Orlinsky, D., M. H. Ronnestad, et al. (2005). A study of therapeutic work and professional growth. Chapter 6 - An overview of the psychotherapist samples. *In D. Orlinsky and M. H. Ronnestad (Eds) How psychotherapists develop: A study of therapeutic work and professional growth.. Washington, American Psychological Association.pp.*

The Psychotherapist's Perspective: Therapeutic Work, Professional Development, and Personal Life

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Part II. Psychotherapist Sample Profiles

Chapter 6 - An Overview of the Psychotherapist Samples

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In this section of the book we aim to introduce readers to the groups of psychotherapists who participated in our study. This introduction serves two aims. The first is to enable us to understand the variations in responses that therapists made to the questions posed in the DPCCQ. As we shall see, psychotherapists share certain basic characteristics but also differ in many ways from one another. A detailed description of the range of therapists' characteristics prepares us to appreciate the degree of generality among those that are shared by most therapists and also helps to interpret the meaning of the differences that we find among them.

A second aim served by the detailed description of a large number of psychotherapists is an old-fashioned but venerable one: simple curiosity.

Psychotherapists are interesting people. Psychologically troubled and emotionally distressed people seek their help. Society recognizes their profession and licenses its practitioners as experts who are qualified to help distressed and deviant individuals. Therapists have become familiar figures as characters in novels, dramas, films, and television. Our curiosity wants to know what psychotherapists (at least, many psychotherapists) are like.

This chapter provides an overview of the nearly 5,000 psychotherapists who accepted our invitation to answer the questions set forth in the DPCCQ. As explained in the last chapter, we can make no claim that those who participated in our study are representative of all psychotherapists, for the simple reason that sufficiently clear definitions of psychotherapy and psychotherapists are impossible to formulate because definitions will vary across cultures and nationalities. On the other hand, the therapist samples we now have available are so large and diverse that we can tell a great deal about those who define themselves and are generally accepted as psychotherapists in their own communities. In the subsequent chapters of Part II, we present comparative descriptions of our therapist samples in terms of professional background, theoretical orientation, career level, and national origin. In what follows here, we provide a general overview of their professional characteristics, the nature of their professional practices, and their demographic and personal characteristics.

Professional Characteristics

Psychotherapists are generally described in terms of their professional training and identification, their theoretical orientation, and their career level. For example, one might be a relatively inexperienced psychodynamically-oriented psychiatrist, another might be a moderately experienced cognitive-behavioral psychologist, and a third might be a highly experienced systemically-oriented social worker. The composition of our therapist sample with respect to these basic professional characteristics is shown in Table 6-1.

Table 6-1.

Therapists' Professional Characteristics (N = 4,923)

Characteristics	n	%
PROFESSIONAL BACKGROUND	2,810	57.3
Psychology	1,378	28.1
Medicine	280	5.7
Social Work	97	2.0
Counseling	91	1.9
Nursing	145	3.0
‚Lay' therapista	107	2.2
Other		
THEORETICAL ORIENTATIONb	2,784	57.6
Analytic/Dynamic	688	14.2
Behavioral	1,154	23.9
Cognitive	593	10.7
[Cognitive Behavioralc]	1,507	31.2
Humanistic	1,008	20.9
Systemic	580	13.4
Other	403	8.4
No salient orientation	2,200	45.5
2+ salient orientations		
CAREER LEVEL		
Novice [< 1.5 yrs]	534	11.3
Apprentice [1.5 to < 3.5 yrs]	549	11.6
Graduate [3.5 to < 7 yrs]	774	16.4
Established [7 to < 15 yrs]	1,429	30.2
Seasoned [15 to < 25 yrs]	1,074	22.7
Senior [25 to 53 yrs]	373	7.9
YEARS IN PRACTICE	M = 11.2	SD = 8.9

Note. Ns vary slightly due to omission of question or missing data.
a ‚Lay' therapist category includes respondents who describe themselves as psychotherapists

or psychoanalysts without also listing a core profession.
b Orientation ‚salient‘ if rated of 4 or 5 on 0-5 scale of influence on therapeutic practice; total exceeds 100% because multiple ratings allowed.
c Subset of therapists who are salient on both Behavioral and Cognitive orientations.

