). The factor structure consists of eight emotional dimensions: (1) Overwhelmed/Disorganized refers to a desire to avoid or flee the patient and strong negative feelings, including dread, repulsion, and resentment; (b) Helpless/Inadequate indicates feelings of inadequacy, incompetence, hopelessness, and anxiety; (c) Positive/Satisfactory covers the experience of a positive working alliance and close connection with the patient; (d) Special/Overinvolved describes a sense of the patient as special, relative to other patients, and includes 'soft signs' of problems in maintaining boundaries, including self-disclosure, ending sessions on time, and feeling guilty about, responsible for, or overly concerned about the patient; (e) Sexualized includes sexual feelings toward the patient or experiences of sexual tension; (f) Disengaged describes feeling distracted, withdrawn, annoyed, or bored in sessions; (g) Parental/Protective is characterized by a wish to protect and nurture the patient in a parental way, above and beyond normal positive feelings toward the patient; (h) Criticized/Mistreated describes feelings of being unappreciated, dismissed, or devalued by the patient. Scores on each of the subscales are yielded by computing the average score of the items that make up each emotional reaction. The Italian version (Tanzilli et al. 2016) showed acceptable to good internal consistency values across the subscales.

Therapists' Perfectionism

The Frost Multidimensional Perfectionism Scale (MPS; Frost et al., 1990) is a 35-item questionnaire which includes four subscales: Concern over Mistakes and Doubts about Actions (i.e. negative reactions to mistakes, perception of even minor errors as failure, and repeatedly doubting the quality of one's performance), Concern with Precision, Order and Organization (i.e. usually not referring to pathological functioning, the tendency to organize behaviour and be neat), Excessively High Personal Standards (i.e. the tendency to set excessively high standards), Parents' Expectations and Evaluation (i.e. perceiving one's parents as having high expectations or being excessively critical). The questionnaire showed good reliability (Frost et al., 1990). The Italian version (Lombardo, 2008) showed acceptable to good internal consistency values across the subscales.

Statistical Analysis

Between-group comparisons were performed through one-way ANOVAs or non-parametric tests to explore differences in emotional responses, perfectionism and demographic features between CBT and psychodynamic therapists. Pearson's bivariate correlation coefficients were calculated separately for the two therapist groups. Values were interpreted according to the following criteria (Cohen et al., 1998): $0 < r < |.30|$ = weak; $|.30| < r < |.50|$ = moderate; $|.50| < r < |.70|$ = strong; $|.70| < r < |1|$ = very strong. A series of generalised linear models (GLMs) was calculated with maximum likelihood estimation by entering main effects of therapist characteristics (theoretical orientation, perfectionism, gender and age) and patient characteristics (presence of a comorbid personality disorder) and therapists'

emotional responses to patients as outcomes. The statistical significance was set at $p < 0.05$ with a Bonferroni correction for multiple hypotheses. The statistical analyses were conducted using SPSS software, version 21.00.

Results

Sample's Characteristics

Ninety-four therapists were included (74 women and 20 men; overall mean age = 42.07 ± 10.17 years). Of these, 47 therapists (50%) had a CBT and 47 (50%) a psychodynamic orientation (Table 2).

Table 2 Descriptive characteristics of the total sample of therapists ($n = 94$)

Therapists' characteristics	*n* (%)	Mean (*SD*)
Gender		
Female	74 (78.70)	
Male	20 (21.30)	
Age (years)		42.07 (10.17)
Marital status		
Single	44 (46.80)	
Cohabitant/married	44 (46.80)	
Separated/divorced	4 (4.30)	
Psychotherapeutic orientation		
CBT	47 (50)	
Psychodynamic therapy	47 (50)	
Patients' demographic and clinical characteristics	***n* (%)**	**Mean (*SD*)**
Gender		
Female	41 (43.60)	
Male	53 (56.40)	
Age		34.67 (11.19)
Presence of a comorbid personality disorder		
No	79 (84)	
Yes	15 (16)	
Presence of a comorbid Axis disorder		
No	77 (81.90)	
Yes	17 (18.10)	

Table 3 Pearson's bivariate correlations for the whole sample of therapists ($n = 94$)

