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Therapeutic attitudes and practice patterns among psychotherapy candidates in Germany

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Abstract

Aim: This study aims to explore what happens to students' or candidates' values and attitudes during their psychotherapeutic training. Furthermore, we want to evaluate how candidates' levels of self-confidence change over the years in training. **Methods**: In a cross-sectional study, 171 candidates in German institutes with different theoretical orientations (Psychoanalysis - PA, Psychodynamic Therapy- PT and Cognitive Behavioral Therapy- CBT) participated. Results are reported from two questionnaires: Therapeutic-Attitudes-Candidate-Version (ThAT-CV) and Work-Involvement-Scales (WIS). **Results**: Therapeutic attitudes were significantly different among candidates in institutes with different theoretical orientations and did not change over training duration. Whereas the PA and CBT candidates endorsed contrasting attitude profiles, the PT group displayed attitudes less differentiated attitudes in-between these contrasts. Stress involvement in therapy sessions decreased over time in training. Most candidates experienced their psychotherapeutic practice as challenging. Female candidates reported more Healing Involvement and felt more competent in general than their male colleagues. School-syntonic attitudes correlated with self-reported therapeutic competence. **Conclusions**: The ThAT-CV discriminates significantly between candidates of different therapeutic schools. Our sample demonstrates high identification with attitudes belonging to their theoretical orientation. This may account for high ratings of self-reported therapeutic competence. Attitudes seem to be formed before training. Less differentiated attitudes may explain PT-candidates' higher Stress involvement.

Keywords: therapeutic training, subjective confidence, therapeutic attitudes, theoretical orientation

Therapeutic attitudes and practice patterns among candidates in psychotherapy training

Introduction

Much remains to be known about the effects of psychotherapeutic training (Ronnestad & Ladany, 2006). This study aims to explore what happens to students' or candidates' values and attitudes during their psychotherapeutic training. Is it a process of the student's gradual accommodation to the values and frame of reference of the specific orientation of one's institute or is the specific institute selected on the basis of the student's values and theoretical frame of reference? Furthermore, we want to evaluate how effective candidates feel as therapists and to what extent their level of self-confidence changes over the years in training.

Research on the therapist

Not only has training been a relatively neglected area in psychotherapy research; in this evidence-base era, with its exclusive focus on the treatment method, the individual therapist's contribution has been considered a mere nuisance variable ("error") which one tries to control by using manualized treatments and adherence control.

However, during the same period, several researchers have drawn attention to the therapist as a critical factor for therapeutic success (Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Elkin, Falconnier, Martinovitch, & Mahoney, 2006; Luborsky et al., 1986; Okiishi, Lambert, Eggett, Nielsen, & Dayton, 2006; Okiishi, Lambert, Nielson, & Ogles, 2003; Wampold, 2001). Even among systematically trained therapists there is large variation in their therapeutic effectiveness (Elkin, 1999), and this variation may be partly mediated by their varying ability (rather than their patients') to contribute to the alliance (Baldwin, Wampold, & Imel, 2007).

In their reviews on therapist factors, Beutler and his coauthors (Beutler, Machado, & Neufeldt, 1994; Beutler et al., 2004) concluded that there is little evidence for the contribution to therapy outcome of observable traits (e.g., age, sex, ethnicity) and only inconsistent evidence for observable states (e.g., theoretical orientation, experience).

Inferred traits like well-being and cultural belief seem to have modest effects on outcome, whereas research on what the authors called inferred states has demonstrated moderately strong effects. Inferred states are, among other things, the values, beliefs, and attitudes pertaining to his or her task that the therapist brings to the consulting room and will likely serve as a backdrop to his or her management of the therapeutic relationship and process. After a latency period or around 20 years the focus of Fey and Rice (Fey, 1958; Rice, Fey, & Kepecs, 1972; Rice, Gurman, & Razin, 1974), McNair and Lorr (1964), Sundland (Sundland, 1977; Sundland & Barker, 1962), Wallach and Strupp (1964), Weissman, Goldschmid and Stein (1971), Wogan and Norcross (1985) and others on these processes was reintroduced by Orlinsky with the Collaborative Research Network within the Society for Psychotherapy Research (Ambühl, Orlinsky, & SPR-Collaborative-Research-Network, 1997; D. E. Orlinsky et al., 1999) and, somewhat later, by Sandell (Sandell et al., 2004; Sandell et al., 2006, 2007).