Professional Background

Although there are many professional psychotherapists, there is as yet no single profession of psychotherapist. Rather, some of the members of several different professions acquire varying amounts of additional training in order to practice psychotherapy as a specialty or subspecialty. The medical profession has traditionally been a major source of psychotherapists through the training of specialists in psychiatry (or psychosomatics and psychotherapy, in Germany)--though currently, in America at least, there is a reduced emphasis on psychotherapy in psychiatric training (Luhrmann, 2000). Additionally, a large number of professional psychotherapists are trained in psychology, and often hold doctoral or comparable university level degrees; but only some psychologists are clinical or counseling psychologists, and only some of those are psychotherapists. The professions of social work, nursing, and others also are sources of trained psychotherapists, while in some countries it is still possible for talented individuals to receive training as „lay“ therapists or analysts without having had a prior training in one of the usual mental health professions.

The psychotherapists who answered the DPCCQ were asked the following question about their professional background: „What is your professional identity? That is, how do you refer to yourself in professional contexts?“ On the basis of their self-descriptions, 58% of the therapists in our sample identified themselves as psychologists, 28% as psychiatrists (or, in Germany, as psychosomatic physicians), 6% as social workers, 2% as counselors, 2% as nurses, and 5% as „lay“ therapists or therapists trained in some other field. Obviously clinical social workers are seriously underrepresented in our current sample, as are psychiatric nurses and others

(e.g., pastoral therapists trained initially in religious ministry) who have not yet been included in the CRN study. Nevertheless, both psychologists and psychiatrists are amply (if perhaps not proportionately) represented, and they are typically among the largest groups of professional therapists in most countries.

Theoretical Orientations

Therapists were asked in the DPCCQ to describe their theoretical orientations by rating the influence on their current practice of each of five characteristically different treatment models: analytic-psychodynamic, behavioral, cognitive, humanistic, and systemic (with a space left for respondents to specify an „other“ orientation if they used one). Each of these was rated on a six point scale, ranging from 0 = „not at all“ influenced to 5 = „very greatly“ influenced. For the purpose of descriptive analysis, therapists were considered to have a strong or „salient“ orientation if they rated the influence of that orientation on their practice as 4 and 5 on the 0-5 scale. (Since therapists could rate several orientations as salient, the figures shown in Table 6-1 add to more than 100%.) In fact, nearly half (46%) of the therapists indicated that their practice was saliently influenced by two or more types of theoretical orientation, reflecting a rather extensive amount of eclecticism.

The type of orientation most commonly rated as salient by the therapists in our sample was analytic/psychodynamic (58%). This was followed by the humanistic (31%), cognitive (24%), systemic (21%) and behavioral (14%). The fact that 11% of our therapists reported both salient cognitive and behavioral orientations shows that half of those with salient cognitive orientations were not strongly behavioral, whereas most of those with salient behavioral orientations said they were cognitive-behavioral. A small group of therapists in our sample (9%) reported having no salient orientation (i.e., did not rate any orientation higher than 3 on the 0-5 scale).

As a further step (not shown in Table 6-1), we examined all the

combinations of salient orientation and found that six mutually exclusive categories could be formed having a reasonable size for statistical purposes. Together these included 79% of our sample. The other 21% reported relatively idiosyncratic combinations of salient orientations that could not be meaningfully combined. The largest category consisted of therapists whose salient orientation was exclusively analytic/psychodynamic (31% of the total sample). There was also a second group whose salient orientations were mainly but not exclusively humanistic (15% of the total), a third group whose salient orientations were mainly but not exclusively cognitive-behavioral (11% of the total), and a fourth group whose salient orientations were mainly but not exclusively systemic (8% of the total). Finally, there was a small but interesting group of therapists, called „broad-spectrum“ integrative/eclectics (5% of the total sample), who reported having more than three salient orientations. Thus, while the psychodynamic orientation was clearly predominant, our sample also includes rather substantial numbers of therapists representing various other patterns of theoretical orientation.

Career Levels

The therapists in our sample represent every career level, with experience in therapeutic practice ranging from a few months to more than fifty years. The median number of years of practice was 10 (M = 11.2, S.D. = 8.9). To illustrate the actual distribution of therapeutic experience, we divided the sample conceptually into six career cohorts. Empirically based literature on the professional development of psychotherapists is scarce. To define career cohorts, we could only partly be guided by the related literature on supervision, which focuses predominantly on the early professional years (Grater, 1985; Hess, 1987; Stoltenberg & Delworth, 1987). Our closest model for the definition of cohorts was the conception of two successive student cohorts and successive four post-graduate cohorts used by Skovholt and Rønnestad (1995) in their study of counselor and psychotherapist development conducted.