	2	3	4	5	6	7	8	9	10	11	12	13
1.MPS Concern over Mistakes and Doubts about Actions	.084	.489**	.429**	.217*	.284**	.070	.295**	.323**	.248*	.267**	.093	.174
2. MPS Concern with Precision, Order and Organization		.327**	.144	−.161	−.117	.049	−.067	−.117	−.183	−.148	−.087	−.192
3. MPS Excessively High Personal Standards			.436**	.045	.027	.119	.128	−.054	.161	.207*	−.142	−.020
4. MPS Excessive Concern with Parents' Expectations and Evaluation				.148	.124	−.005	.211*	.124	.188	.112	−.056	.063
5.TRQ Helpless/Inadequate					.670**	−.236*	.553**	.665**	.378**	.220*	.169	.623**
6.TRQ Overwhelmed/Disorganised						.079	.617**	.631**	.615**	.581**	.299**	.369**
7.TRQ Positive/Satisfactory							−.166	−.138	.248*	.572**	.079	−.243*
8.TRQ Hostile/Angry								.617**	.441**	.279**	.280**	.496**
9.TRQ Criticised/Devalued									.406**	.249*	.367**	.406**
10.TRQ Special/Over-involved										.612**	.343**	.204*
11.TRQ Parental/Protective											.240*	−.016
12.TRQ Sexualised												.093
13.TRQ Disengaged												1

MPS, Multidimensional Perfectionism Scale; TRQ, Therapist Response Questionnaire. *$p < 0.05$, ** $p < 0.001$

Bivariate Associations Between Therapists' Perfectionism and Emotional Responses in the Whole Sample

Correlation coefficients are shown separately for the whole sample of therapists in Table 3.

Concern over Mistakes and Doubts about Actions correlated positively and weakly to moderately with all the emotional reactions except for positive/satisfactory, sexualized, and disengaged feelings. 2. MPS Concern with Precision. Order and Organization did not have significant correlations with any of the feelings. Excessively High Personal Standards correlated positively and weakly only with parental protective feelings. Excessive Concern with Parents' Expectations and Evaluation correlated positively and weakly only with hostile and angry feelings.

Bivariate Associations Between Therapists' Perfectionism and Emotional Responses in the Separate Groups

Correlation coefficients are displayed separately for the two therapist groups in Table 4.

Therapists' and patients' age and number of sessions were not related to any emotional responses and perfectionism dimensions in the CBT group. In the psychodynamic group, these variables were not related to emotional responses and perfectionism, but the number of sessions was positively and moderately related to hostile/angry responses (more sessions were associated with more hostile/angry responses).

In the CBT group, concern over mistakes and doubts about actions correlated positively and moderately with hostile/angry and criticised/devalued, while in the psychodynamic group this perfectionism dimension was associated positively and moderately with hostile/angry, overwhelmed/disorganised and special/over-involved feelings.

In the CBT group, concern with precision, order and organization was not related to any emotional responses while, interestingly, in the psychodynamic group, it correlated negatively with parental/protective and disengaged feelings.

In the CBT group, excessively high personal standards and excessive concern with parents' expectations were positively and moderately associated respectively with parental/protective and hostile/angry emotions. In the psychodynamic group, these two perfectionism dimensions were not related to any emotional responses.

Comparisons Between Therapist Groups on Emotional Responses

CBT therapists reported significantly lower overwhelmed/disorganized, hostile/angry and criticised/devalued emotional responses towards their OCD patients than psychodynamic therapists. No significant differences emerged between the two groups regarding the other emotional responses measured by the TRQ. The results of the comparison are presented in Table 5.

Table 4 Pearson's bivariate correlations for CBT (above the diagonal) and psychodynamic group (under the diagonal)

	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Therapist's age (years)	.273	.391**	−.052	−.058	−.041	.101	.126	−.148	−.047	.056	.146	.038	−.188	−.041	−.031
2. Number of sessions	1	.205	−.003	.126	−.012	−.031	−.058	.108	.106	.037	.098	.019	.185	.213	−.031
3. Patient's age (years)	.019	1	.000	−.191	−.209	−.070	−.048	−.230	−.213	−.104	.065	−.030	−.173	.083	−.141
4. MPS Concern over Mistakes and Doubts about Actions	−.061	.098	1	.166	.548**	.431**	.280	.349*	−.027	.355*	.450**	.175	.283	−.094	.114
5. MPS Concern with Precision. Order and Organization	−.081	.155	−.043	1	.348*	.089	−.141	.106	.298	.067	−.174	−.103	.146	−.080	−.252
6. MPS Excessively High Personal Standards	.123	.017	.433**	.232	1	.477**	.233	.214	.160	.288	.100	.255	.344*	−.156	.038
7. MPS Excessive Concern with Parents' Expectations and Evaluation	−.105	.146	.522**	.126	.496**	1	.250	.192	−.125	.390**	.268	.227	.186	−.128	.081
8. TRQ Helpless/Inadequate	.123	.191	.242	−.153	−.033	−.035	1	.575**	−.336*	.493**	.696**	.303*	.135	−.033	.649**
9. TRQ Overwhelmed/Disorganised	.116	.201	.288*	−.242	−.059	.074	.742**	1	.041	.517**	.570**	.414**	.534**	.055	.337*
10. TRQ Positive/Satisfactory	.056	−.085	.093	−.146	.080	.197	−.061	.219	1	−.359*	−.204	.094	.479**	.012	−.40**
11. TRQ Hostile/Angry	.409**	.274	.336*	−.096	.094	.136	.631**	.652**	.133	1	.514**	.274	.083	.022	.588**
12. TRQ Criticised/Devalued	−.005	.148	.258	.012	−.132	.028	.637**	.615**	−.052	.695**	1	.368*	.205	.120	.379*
13. TRQ Special/Over-involved	.210	−.034	.377**	−.189	.173	.268	.415**	.730**	.497**	.522**	.381**	.705**	.491**	.142	.148
14. TRQ Parental/Protective	.182	−.098	.260	−.298*	.141	.134	.304*	.616**	.699**	.397**	.221	.462**	1	−.032	−.060
15. TRQ Sexualised	−.057	−.226	.231	−.073	−.163	−.035	.353*	.415**	.172	.461**	.508**	.276	.408**	1	−.029
16. TRQ Disengaged	.035	.150	.279	−.309*	−.043	−.092	.639**	.436**	−.096	.558**	.479**	.705**	.088	.153	1