Therapeutic attitudes and work involvement

Therapists of various theoretical orientations differ in their epistemological style, that is, styles of thinking, theories of knowledge, and general concepts of mankind (see reviews by Athur, 2001; Sandell & al., 2009). Sandell et al. (2001) combined such epistemological concepts with important aspects of therapeutic action in a questionnaire called Psychotherapeutic Identity (ThID). The heart of the questionnaire is three sets of rating scales about therapists' values and beliefs, subdivided in statements about curative factors in psychotherapy, statements about the individual therapeutic style, and general assumptions about the nature of the human mind and the character of psychotherapy. Sandell et al. (2004) used the ThID on a random sample of licensed Swedish therapists and, on the basis of a factor analysis in each set, developed the Therapeutic Attitude Scales (TASC-2). The TASC-2 scales consist of nine subscales that have been found reliably to discriminate therapists of different theoretical orientations: Adjustment, Insight, and Kindness as curative factors; Neutrality, Supportiveness, and Self-doubt as therapeutic style factors, and Irrationality, Artistry, and Pessimism as basic assumption factors. All of them, except Self-doubt, significantly differentiated between therapists with different self-assigned theoretical orientations and training at institutes with different theoretical orientations (Sandell et al., 2004).

Meanwhile, the TASC-2 scales were validated by an independent research group in Germany (Klug, Henrich, Kächele, Sandell, & Huber, 2008). The authors replicated the findings from Sandell et al. (2004) on a representative sample of 451 German licensed therapists of psychoanalytic, psychodynamic and cognitive-behavioral schools. Almost all subscales discriminated significantly between the three groups. Considering the correlations among the subscales, they found that the curative factors Insight and Adjustment alone permitted a clear differentiation between the groups (Klug et al., 2008, pp.88-89).

Applying the TASC-2-Scales on a sample of 167 therapists from the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (STOPPP) Sandell et al. (2006, 2007) found that patients' changes in psychological distress were moderated by therapists' attitudes. Kindness as a curative factor, Neutrality as a therapeutic style factor, and Artistry as a basic assumption factor were associated with long-term success. However, as the sample consisted of only psychoanalytic or psychodynamic therapists these results cannot be generalized to therapists of other schools.

On the basis of a study by the Collaborative Research Network of the Society of Psychotherapy Research (CRN SPR) on almost 5000 therapists from more than 12 different countries Orlinsky & Ronnestad (2005) created a model of the professional development of psychotherapists. The model includes two alternative cycles, a positive and a negative one. Good basic relational skills; broad theoretical orientation; a sense of satisfaction with one's own work as well as with one's work environment; breadth and depth of case experiences; and resources like supervision and personal therapy are factors contributing to a positive cycle, whereas a lack of most or all of them basically defines the negative cycle (Orlinsky & Ronnestad, 2005, pp.168f.). Comparisons within the large sample clearly showed that those with less experience were more vulnerable to disturbing influences and therefore more likely to be caught in a negative cycle of development. To prevent this, determinants of a positive development for trainees need to be more clearly defined. To this end Orlinsky and Ronnestad (2005) created the Work Involvement Scales with the subscales Healing Involvement (Healing) and Stress Involvement (Stress). Healing refers to therapist qualities like kindness, warmth, and tolerance that engage therapists in effective and constructive work patterns. In contrast, Stress refers to feelings related to anxiety, boredom, and conflict-

avoidance strategies. Especially psychotherapeutic beginners have higher Stress scores (Orlinsky & Ronnestad, 2005, pp. 64ff.). Based on the two dimensions Orlinsky and Ronnestad identified four different practice patterns: effective (high Healing, low Stress), challenging (high Healing, high Stress), disengaged (low Healing, low Stress) and distressed (low Healing, high Stress).