After examining the distribution of therapists in our own data, we defined the following as psychologically meaning and statistically viable cohorts: Novices, that is, those who had done therapy for less than 1.5 years; Apprentices, that is, those having had 1.5 to less than 3.5 years of experience; Graduates, that is, those who had practiced therapy for 3.5 up to 7 years; Established therapists who had practiced for 7 up to 15 years; Seasoned therapists (Goldberg, 1992) with from 15 up to 25 years of experience; and Senior therapists who had practiced from 25 to 53 years.

The largest career cohort in our sample (30%) consisted of Established therapists, whose range of 7 to 15 years of experience brackets the average for the entire sample. Novice and Apprentice therapists who, with less than 3.5 years of experience, would still be trainees or supervisees in most professions, jointly comprise about a quarter (23%) of our sample. On the other hand, Seasoned and Senior therapists together constitute nearly a third (31%) of the sample.

Practice Characteristics

A further understanding of the therapists in our sample depends on knowing something about the kinds of professional practice in which they engage. The information collected in the DPCCQ included the types of setting in which they practice, the types of clients they treat, their levels of symptomatic impairment, the treatment modalities they use, and their current caseload. This information is summarized for the total sample in Table 6-2.

Table 6-2.

Therapists‘ Practice Characteristics

Characteristics	n	%		n	%
PRACTICE SETTING			CLIENT AGE		
Any inpatient?	1,40	28.4	GROUPS	1,131	25.1
Any outpatient?	0	43.1	Children (≤ 12 yrs)	2,058	45.7
Any independent practice?	2,80	44.0	Adolescents (13-19	3,927	87.1
Only independent practice	1	25.1	yrs)	2,479	55.0
Works in > 1 setting	2,16	44.2	Adults (20-49 yrs)		19.0
	5		Older adults (50-64	858	72.3
	1,23		yrs)	3,366	
	5		Seniors (65+)		
	2,17		Treats > 1 age group		
	8				

IMPAIRMENT LEVELS			TREATMENT MODALITY		
Absent or minimal		19.2			
symptoms	901	39.9	Individual	4,250	93.3
Transient, situational	1,87	63.5	Couple	1,533	34.1
symptoms	2	69.1	Family	1,269	27.9
Mild but enduring	2,98	68.6	Group	1,551	34.1
symptoms	6	44.6	Other	420	9.2
Moderate symptoms	3,24	26.9	Uses only individual	1,380	30.5
Serious symptoms	9	21.3	ptx. Uses > 1	2,905	63.8
Significant impairment	3,22		modality		
Serious impairment	4				
Real danger to self or	2,09				
others	5				
	1,26				
	5				
	1,00				
	0				

CURRENT CASELOADa Mdn = 12.0 M = 16.5 SD = 14.5

Note. Ns vary slightly due to omission of question or missing data.
a Total number of cases summing across treatment modalities.

Practice Setting

Nearly half (44%) of the therapists in our sample practiced therapy in more than one type of setting. About the same percentages treated at least some of their patients in public or private outpatient settings (43%) or in independent private practice (44%), and a substantial fraction of the sample (25%) did therapy exclusively in private practice. Slightly more than a fourth of our therapists (28%) treated any psychotherapy patients in public or private inpatient settings.

Client Age Groups

Nearly all (87%) in our sample treated adults in the 20 to 49 year old age range, and about half (55%) also treated older adults of 50 to 64 years of age--

although only one in five (19%) of the therapists treated seniors aged 65 or more. Adolescent patients aged 13 to 19 were present in the practices of nearly half (46%) of our therapists, but only 25% treated children younger than 13. Overall, nearly three quarters (72%) of the therapists had patients at two or more stages of life.