CBT, Cognitive Behavioural Therapy; CI, Confidence Interval; MPS, Multidimensional Perfectionism Scale; TRQ, Therapist Response Questionnaire. *$p < 0.05$, **$p < 0.001$

Table 5 Comparisons between CBT ($n=47$) and psychodynamic therapists ($n=47$)

Perfectionism (MPS scales)	Therapist's orientation	Mean	*SD*	95% CI		$F_{(1.93)}$	*p*-value
				Lower	Upper		
Concern over Mistakes and Doubts about Actions	CBT	31.89	10.793	28.72	35.06	0.490	0.486
	Psychodynamic	30.53	7.843	28.23	32.83		
Concern with Precision. Order and Organization	CBT	22.45	4.889	21.01	23.88	3.746	0.056
	Psychodynamic	20.57	4.481	19.26	21.89		
Excessively High Personal Standards	CBT	22.26	5.507	20.64	23.87	2.045	0.156
	Psychodynamic	20.85	3.873	19.71	21.99		
Excessive Concern with Parents' Expectations and Evaluation	CBT	17.87	7.444	15.69	20.06	0.037	0.847
	Psychodynamic	17.60	6.364	15.73	19.46		
Emotional response to the patient (TRQ scales)	Therapist's orientation	Mean	*SD*	95% CI		$F_{(1.93)}$	*p*-value
				Lower	Upper		
Helpless/Inadequate	CBT	16.02	6.825	14.02	18.03	5.254	0.024
	Psychodynamic	19.09	6.114	17.29	20.88		
Overwhelmed/Disorganised	CBT	16.91	5.633	15.26	18.57	6.927	0.010
	Psychodynamic	20.45	7.274	18.31	22.58		
Positive/Satisfactory	CBT	22.70	6.175	20.89	24.52	1.883	0.173
	Psychodynamic	21.00	5.846	19.28	22.72		
Hostile/Angry	CBT	11.05	4.799	9.65	12.46	7.980	0.006
	Psychodynamic	14.23	5.984	12.45	16.01		
Criticised/Devalued	CBT	9.51	3.296	8.54	10.48	8.617	0.004
	Psychodynamic	11.77	4.108	10.56	12.97		
Special/Over-involved	CBT	8.74	2.907	7.89	9.59	1.754	0.189
	Psychodynamic	9.60	3.375	8.60	10.61		

Table 5 (continued)

Emotional response to the patient (TRQ scales)	Therapist's orientation	Mean	*SD*	95% CI		$F_{(1, 93)}$	*p*-value
				Lower	Upper		
Parental/Protective	CBT	12.15	3.816	11.03	13.27	1.743	0.190
	Psychodynamic	13.30	4.587	11.95	14.64		
Sexualised	CBT	4.69	1.078	4.38	5.01	0.596	0.442
	Psychodynamic	4.90	1.503	4.46	5.35		
Disengaged	CBT	9.23	3.919	8.08	10.38	0.031	0.860
	Psychodynamic	9.38	4.240	8.14	10.63		

CBT, Cognitive Behavioural Therapy; CI, Confidence Interval; MPS, Multidimensional Perfectionism Scale; TRQ, Therapist Response Questionnaire

Table 6 Comparison between CBT and psychodynamic therapists on demographics, session number and patients' characteristics ($n = 94$)