Hypotheses about changes during therapeutic training

Therapeutic training is an intensely engaging and long process, in which the student's or the candidate's professional and personal qualities, values and beliefs are involved and scrutinized. In the classical tri-partite model, didactic theoretical seminars, clinical supervision, and personal therapy form a melting-pot that is likely to influence the student profoundly. Yet, whereas there is some research on the didactic effects of training (Botermans, 1996; Ronnestad & Ladany, 2006), effects of supervision (Ladany, 2005), and personal therapy (Geller, Norcross, & Orlinsky, 2005; Sandell et al., 2002), little is as yet known about changes in therapeutic attitudes and practice patterns.

There are several competing hypotheses about how therapeutic attitudes change during psychotherapeutic training. As differences between therapeutic schools have been found to decrease with growing professional experience (Fiedler, 1950; Sandell et al., 2004), one hypothesis is that candidates in different schools will become more similar with increasing years in training. Another hypothesis is that candidates will gradually accommodate to the prevailing attitudes of their respective school and thus become gradually less similar across schools. Still another hypothesis is that candidates' attitudes are preformed and serve as one basis for their selection of a school. In that case, there should be initial and unchanging attitudinal differences between candidates in different schools during training. These three hypotheses are incompatible, one predicting convergence, one divergence, and one stable difference among the schools. Exploring the tenability of these hypotheses is one aim of this study.

As another focus of the present study, we are interested to explore how candidates' feelings of competence and self-efficacy change during training and whether these differ among candidates in different schools. Specifically, we hypothesize that candidates, from a position

of insecurity and self-doubt, tend to reach the positive developmental cycles described by Orlinsky and Ronnestad (2005) by decreasing their mean scores on Stress and also on Self-doubt. As we also predict increasing Healing scores as a consequence of more training, candidates are hypothesized to move from the challenging to the effective practice pattern during their training, irrespective of their schools. As a consequence we expect feelings of therapeutic competence to increase during training.

Method

Participants

Psychotherapeutic training for psychologists in Germany aiming to achieve a license to practice is regulated by the German Psychotherapy Law ("Psycho-Therapeuten-Gesetz", PTG). The law prescribes the tripartite model consisting of personal therapy, theoretical seminars, and clinical experience with patients under supervision. The minimum duration of all programs is defined by the PTG and ranges from three years (full time training) to five (part time training). For graduation psychotherapeutic candidates in Germany have to document 600 hours of theoretical training, 1800 hours of clinical practice in psychiatry and outpatient departments as well as 600 hours of psychotherapy with at least 6 different patients and 150 hours of supervision. To become a licensed psychotherapist at least 120 hours of personal therapy are also required, but individual programs differ considerably in the additional amount of personal therapy they require.

Psychotherapeutic training is mainly offered by state-certified institutes (173 institutes in total, of which 142 (82%) are private institutes and 31 (18%) are run by universities. Training costs range from 20.000 to 30.000€ (Strauß et al., 2009), whether in private or university institutes. The national psychotherapy guidelines (Rüger, Dahm, & Kallinke, 2005) consider psychoanalytic therapy (PA), psychodynamic therapy (PT)[1] and cognitive -behavioral therapy (CBT) as evidence-based and we accordingly chose to include candidates at institutes representing those theoretical orientations in our study. During the study we decided also to include a cohort of candidates at the only two institutes in Germany that offer training in client-centered psychotherapy (Strauß et al., 2009).

Our study design was cross-sectional and naturalistic. The questionnaires were sent to a number of private and university training institutes. First we contacted institutes and candidate representatives to obtain informed consent. A few PT and CBT institutes refused to cooperate due to their current involvement in other research projects. We sent 700 questionnaires to 25 state-certified institutes throughout Germany who had consented to cooperate with the study. At their own discretion the institutes used different ways of distribution; some simply handed out questionnaires in the seminar rooms whereas others sent them by mail to their candidates asking them to fill out and return the questionnaires. Participation was voluntary and anonymity was offered to every participant. Those interested in some type of follow-up had the option to give away their names and addresses for future contacts. Respondents returned their questionnaires to the first author individually by pre-addressed stamped envelopes. After three reminders through the institutes we had 171 filled-out questionnaires; the total response rate was 24% (23% from PA institutes, 27% from PT institutes; 22% from CBT institutes). There was no information available about reasons for non-response except complaints from some institutes about already existing workloads during training. As a consequence of the distribution and return procedures a proper analysis of non-responders was not possible. However, the response rate is typical for German surveys on psychotherapists nowadays (Stehle, 2004), and the distributions of the responders in terms of sex and age are in agreement with what has been found in a recent representative survey (Strauß et al., 2009).