Impairment Levels

Therapists were asked, „How disturbed or impaired are the patients you are currently treating in psychotherapy?“ They were asked to respond by indicating how many patients in their practice were currently functioning at each of eight levels based on Axis V of the DSM system (American Psychiatric Association, 1994). Over two thirds (69%) of the therapists in our sample reported treating patients with moderate symptoms (e.g., occasional panic attacks) or moderate difficulty in social, occupational or school functioning, and the virtually same proportion of therapists (69%) reported treating patients with serious symptoms (e.g., suicidal ideation, severe obsessional rituals) or serious impairment in social, occupational or school functioning (e.g., no friends, inability to keep a job). Most (81%) of the therapists in our sample were not treating the so-called „worried well,“ that is, those with absent or minimal symptoms who are socially effective, generally satisfied with life, and have no more than everyday problems or concerns. In fact, more were treating patients at the other end of the severity spectrum: some (27%) with patients seriously impaired in communication or judgment (e.g., considerably influenced by delusions or hallucinations) or unable to function in almost all areas, and some (21%) with patients in real danger of hurting self or others (e.g., suicide attempts, recurrent violence) or patients so grossly impaired that they could not communicate or maintain minimal personal hygiene. Overall these data show little evidence of specialization, with an average of four patient severity levels in our therapists‘ practices, most of which reflect significant mental health problems.

Treatment Modalities

Individual psychotherapy of one type or another was by far the most prevalent treatment modality, with 93% of our therapists reporting they had at least one individual therapy case. Indeed, nearly a third (31%) of the therapists were practicing only individual therapy. However, the predominant pattern of practice was to combine individual therapy with one or more other treatment modalities, either group therapy (34%) or couple therapy (34%) and family therapy (28%). Fewer than a tenth of the therapists reported using some other therapeutic modality.

Caseload

Therapists vary greatly in the number of treatment cases they carry. However, most do seem to work hard at their practice. Summing across all treatment modalities, the median number of therapy cases was 12 (M = 16.5, S.D. = 14.5), with half the therapists treating between 6 and 22 cases, and another quarter treating more than 22. Moreover, since couple, family and group psychotherapies involve multiple patients, the caseload figures underestimate the number of patients that the therapists are actually treating.

Demographic Characteristics

The demographic characteristics most relevant to the description of our therapist sample are nationality, gender, age, and marital status. This information is summarized in Table 6-3.

Table 6-3.
Therapists' Demographic Characteristics

Characteristics	n	%

NATION			
	USA	844	17.3
	Germany	1,059	21.7
	Switzerland	263	5.4
	Norway	804	16.5
	Denmark	158	3.2
	Sweden	117	2.4
	Portugal	188	3.8
	Spain	182	3.7
	Belgium	132	2.7
	France	117	2.4
	Russia	110	2.3
	Israel	100	2.0
	S. Korea	538	11.0
	Other	272	5.6
NON-NATIVE BORN			
	Born elsewhere	423	10.9
MINORITY STATUS			
	Minority	457	10.5
GENDER	Female	2,580	53.0
	Male	2,288	47.0

Characteristics	n	%
MARITAL STATUS		
Single	833	17.9
Living with partner	777	16.7
Married	2,608	56.0
Separated/Divorced	395	8.5
Widowed	44	0.9
AGE	Mdn = 41.8	M = 42.4 SD = 10.6

Note. Ns vary slightly due to omission of question or missing data.

Nationality

The therapists in our study live and work in many countries. However, three countries at present account for the largest numbers. About one fifth (22%) of our sample are psychologists, psychosomatic physicians and psychiatrists from Germany (n = 1,059). About one sixth (17%) are psychologists and social workers from the USA (n = 844) and another sixth (17%) are psychologists from Norway (n = 804). These three countries account for over half (56%) of the therapists presently in the sample. Other substantial groups of therapists are South Korean (n = 538), Swiss (n = 263), Portuguese (n = 188) and Spanish (n = 182), with smaller representations from Denmark (n = 158) and Sweden (n = 117), Belgium (n = 132) and France (n = 117), Russia (n = 110) and Israel (n = 100). There are also groups of fewer than 100 from Argentina, Austria, India, Italy, Mexico, the United Kingdom, and a few East European countries.

Social Status

Professional psychotherapists would be viewed by sociologists as having middle class status by virtue of their education and occupation, although variations in income and lifestyle would undoubtedly place some as upper middle class. Other marks of social standing in a community include minority status and immigrant status, either of which can lead an individual to be seen as an „outsider.“ Overall, it seems that most psychotherapists (89%) are native born and most (89%) feel they would not be viewed as members of a social, cultural or ethnic minority. While the 11% who are not native born are three times more likely to report that they also have a minority status (21% vs. 7%), the overwhelming majority (83%) of therapists in our sample were both native born and majority status members of the countries where they live. This contrasts markedly with the emphasis on cultural marginality reported by Henry, Sims and Spray (1971) in their earlier survey of American psychotherapists, suggesting that their findings may have been specific to the

country and historical period of their study.