Therapist'/patient's characteristics	Therapist's orientation	Mean	*SD*	95% CI		$F_{(1, 93)}$	*p*-value
				Lower	Upper		
Age of the therapist (years)	CBT	42.62	10.584	39.51	45.72	0.265	0.608
	Psychodynamic	41.53	9.835	38.64	44.42		
Number of sessions with the patient	CBT	69.25	127.311	30.54	107.96	0.108	0.743
	Psychodynamic	76.88	82.002	51.33	102.43		
Age of the patient (years)	CBT	33.24	11.729	29.76	36.72	1.530	0.219
	Psychodynamic	36.13	10.546	32.97	39.30		

		CBT (*n*)	Psychodynamic (*n*)	Total	$\chi^2_{(1)}$	*p*-value
Therapist's gender	Male	10	10	20	0	1.000
	Female	37	37	74		
Patient's gender	Male	29	24	53	1.081	0.298
	Female	18	23	41		
Patient with a comorbid personality disorder	No	40	39	79	0.079	0.778
	Yes	7	8	15		

CBT, Cognitive Behavioural Therapy

Comparison Between Theoretical Orientation and Therapists' Demographics and Patients' Characteristics

The therapists' groups were matched by age and gender and were not significantly different regarding therapists' and patients' demographic characteristics. The comparisons between CBT and psychodynamic therapists are shown in Table 6.

Multivariate Effects of Therapists' Orientation and Perfectionism on Emotions Towards Patients

The results of the GLMs are presented in Table 7. With regard to therapist's variables, theoretical orientation, perfectionism and gender had specific effects on specific emotional reactions to patients. CBT orientation was associated with lower overwhelmed/disorganized, hostile/angry, criticised/devalued, parental/protective and special/over-involved emotional responses to patients.

Specific therapist perfectionistic traits were associated with some of the emotional reactions. In particular, higher parents' expectations and evaluation correlated with higher hostile/angry reactions. Higher concerns over mistakes and doubts about actions were associated with more intense criticised/devalued emotions. Stronger concerns with precision, order and organization were related to lower disengagement responses.

Table 7 General linear models: effects of therapist and patient characteristics on therapists' emotions towards patients ($n = 94$)

Outcome: TRQ Helpless/Inadequate	95% CI				
	β	Lower	Upper	Wald's $\chi^2_{(1)}$	p-value
Intercept	16.185	6.559	25.812	10.860	.001
Therapist's male gender	1.760	−.757	4.276	1.878	.171
Therapist's female gender	0[a]				
Therapist's age (years)	−.002	−.126	.121	.001	.971
CBT orientation	−3.118	−5.642	−.595	5.867	.015
Psychodynamic orientation	0[a]				
Absence of a comorbid personality disorder	−3.121	−6.511	.270	3.254	.071
Presence of a comorbid personality disorder	0[a]				
MPS Concern over Mistakes and Doubts about Actions	.078	−.091	.247	.821	.365
MPS Concern with Precision. Order and Organization	−.217	−.500	.066	2.264	.132
MPS Excessively High Personal Standards	.175	−.154	.503	1.087	.297
MPS Parents' Expectations and Evaluation	.079	−.137	.295	.516	.473
Patients' age (years)	.040	−.074	.155	.476	.490
Outcome: TRQ Overwhelmed/Disorganized	95% CI				
	β	Lower	Upper	Wald's $\chi^2_{(1)}$	p-value
Intercept	18.516	8.846	28.187	14.083	.000
Therapists' male gender	1.781	−.747	4.309	1.907	.167
Therapists' female gender	0[a]				
Therapists' age (years)	−.070	−.194	.054	1.238	.266
CBT orientation	−3.856	−6.392	−1.321	8.890	.003
Psychodynamic orientation	0[a]				
Absence of a comorbid personality disorder	−1.278	−4.684	2.129	.540	.462
Presence of a comorbid personality disorder	0[a]				
MPS Concern over Mistakes and Doubts about Actions	.147	−.023	.317	2.890	.089
MPS Concern with Precision. Order and Organization	−.055	−.339	.229	.145	.704
MPS Excessively High Personal Standards	−.022	−.352	.308	.017	.897
MPS Parents' Expectations and Evaluation	.091	−.125	.308	.685	.408
Patients' age (years)	.017	−.099	.132	.081	.776
Outcome: TRQ Positive/Satisfactory	95% CI				
	β	Lower	Upper	Wald's $\chi^2_{(1)}$	p-value
Intercept	13.551	4.370	22.732	8.368	.004
Therapists' male gender	1.224	−1.176	3.625	.999	.317
Therapists' female gender	0[a]				
Therapists' age (years)	.027	−.090	.145	.210	.647
CBT orientation	.558	−1.849	2.964	.206	.650