Measures

The questionnaire included the following sections:

The Work-Involvement-Scales (WIS; Orlinsky & Ronnestad, 2005) is a short self-report form based on the findings with the Common Core Questionnaire (DPCCQ, D. Orlinsky et al., 1999) with 6-point and 4-point rating scales. Items are rated from 0 (never) to 5 (very often) or from 0 (not at all) to 3 (very much). The items are scored for two subscales, Healing Involvement (Healing) with 25 items and Stressful Involvement (Stress), with 22 items. Their reliabilities (internal consistency, Cronbachs α) were .74 for Healing and .66 for Stress, respectively.

The Therapeutic Attitudes Candidate Version (ThAt-CV; Sandell, Taubner, Rapp, Visbeck, & Kächele, 2008) is a version of the ThId for psychotherapists in training (Sandell et al., 2001). It includes questions on personal background in terms of age and sex, training, professional experience, and personal therapy. Further questions about training contentment referring to general and specific satisfaction (supervision, theoretical training, self-analysis) were included using 5-point rating scales ranging from “not at all” to “very much”. Furthermore, we included open questions about why the candidate wanted to become a psychotherapist, why the candidate had chosen the specific school, and what he or she would like to change in their training conditions. As a last item we included a question about how competent as a psychotherapist the candidate felt at the moment, again using a 5-point rating scale ranging from “not at all” to “very much”. Due to the low reliability of the Self-doubt scale in former studies, five more statements related to self-doubt were included. Questions about the candidates’ theoretical orientations were extended to take into account different psychoanalytic “subschools”: classic Freudian psychoanalysis, Ego psychology, Object relations theory, Self psychology, Kleinian theory, Lacanian theory and Relational/ Intersubjectivistic psychoanalysis. The TASC-2 scales had the following reliabilities (internal consistency; k = number of items): Adjustment (k = 13) .82; Supportiveness (k =9) .64; Kindness (k = 5) .70; Neutrality (k = 10) .66; Insight (k = 12) .86; Self-doubt (k = 9) .63; Irrationality (k = 4) .57; Artistry (k = 5) .49; Pessimism (k = 5) .12. As a consequence Pessimism was excluded from further analyses. Normal probability plots and detrended normal probability plots did not indicate any wide deviations from normality for any of the scales. We therefore decided to use parametric statistics throughout.

The INTREX-Short Version (Tress & Benjamin, 1989-1991) relies on the Circumplex-Personality-Model and asks about interpersonal styles with the most important attachment figure in good and bad times. Results of the INTREX will be reported elsewhere.

Open-ended questions in the ThAt-CV were analyzed according to the rules of qualitative diagnostic research (Frommer, 1996), combining strategies of discourse analysis (Mayring, 1983) and comparative casuistic (Jüttemann, 1990). The method focuses the text until the whole dataset is reduced to single statements. In a second step the single statements are grouped together. Similar statements get a superscription which is named category. A

category includes at the most one single statement of each subject. Therefore the number of occurrence shows how many candidates made statements in one category. We report only the results from the open question, “Why did you choose your theoretical orientation?”

Results

The candidates

The distributions of our sample on some background variables are given in Table 1. In psychoanalytical training (PA)were 36%, followed by 29% psychodynamic candidates ((PT) and 27% cognitive-behavioral candidates (CBT) (. The distribution of 22% male and 78% female participants agrees with the candidate population in Germany. At an average a PA candidate was 4 years older than a PT-candidate and 7 years older than a CBT-candidate. Also, the PA candidates had been in training the longest, followed by PT and CBT. Candidates with a medical academic qualification were only present in the PA group (except one in the PT group) which may be due to our selection of private institutes. Medical doctors are often offered to include psychotherapeutic training in their clinical education in hospitals which is less costly than training at a private institute. Furthermore, CBT-trainings are mainly chosen by psychologists (Strauß et al., 2009) while medical doctors tend to choose PA training in addition to their hospital training in private institutes. The candidates in our study were mostly focused on psychotherapy with adults (84%); only 26 candidates reported treating children.