Gender and Age

Our therapist sample is fairly evenly divided between men (47%) and women (53%), although the percentages vary from country to country and from one profession to another (as described in subsequent chapters of Part II). The ages of therapists in the sample range from 21 to 90 years (median = 41.8, M = 42.4, S.D. = 10.6), but half of the therapists are between 35 and 49 years old.

Women are somewhat over-represented in the two youngest groups of therapists (86% for those under 25, 56% for those who are between 25 and 35), while there are proportionately more men among the two oldest groups (65% for those aged from 65 to 75, and 75% for those 75 and older). The association is statistically significant but relatively small, and probably reflects differences in professional background as much as a possible historical trend, since the two youngest groups include a significant number of American social workers.

Marital Status

Nearly three quarters of the therapists in our sample are either currently married (56%) or living with a partner (17%). Fewer than one in five are single, and less than one in ten separated or divorced or widowed and not remarried or with a new partner. However, there are clear differences in marital status between male and female therapists, even when differences in age are controlled. Four fifths (81%) of the men but only two thirds (66%) of the women were currently married or living with a partner. Proportionally more women than men were single (21% vs. 14%), and more women than men were separated or divorced (12% vs. 5%). The reasons for this are not clear, but the fact should be borne in mind when interpreting differences among other factors that may be associated with marital status.

Summary and Prospect

The diversity of the therapists in our sample does not lend itself to summarization by describing a „typical“ or „average“ psychotherapist which all

approximate to some extent. Most of our therapists were trained in psychology or medicine, but a number of other professions are represented, if still insufficiently so. The work of many is saliently influenced by psychodynamic models of treatment, but large numbers are also influenced by humanistic, cognitive, behavioral, and systemic theories of therapy--and many by more than one. Our sample also includes substantial numbers of therapists at all career levels, from novices to seniors.

Despite these diverse professional characteristics, there are some commonalities in practice. Most therapists treat their patients on an outpatient basis, either in public or private institutions or in independent private practice, and many do in more than one type of setting. Most therapists utilize individual psychotherapy, either alone or in combination with other treatment modalities. Most psychotherapists treat adult patients, though many also treat adolescents. Most therapists treat patients with significant levels of emotional disturbance and psychological impairment.

In terms of demographic and social characteristics, there are both differences and commonalities in our therapist sample. There are major differences in nationality, although most of our therapists live in Western countries with broadly similar cultures. There are differences in gender, with our sample divided fairly evenly between men and women. On the other hand, most of the therapists in our sample are native-born, non-minority, and (by virtue of their education and occupation) middle- to upper-middle class members of their societies. Most live in settled domesticity with their spouses or partners. Overall, our therapists seem to be part of the mainstream of society rather than outsiders within it.

At this point, readers should be warned again not to view the therapists in our sample as representative of all therapists at large. They may be in some respects and may not be in others. We simply do not know at this stage of research, and probably cannot know until a generally valid rational definition is

accepted that distinguishes the population of professional psychotherapists.

Readers also should be aware that many of the professional, practice, and demographic characteristics summarized in this chapter are not evenly distributed across therapists but rather tend to be confounded with one another. This is partly due to the nature of the therapeutic professions (e.g., social workers most often are women) and partly to the vicissitudes of data collection (e.g., few of our American or Norwegian therapists are psychiatrists). What this means is that the various groups of therapists in our sample differ from one another in more than one way, making it difficult to interpret any between-group differences that may be found unless relevant statistical controls are used. For example, differences that might be observed between therapists of different countries might be due not to nationality but rather to the fact that the proportions of therapists‘ professions or theoretical orientations or genders differ from one national group to another. The key to valid interpretation is knowing which confounding variables should be statistically controlled. On the other hand, the same situation permits stronger inferences about observed commonalities between groups, since these are found despite the fact that the groups differ in multiple ways.

A proper understanding of the findings about therapists‘ experiences of therapeutic work, professional development, and personal life (to be reported in Parts III, IV and V respectively) is predicated on recognition of these confounds. The general reader may be inclined to trust that we have taken adequate account of those confounds in our analyses and interpretations, and may want to proceed directly to reading about the results of our study (e.g., in Part III chapter 1). However, for our research colleagues and other cautious readers we offer next in Part II a series of short chapters that explore the characteristics of our therapists when analyzed separately by professional background, theoretical orientation, career level, and country of residence.

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