Table 7 (continued)

Outcome: TRQ Positive/Satisfactory	95% CI				
	β	Lower	Upper	Wald's $\chi^2_{(1)}$	*p*-value
Psychodynamic orientation	0[a]				
Absence of a comorbid personality disorder	2.352	−.882	5.586	2.033	.154
Presence of a comorbid personality disorder	0[a]				
MPS Concern over Mistakes and Doubts about Actions	−.023	−.184	.138	.078	.779
MPS Concern with Precision. Order and Organization	.133	−.136	.403	.937	.333
MPS Excessively High Personal Standards	.182	−.132	.495	1.288	.256
MPS Parents' Expectations and Evaluation	.035	−.170	.241	.114	.736
Patients' age (years)	−.039	−.149	.070	.493	.483
Outcome: Hostile/Angry	95% CI				
	β	Lower	Upper	Wald's $\chi^2_{(1)}$	*p*-value
Intercept	4.688	−3.081	12.457	1.399	.237
Therapists' male gender	1.790	−.247	3.826	2.966	.085
Therapists' female gender	0[a]				
Therapists' age (years)	−.001	−.100	.099	.000	.990
CBT orientation	−3.243	−5.289	−1.198	9.655	.002
Psychodynamic orientation	0[a]				
Absence of a comorbid personality disorder	−.445	−3.187	2.297	.101	.751
Presence of a comorbid personality disorder	0[a]				
MPS Concern over Mistakes and Doubts about Actions	.064	−.072	.200	.846	.358
MPS Concern with Precision. Order and Organization	−.035	−.265	.194	.091	.763
MPS Excessively High Personal Standards	.101	−.165	.367	.550	.458
MPS Parents' Expectations and Evaluation	.189	.013	.365	4.419	.036
Patients' age (years)	.061	−.032	.155	1.643	.200
Outcome: TRQ Criticised/Devalued	95% CI				
	β	Lower	Upper	Wald's $\chi^2_{(1)}$	*p*-value
Intercept	8.112	3.199	13.026	10.473	.001
Therapists' male gender	1.517	.232	2.801	5.358	.021
Therapists' female gender	0[a]				
Therapists' age (years)	.043	−.019	.106	1.833	.176
CBT orientation	−1.833	−3.121	−.545	7.782	.005
Psychodynamic orientation	0[a]				
Absence of a comorbid personality disorder	−1.404	−3.135	.326	2.530	.112
Presence of a comorbid personality disorder	0[a]				
MPS Concern over Mistakes and Doubts about Actions	.116	.029	.202	6.902	.009

Table 7 (continued)

Outcome: TRQ Criticised/Devalued	95% CI				
	β	Lower	Upper	Wald's $\chi^2_{(1)}$	p-value
MPS Concern with Precision. Order and Organization	−.057	−.201	.087	.603	.437
MPS Excessively High Personal Standards	−.124	−.292	.044	2.094	.148
MPS Parents' Expectations and Evaluation	.092	−.018	.202	2.674	.102
Patients' age (years)	.008	−.051	.066	.065	.799
Outcome: TRQ Special/Over-Involved	95% CI				
	β	Lower	Upper	Wald's $\chi^2_{(1)}$	p-value
Intercept	5.406	.798	10.015	5.288	.021
Therapists' male gender	.664	−.545	1.872	1.159	.282
Therapists' female gender	0[a]				
Therapists' age (years)	.001	−.058	.060	.002	.969
CBT orientation	−1.226	−2.439	−.012	3.919	.048
Psychodynamic orientation	0[a]				
Absence of a comorbid personality disorder	1.655	.029	3.282	3.980	.046
Presence of a comorbid personality disorder	0[a]				
MPS Concern over Mistakes and Doubts about Actions	.012	−.069	.093	.085	.770
MPS Concern with Precision. Order and Organization	−.131	−.268	.005	3.571	.059
MPS Excessively High Personal Standards	.140	−.018	.298	3.029	.082
MPS Parents' Expectations and Evaluation	.099	−.005	.204	3.479	.062
Patients' age (years)	.005	−.051	.060	.026	.871
Outcome: TRQ Parental/Protective	95% CI				
	β	Lower	Upper	Wald's $\chi^2_{(1)}$	p-value
Intercept	9.323	2.977	15.669	8.292	.004
Therapists' male gender	.797	−.862	2.456	.886	.347
Therapists' female gender	0[a]				
Therapists' age (years)	−.023	−.104	.058	.307	.580
CBT orientation	−1.737	−3.400	−.073	4.188	.041
Psychodynamic orientation	0[a]				
Absence of a comorbid personality disorder	.694	−1.541	2.929	.371	.543
Presence of a comorbid personality disorder	0[a]				
MPS Concern over Mistakes and Doubts about Actions	.062	−.050	.173	1.173	.279
MPS Concern with Precision. Order and Organization	−.072	−.258	.115	.570	.450
MPS Excessively High Personal Standards	.186	−.031	.402	2.824	.093
MPS Parents' Expectations and Evaluation	.053	−.089	.195	.536	.464
Patients' age (years)	−.019	−.095	.057	.246	.620