(Insert Table 1 about here)

Respondents also reported about their experiences with personal therapy, and this is summarized in Table 2. Only 29 (17%) candidates reported no personal therapy before their

psychotherapeutic training, and these were all CBT candidates. Thus, every candidate in PA or PT training reported at least one previous round of therapy, and several in these groups had been in more than one round of psychotherapy or psychoanalysis. PA candidates had most often been in psychoanalysis before training, PT candidates most often in psychodynamic therapies. This trend to choose to train in the specific orientation that candidates have already experienced as patients was not true for the CBT candidates. The majority of those who had been in personal therapy had chosen group therapy rather than CBT. The total amount of personal therapy includes previous psychotherapies as patients as well as therapy during training. Not surprisingly, mean values were highest for PA candidates and lowest for CBT candidates.

When experiences with patient work are concerned, in every theoretical orientation only few candidates were total debutants. The majority had treatment experiences with one to five patients, only a few PA and PT candidates had treatment experiences with more than 10 patients, which was in contrast to the CBT group. This is likely a matter of the typical treatment durations in CBT and PA or PT.

(Insert Table 2 about here)

Were there differences in therapeutic attitudes between candidates who have chosen to train in different schools?

The quantitative data from the ThAt-CV (Sandell et al., 2008) and the WIS (Orlinsky & Ronnestad, 2005) were analyzed with the Statistical Package for the Social Sciences, version 15.0.

A multivariate analysis of variance (MANOVA) confirmed that there were clear differences in therapeutic attitudes between different theoretical schools during training, $F(16; 268) = 7.53$, $p < .001$. All subscales except Self-doubt had significant between-groups variances ($p < .02$ for Artistry, $p <. 001$ for Adjustment, Support, Kindness, Neutrality, Insight, and Irrationality). As shown in Figure 1, CBT and PA candidates tended to have contrasting

attitudes. Whereas CBT candidates valued Adjustment, Support, and Kindness, PA candidates put higher values on Neutrality, Insight, and Irrationality. PT candidates also favored Insight as a curative factor but generally tended to occupy a middle-of-the-road position between the CBT and PA groups.

Certainly, this does not exclude individual exceptions. A discriminant analysis revealed that 27% of the PA candidates had attitudes that were more characteristic of the PT group, whereas 21% of the PT candidates had PA-type attitudes and 10% CBT-type attitudes. In that sense, the CBT candidates were more orthodox: Not more than 13% endorsed attitudes that were more typical of another school, the vast majority of whom (11%) had attitudes of the PT type.

(Insert Figure 1 about here)

Did differences in therapeutic attitudes between the schools change during training?

When we grouped the candidates in three groups according to number of semesters in training, early (< 5 semesters); intermediate (5-9 semesters); late (> 9 semesters), the MANOVA showed no main effect of time in training, whether multivariately or univariately, $F(18; 264) = 1.01$, $p = .45$. Neither was there any school by time interaction, $F(36; 496) = 0.85$, $p = .72$, meaning that there was no trend across time in any group.

Nevertheless, in the entire candidate sample there were significant correlations between time in training and all subscales except Artistry ($p < .05$). However, *within* each candidate group there were almost no significant correlations, indicating that the pooled-groups correlations mainly reflected between-groups correlations. Thus, at an average, the PA candidates had been longer in training and had higher scores on Neutrality, Insight, and Irrationality, whereas the CBT candidates had spent fewer semesters in training and had higher mean scores on Adjustment, Support, and Kindness.

Candidates' age correlated significantly with time in training ($r = .44$, $p < .001$). As with time in training, significant correlations between age and Adjustment, Supportiveness, Kindness, Insight, Irrationality, and Artistry (p's $< .05$) generally disappeared within-schools, as a consequence of the between-schools differences in age. Correspondingly, mean differences between female and male candidates on Supportiveness ($p = .01$) and Kindness ($p = .03$) reflected the differences between CBT and PA candidates in sex distributions.

Did self-confidence as a therapist change during training?

