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An Inquiry into the Therapist Variable:

Comparing Psychoanalytic, Psychodynamic and Behavior Therapists[1]

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Beutler et al. (2004) in their most recent handbook article on the therapist variable stated that neither efficacy nor effectiveness research has up to now dealt adequately with the unique contributions therapists make in the therapeutic process because outcome studies are designed predominantly to identify the impact of treatments. Above all one of the most promising features, the therapeutic attitude, conceived as the therapist's personal backdrop against which the therapeutic process is unfolding during treatment (Sandell, 2004), has been neglected. Therefore, the present study aims at further elucidating especially the therapeutic attitude. In order to more subtly differentiate the person of the "healer", psychodynamic psychotherapists, psychoanalytic psychotherapists and behavioral therapists are investigated. We hypothesize that there are significant differences in attitude on core convictions between members of different therapeutic orientations.

Method

Measure. The Therapeutic Attitude questionnaire (ThAt), the German translation of the Therapeutic Identity questionnaire (ThId; Sandell et al., 2004), was applied to explore therapist´s convictions. This measure was standardized on a random

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sample of Swedish psychotherapists and the Stockholm Therapy Outcome Study of Psychoanalysis and Psychoanalytic Psychotherapies (STOPP). It is one of the most sophisticated and elaborated measures of the therapist variable in the field combining the economic advantages of a questionnaire, that allows to tap a sample large enough for empirical research, with the possibility to access the conscious and preconscious area of the therapist's work. The questionnaire comprises therapists' demographics, academic and professional training, professional experience, personal therapy or training analysis and therapist's theoretical orientation. Six variables were constructed from these items ("socialisation variables"): experience, self-experience, scope of training, variability of therapeutic settings, supervisory activities and interest in professional communication. Therapist's attitude in the strict sense is composed of therapist's belief in curative factors, individual technique and basic assumptions; by means of a factor analysis they were condensed into the Therapeutic Attitudes Scales (TASC-2): Adaptation, Insight, Kindness, Neutrality, Supportiveness, Self-doubt, Irrationality, Artistry and Pessimism (Sandell et al., 2004). Furthermore, therapists described in free-text format their strengths, limitations, aims and difficulties in therapy, categorized as follows: strengths: technical-cognitive (e.g. psychodynamic knowledge), technical-emotional (e.g. curiosity, tolerance of ambiguity), personal-cognitive (e.g. patience, flexibility), personal-emotional (e.g. tolerance, warmth); limitations: external narcissistic (e.g. constraints by theoretical guidelines and professional medical organizations), internal narcissistic (e.g. perfectionism, high expectances); external object-directed (e.g. negative transference, resistance), internal object-directed (e.g. pessimism, self-doubt); aims: disease-oriented (e.g. symptomatic relief),

adaptation-oriented (e.g. coping), individual-oriented (autonomy, identity), problem-oriented (e.g. grief, reconciliation); negative influence on psychotherapy: environment-oriented (e.g. negative attitudes of family and society), patient-oriented (e.g. insufficient motivation, immature defence), therapist-oriented (e.g. neurotic counter-transference), relation-oriented (e.g. mismatch of patient and therapist).

Participants.

Graduated members were recruited from rosters of four Munich training institutes for psychoanalytic, psychodynamic and behaviour therapists. A questionnaire together with a recommendation letter of the institute and a free-stamped reply envelope was mailed to 871 active members. After four reminders, 451 psychotherapists returned the questionnaire, corresponding to a response rate of 52 %. We operationalised psychoanalytic (PA), psychodynamic (PD) and behaviour therapists (BT) according to the guidelines of the Bavarian General Medical Council. The psychoanalytic therapist sub-sample comprised 208 therapists [male 67 (=32%), female 141 (=68%), mean age of 52 years (SD = 8.6)]; the psychodynamic therapist sub-sample comprised 81 therapists [male 23 (=28%), female 58 (=72%), mean age of 48 years (SD = 7.9)] and behavior therapist sub-sample comprised 162 therapists [male 56 (35%) female 105 (65%), mean age of 47 years (SD = 9.3)].

Statistical Analyses.

Data were analyzed by using the current version of SPSS. Chi-square-tests for categorical data and univariate one-way analyses of variance (ANOVA) for continuous data were applied. Furthermore SPSS procedure CHAID ("CHi-squared Automatic Interaction Detector") was used as a non-parametric, multivariate procedure. CHAID divides the sample by means of the "best" predictor in two or more distinct groups. The groups, gathered this way, will be divided into smaller subgroups by means of further predictors in the next steps. This process of segmentation will be continued until there will be no more significant predictors left. Because of multiple testing only results at least on a 1%level of significance are reported.