Table 7 (continued)

Outcome: TRQ Sexualised	95% CI				
	β	Lower	Upper	Wald's $\chi^2_{(1)}$	p-value
Intercept	5.371	3.348	7.394	27.083	.000
Therapists' male gender	.122	− .413	.657	.200	.655
Therapists' female gender	0[a]				
Therapists' age (years)	− .007	− .033	.019	.272	.602
CBT orientation	− .186	− .718	.345	.471	.492
Psychodynamic orientation	0[a]				
Absence of a comorbid personality disorder	.318	− .394	1.031	.766	.381
Presence of a comorbid personality disorder	0[a]				
MPS Concern over Mistakes and Doubts about Actions	.009	− .026	.045	.271	.603
MPS Concern with Precision. Order and Organization	.004	− .056	.063	.014	.907
MPS Excessively High Personal Standards	− .043	− .112	.026	1.507	.220
MPS Parents' Expectations and Evaluation	.010	− .036	.055	.168	.682
Patients' age (years)	− .004	− .028	.020	.109	.742
Outcome: TRQ Disengaged	95% CI				
	β	Lower	Upper	Wald's $\chi^2_{(1)}$	p-value
Intercept	12.846	6.736	18.956	16.979	.000
Therapists' male gender	.411	− 1.186	2.009	.254	.614
Therapists' female gender	0[a]				
Therapists' age (years)	− .040	− .118	.038	1.004	.316
CBT orientation	.002	− 1.600	1.604	.000	.998
Psychodynamic orientation	0[a]				
Absence of a comorbid personality disorder	− .566	− 2.718	1.586	.266	.606
Presence of a comorbid personality disorder	0[a]				
MPS Concern over Mistakes and Doubts about Actions	.053	− .054	.160	.930	.335
MPS Concern with Precision. Order and Organization	− .224	− .404	− .045	5.995	.014
MPS Excessively High Personal Standards	.047	− .162	.256	.194	.659
MPS Parents' Expectations and Evaluation	− .016	− .153	.121	.052	.820
Patients' age (years)	.016	− .057	.089	.187	.665

CBT, Cognitive Behavioural Therapy; CI, Confidence Interval; MPS, Multidimensional Perfectionism Scale; TRQ, Therapist Response Questionnaire

[a]Parameters are set at zero because they are redundant in the statistical model

Therapist's male gender was associated with higher criticised/devalued feelings. Absence of a comorbid personality disorder in the patient was related to higher special/over-involved reactions.

Discussion

The present study is the first investigation of the therapeutic relationship with OCD patients from the therapist's perspective. The model proposed by Betan et al. (2005) identifies specific patterns of emotional responses experienced by therapists towards patients. However, little is known about the role of therapists' orientation and perfectionism. Therapists' emotional reactions to patients represent clinically informative material about patients' interpersonal functioning and might support supervisory practice. We compared the emotional reactions to OCD patients of therapists with a CBT orientation to those with a psychodynamic one. We also explored the role of therapists' perfectionism on emotional reactions.

Overall, in the whole sample of therapists, in line with previous data regarding the maladaptive effects of perfectionism on the therapeutic alliance (Ganske et al., 2015; Zuroff et al., 2010) we found that those therapists with higher concern over mistakes and doubts about actions were more likely to report more intense emotional reactions including helpless/inadequate, overwhelmed/disorganised, hostile/angry, criticised/devalued, special/over-involved, and parental/protective feelings except for positive feelings related to a satisfactory relationship, sexualised, and disengaged feelings towards their patients. Excessively High Personal Standards correlated positively and weakly only with parental protective feelings. Therapists with excessive concern with parents' expectations and evaluation reported more hostile and angry feelings. Finally, therapists with higher concern with precision, order and organization did not report any emotional feelings towards patients.