In line with our hypothesis another MANOVA showed a significant main effect of stage in training, $F (4; 236) = 2.51$, $p = .04$, with significantly decreasing Stress scores, $F (2; 119) = 7.72$, $p = .02$, but no such trend for Healing, $F (2; 119) = 3.14$, $p = .10$. This pattern did not differ among the schools—the school by time interaction was non-significant for both variables. However, there was significant variation among the schools when their levels of Stress were compared, $F (2; 119) = 7.69$, $p = .02$, whereas there were no differences on Healing. Thus, PT candidates had significantly higher scores for Stress than the PA group ($p = .02$). Furthermore, both Healing and Stress were significantly different depending the candidates' gender, $F (2; 126) = 8.32$, $p < .001$. Female candidates had higher Healing scores ($p = .01$) and lower Stress scores ($p = .02$) than male candidates. Means and standard deviations are displayed in Table 3. These differences suggest that more female candidates would experience an effective practice pattern whereas more male candidates would experience more challenge as therapists.

(Insert Table 3 about here)

Practice patterns were calculated according to the cut-off-measures suggested by Orlinsky and Ronnestad (2005).[2] Most candidates experienced their psychotherapeutic practice as challenging, followed by effective and distressing. Only one candidate reported a disengaged

practice pattern. In comparison with a beginners group of German psychotherapists (Orlinsky & Ronnestad, 2005, p. 285) our sample reported considerably more positive practice patterns, that is effective or challenging practice, and less disengaged or distressing practice patterns. The distributions are given in Table 4, which indicates the non-random pattern, χ^2 (1, N = 133) = 7.18, p = .01.

(Insert Table 4 about here)

The distributions of practice patterns were roughly equal in the CBT and PA groups, whereas the PT candidates reported relatively more challenging work experiences. These differences were not significant (p = .76).

Comparing groups at different stages of training, 50% in the advanced group experienced an effective working pattern and 39% a challenging one. In the beginners and the intermediate groups the rank order was the reverse, with 29% and 36% effective patterns and 57% and 55% challenging ones, respectively. Again, these differences were not significant (p = .28).

The differences between male and female candidates were significant, however, χ^2 (3, N = 133) = 11.72, p = .01. Among the females 43% had an effective practice pattern, compared to 17% among the males. In contrast, the distressing pattern was found with 21% of the male but only with 8% of the female candidates.

Analysis of variance (ANOVA) of the Self-doubt scale revealed no significant main or interaction effects, whether of school, time in training, or candidate gender. However, there were substantial correlations between Self-doubt and the WIS scales, -.42 with Healing and .47 with Stress (p < .001 for both). Consequently, practice patterns could be clearly differentiated by the level of Self-doubt, F (3; 128) = 10.59, p < .001. Besides the single disengaged candidate, the candidates with an effective practice had the lowest and those with a distressing practice the highest Self-doubt scores. Kindness and Supportiveness had relations of borderline size (p = .06) with practice patterns, in both cases with the lowest

scores for candidates with a distressing practice pattern. To test school-specific relations between attitudes and therapeutic self-confidence, correlations were calculated between TASC- und WIS-scales for each school separately. For the PA candidates Stress correlated with Adjustment (.34) and inversely with Irrationality (-.31) while Healing correlated with Supportiveness (.28). PT candidates had higher Healing with higher Insight (.38) and Kindness (.44). For CBT candidates there were significant correlations for Healing and Adjustment (.33) as well as Supportiveness (.32). Furthermore, Stress correlated with Neutrality (.46).

As might have been expected self-rated Competence correlated significantly with Healing (.42), Stress (-.30), and Self-doubt (-.42). The number of candidates reporting feelings of high competence was 42% (“very” and “very much” competent), whereas only 8% considered their therapeutic competence as low (“not at all competent”). Female candidates felt significantly more competent than male ones, $F (1; 140) = 2.21$, $p = .02$. Neither school, nor age had any unique effect on competence ratings.

“Why did you choose your theoretical orientation?”