Results

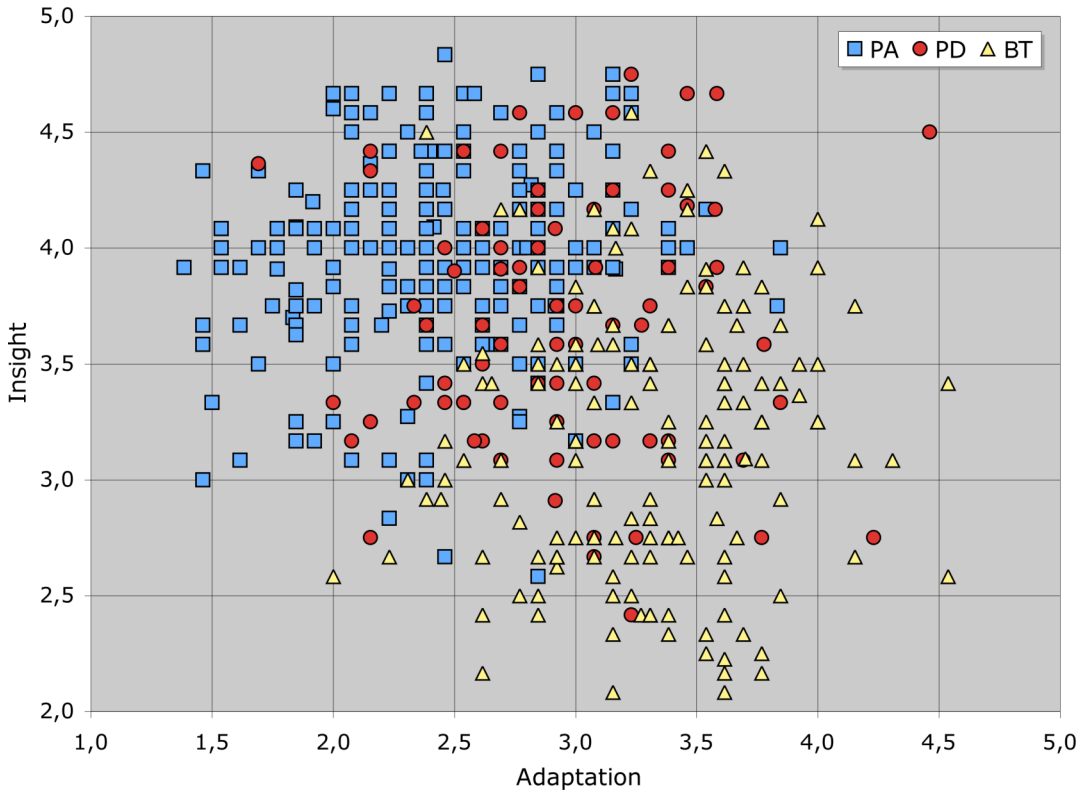
Psychoanalytic therapists think that among curative factors insight contributes to stable therapeutic change the most and adaptation and kindness the least, whereas behavior therapists believe that adjustment and kindness contribute to stable change the most while insight the least. Psychodynamic psychotherapists believe in insight as a curative factor less than psychoanalytic therapist but more than behaviour therapists, but believe in adjustment and kindness as curative factors less than behaviour therapist and more than psychoanalytic therapists. As a technique, psychoanalytic therapists apply neutrality the most and supportiveness the least, while behavior therapists use supportiveness as a technique the most. Psychodynamic therapists take a neutral stance less than psychoanalytic therapists but more than behavior therapist, but they are less supportive than behaviour therapists and more than psychoanalytic therapists.

Among the basic assumptions, psychoanalytic therapists consider that irrational factors determine human mind and that psychotherapy is more an artistry, whereas behaviour therapists think that human mind is determined by rationality and psychotherapy is more a craft. Psychoanalytic therapists have more than behavior therapists a pessimistic view. Psychodynamic therapists believe in irrational factors in the human mind less than psychoanalytic therapists but more than behavior therapists.

Psychoanalytic therapists formulate therapy goals more individual-oriented and consider negative influences on therapy more therapist-oriented than behavior therapists. Behavior therapists on the other hand consider personal-emotional factors as their strengths and formulate disease- and adaptation-oriented aims more than psychoanalytic therapists. Psychodynamic therapists regard personal-emotional factors less than psychoanalytic therapists as their strength and formulate goals less adaptation-oriented but more individual-oriented than behavior therapists.

Univariate ANOVAs revealed that psychoanalytic therapists were more experienced, more self-experienced, more active as supervisors and more interested in professional communication than behavior therapists. Behavior therapists worked more than psychoanalytic and psychodynamic therapists in variable settings. Psychodynamic therapists were the least experienced, the least active as supervisors and the least working in variable settings but as to interest in communication and self-experience between the other groups.

Figure 1. Scattergram of variable adaptation and insight



CHAID analysis with the TASC-2 variables shows that adaptation contributes the most to the differentiation of the groups of therapists. Insight explains after further segmentation most additional variance, kindness and supportiveness explains only to a very limited extent additional variance. CHAID analysis of combined variables shows that interest in communication contributes to the segmentation of therapists.

Discussion

A response rate of 52 % is acceptable for a study performed with mental health care professionals but a limitation of the study is that, obeying strict anonymity, no information about the non-responders can be provided.

Univariate and multivariate analysis confirm that therapists' assumptions about the curative factors distinguish significantly the three groups in a theoretically expected way. The variables adaptation and insight differ most stringently between behavior therapy and psychoanalytic and psychodynamic therapy (figure 1). Taking this result, the other TASC variables and the differences in the strengths, limitations, aims and difficulties together, there are three distinct types of therapists. Behavior therapist believe in adaptation as the main curative agent, apply support as their preferred technique, consider personal-emotional factors to be their strengths and formulate disease- and adaptation-oriented goals for patients they consider to be moved by rational, conscious motives. They prefer to work with variable settings and a substantial part of them is not much interested in professional communication. Psychoanalytic therapists believe in insight as the main curative agent, take a neutral, non-supportive stance about which they are skeptical at the same time and aim at addressing issues of identity and autonomy in patients they consider as driven mainly by irrational, unconscious drives. They are experienced and self-experienced and interested in professional communication. Psychodynamic therapists are in between thus taking a more eclectic stance.

The findings confirm our hypothesis and thus support the idea that there is such a thing like a psychoanalytic therapist, a psychodynamic therapist and a behavior therapist.

References

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