We found that compared to psychodynamic therapists, CBT therapists had less negative feelings on some specific emotional patterns, particularly helpless/inadequate, overwhelmed/disorganized, hostile/angry and criticised/devalued emotional responses to patients. An interpretation of this result may be related to one of the key processes usually occurring during psychotherapy for OCD, i.e. patients' tendency to seek more and more reassurance from therapists about the validity of their obsessional doubts (e.g., Kobori and Salkovskis 2013). CBT therapists may have more skills to manage this difficult aspect of the therapeutic relationship. Generally, OCD patients expect therapists to be able to offer immediate reassurance about their doubts and neutralize their discomfort. A therapist who is not aware of this interpersonal cycle may provide reassurance to each request with the aim of immediately reducing the patient's discomfort; in turn, this can reactivate the patient's doubts in the long-term thus reinforcing discomfort again. A therapist who offers reassurance may get entrapped in special and over-involved feelings (when the patient's distress is initially reduced) but also in angry and criticised emotions because reassurance becomes more and more ineffective. We can speculate that compared to psychodynamic therapists, CBT therapists might be more aware of these interpersonal vicious cycles and more prepared to manage reassurance-seeking. These skills in CBT therapists may prevent or attenuate some interpersonal scripts which OCD patients manifest during sessions,

particularly feelings of abandonment, dependence, vulnerability, and insufficient self-control (e.g., Voderholzer et al. 2014). In addition, one of the key elements of CBT which may help these therapists more effectively manage the relationship is case formulation, a therapist and patient shared goal-oriented process of understanding how OCD and therapy work (e.g., Natrass et al. 2015). CBT case formulation of OCD assumes that therapy works by exposing the patient to doubts and helping him/her to accept uncertainty (e.g., Clark, 2003). We can speculate that this element might help CBT therapists to tolerate and more effectively manage overwhelming feelings deriving from the client's reassurance requests in the therapeutic relationship. Regarding the psychodynamic approach, there is not consensus about the most effective attitude to adopt toward OCD patients' reassuring requests, the reason why we hypothesized that psychodynamic therapists experienced more overwhelming feelings towards patients (King, 2017). The techniques used in CBT involve exposure and response prevention. As reassurance may often be inappropriately used to counter anxiety generated by obsessive thinking, reassurance seeking may be a compulsive action that a CBT therapist would not reinforce as he/she tends to be aware of the role of providing reassurance as a reinforcing factor of OCD symptoms. CBT therapists would not become angered by reassurance-seeking, but would see that action as part of the condition and an area for treatment targeting, not something that would cause emotional distress.

Therapists' responses to patients' reassurance requests are central for treating psychopathology also within a psychodynamic perspective. In psychodynamic psychotherapies, there is an emphasis on the evocation of affect, on bringing unconscious into awareness, and on integrating current difficulties with previous life experience, using the therapist–patient relationship as a change agent (Jones & Pulos, 1993). An explanation why CBT therapists reported less overwhelming feelings than the psychodynamic ones might be that the latter do not directly focus on symptoms (i.e., the content of obsessional doubts, the vicious cycle of reassurance seeking) and perhaps are not skilled in managing symptoms in the short term (i.e., when obsessions and compulsions arise) (McKay, 2011).

Interestingly, the two therapist groups were not different on any perfectionism dimensions, indicating that perfectionism might be a transtheoretical characteristic and therefore independent of therapists' theoretical orientations.

Bivariate associations showed that in both the orientations, concerns over mistakes and doubts about actions were associated with angry feelings. In addition, this perfectionism dimension was related, respectively, to criticised emotions in the CBT group and to overwhelmed and over-involved reactions in the psychodynamic one. While in the CBT group a higher concern with precision, order and organization was not associated with any emotional patterns, it was related to lower parental/protective and disengaged feelings among the psychodynamic therapists. Interestingly, high personal standards and excessive concern with parents' expectations were associated with parental and angry emotions in CBT therapists, while this perfectionism dimension was not related to any emotional pattern in the psychodynamic group.

The results of the GLMs further supported the effects found through direct comparisons of therapists' orientations. This result suggests that some negative emotional reactions are related to the therapist's theoretical orientation and skills.

In addition, we found some therapists' perfectionistic traits had a role regardless of orientation. Specifically, concern over mistakes and doubts about actions was associated with criticised feelings, and parents' expectations and evaluation were related to hostile feelings. This result suggests that supervisory practice should consider these perfectionism features as interpersonal therapist characteristics potentially interfering with the therapeutic relationship with OCD patients. The role of excessively high standards was not significant, in contrast with previous research on psychotherapy processes (Presley et al., 2017).

Interestingly, therapists more concerned with precision, order and organization experienced lower disengagement reactions. This result may be in line with the bidimensional model of perfectionism where this dimension may have a positive effect on the resources of the individual, i.e. coping and resiliency (Enns et al. 2005; Stoeber & Otto, 2006).

Surprisingly, none of the variables examined were associated with a positive therapeutic relationship. This suggests the importance of deeply understanding what factors determine a better relationship between therapist and patient. An interpretation may be that this emotional dimension is a transtheoretical element related to alliance and common factors rather than specific techniques. Alternatively, it may be that some variables not considered in the present study have an effect: for example, patient's adherence to therapy and symptom improvement may facilitate self-efficacy feelings in the therapist which make him/her perceive the relationship more positively. The fact that the absence of a comorbid personality disorder was associated with a better therapeutic relationship may be attributable to the fact that the presence of a comorbid personality disorder in OCD has been found to be not related to drop-out or less symptom improvement by some studies (Dèttore et al., 2013; Olatunji et al., 2013). Another interpretation may be that if the therapist is aware of a patient's personality comorbidity, he/she may have lower expectations regarding the patient's interpersonal functioning or may be more careful about collusion with interpersonal vicious cycles.

Implications for Clinical and Supervisory Practice

Since we found that some perfectionism dimensions were associated with some negative emotional reactions to patients with OCD, it is clear that reducing perfectionistic strivings and concerns might be essential to prevent their potential destructive impact on the clients' well-being, independently of the theoretical model. Supervisory practice of therapists working with OCD clients should be focused on therapists' perfectionism and their emotional experience towards this type of patients. Not embracing methods to reduce perfectionism might imply conveying pressure to clients, who may be deprived of learning that mistakes are inevitable and should be accepted. As Wittenberg and Norcross suggested (2001), both the CBT and the psychodynamic approach embrace methods or techniques to reducing perfectionism: restructuring of the self-destructive

"shoulds," and selective abstraction, the former; therapy's incorporation of a less punitive superego, the latter. Cognitive restructuring, which revealed to be an effective intervention for perfectionism (DiBartolo et al., 2001; Rozental, 2020), might be introduced in supervisory sessions of therapists to target perfectionistic cognitions related to their clients with OCD. Another type of intervention that might be integrated in supervisory practice might include self-compassion exercises which may be useful for therapists with high perfectionistic tendencies and negative emotional responses towards their OCD patients, as suggested by the promising use of this intervention with psychotherapy trainees (Richardson et al., 2020).

Limitations

The cross-sectional design and the lack of a random assignment of therapists to patients did not allow us to ascertain a causal effect and exclude the possibility that the observed relations were spurious. In addition, another relevant issue concerns the fact that each therapist rated his/her emotions towards only one patient, as in previous studies using the TRQ (e.g., Gazzillo et al., 2015; Tanzilli et al., 2016). It could be argued that the emotions reported by the therapist in this study were related to the characteristics of a specific patient and not just to the clinical features of OCD. Therefore, further studies should assign each therapist to multiple patients with OCD and use multilevel analyses to distinguish the effects of therapist' and patient's features, and the effects of OCD. Future studies should also investigate whether therapists' emotional responses predict treatment outcome and/or drop-out by a longitudinal design. It may be interesting to assess whether therapists' emotions are associated with other patient characteristics and processes, such as interpersonal maladaptive schemas which may have an impact on the therapeutic relationship.

A key issue regards the fact that novelty in working with OCD patients was not assessed, since the experience of therapists was only detected by a generic variable, i.e., therapists' age. Therefore, future research should examine the role of this variable that could impact on the emotional reactions of therapists, for example by assessing the number of OCD patients treated in the therapists past working experience and/or the number/type of clinical trainings about OCD psychotherapy. Another point which needs investigation is the association between therapists' emotional responses and the therapeutic alliance as perceived by patients. Our protocol may also be improved by adding other measures of therapists' emotional responses such as observer-based or psychophysiological measures. Finally, further research may use other therapist orientations and other patient's psychological conditions as further comparison groups such as other OCD spectrum conditions (Pozza et al., 2016a).

Conclusions

The present study is the first empirical investigation on the emotional responses of therapists towards patients with OCD. Therapists' CBT orientation and lower perfectionistic traits might be associated with better emotions towards the patients suggesting

a better therapeutic relationship, at least from the therapist's perspective. Supervisory practice should take into account the emotional responses experienced by the therapist and therapist's orientation and perfectionism with the aim to monitor and improve the therapeutic relationship and potentially the effectiveness of treatment.

Authors' contributions AP designed the study, conducted the literature searchers, collected the data, analysed the data, wrote the first draft of the paper; SC designed the study, conducted the literature searches, wrote the first draft of the paper and checked the final version; DD designed the study, conducted the literature searches, collected the data, wrote the first draft of the paper and checked the final version.

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Availability of data and materials Data will be made available upon request.

Declarations

Conflict of interest The authors have no conflicts of interest to declare.

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