One hundred and forty-three participants answered the question why they had chosen their specific theoretical orientation. The answers could be differentially assigned to 17 different categories, as in Table 5. When the number of occurrences of a category were counted separately for each school, the most frequently used category for each school was a deep identification with the school’s goal, effectiveness and concept of mankind (70 instances in all). Twenty-eight candidates also felt that there was a “personal fit“ with their school’s concepts. Candidates in the different schools differed in the weighing of financial and labour market reasons for their choice. This was relatively more frequent among CBT candidates (but also PT ones) than among PA candidates. The latter rather emphasized their curiosity, the wish to understand a patient “deeply” and contribute to patients’ change as well as to the development of their own personalities.

(Insert Table 5 about here)

Discussion

In sum, our results suggest that there are wide attitudinal differences between candidates of different schools. Deviations from the school norms are more frequent among PA and PT candidates. The attitudes do not seem to change with time in training in each school. Most candidates experienced their psychotherapeutic practice as challenging, more so than effective and distressing. But the longer they were in training the more they reported effective practice patterns, which may be taken as a positive effect of training. There were no relations between practice patterns and theoretical orientations.

Like the ThID, the ThAT-CV discriminates significantly between different therapeutic schools (Sandell et al., 2004). The profiles of this candidate sample replicate almost identically the findings of Klug et al. (2008) with experienced psychotherapists: Insight, Neutrality and Irrationality are favored therapeutic styles and curative factors by psychoanalytic candidates and therapists, Adjustment and Supportiveness are favored by CBT candidates and psychotherapists. The middle-of-the-road position of PT psychotherapists can also be found in our candidate sample, with the exception of Insight, which is close to the PA scores.

As in previous studies (Sandell et al., 2007) Pessimism had low internal consistency and was therefore excluded from further analysis. In view of the fact that candidates spend considerable amounts of money and time on their training how to make changes possible, facing the possibility that certain disorders are unchangeable and uncontrollable may arouse inner conflicts. Possibly, the Pessimism scale will show higher internal consistency in a longitudinal setting, so we suggest no changes in the questionnaire unless the low internal consistency will be replicated in further investigations. Meanwhile, the Self-doubt scale performed acceptably with the newly included items. In contrast to the other TASC-2 scales Self-doubt did not differentiate between school types, which is again a replication of former investigations (Klug et al., 2008; Sandell et al., 2004). Correlated with self-rated competence, Stress, and Healing, Self-doubt seems to capture the candidate's general self-confidence

during therapeutic action, but it is an issue worth to explore if and how this influences his or her therapeutic style. One hypothesis might be that low-scorers would be more cautious and "by-the-book" than high-scorers.

Sandell et al. (2004) and Klug et al. (2008) reported considerable variances in attitudes within schools of the same theoretical orientation, confirming Fiedler's (1950) early finding that growing therapeutic experience weakens differences between schools. Sandell (2004) found two eclectic clusters of mainly psychodynamic therapists between the CBT and psychoanalytic profiles. In our candidate sample there were also "deviates," especially among the PA and PT candidates, whereas the CBT candidates in general showed more allegiant attitudes. The greatest overlap was between the PA and PT groups where more than 20% of each group endorsed attitudes more typical of the other one. This result is not surprising as both schools are based on a psychoanalytic framework. In general, the hypothesis that candidates would be more orthodox in their therapeutic attitudes during training than experienced psychotherapists seems correct.

Since there was no interaction between duration of training and attitudes, it appears that the choice of an orientation does not change in or by training but rather is predetermined, in the sense that therapists-to-be have established their therapeutic attitudes as they begin their training and probably select an institute on those grounds. This conclusion is supported by a study by Heffler and Sandell (2009) on 175 psychology students who were assessed by the Learning Style Inventory (Kolb, 1984) twice, in the beginning of their study (3rd semester) and again in the 7th semester when they were to select a psychotherapeutic orientation (Cognitive Behavioral vs. Psychodynamic Psychotherapy) for their clinical training. The authors found that the two groups of students tended to diverge and gradually changed their learning styles towards their future theoretical orientation long before they had to choose or had any practical experience. Thus, the absence of change in therapeutic attitudes in our sample may be explained by the fact that attitudes were already established before training. This interpretation is validated by the qualitative material provided by the ThAt-CV. Thus, our sample seems to have been initially highly identified with attitudes that are typical of their specific theoretical orientations. Possibly this may contribute to a positive work experience.

From our qualitative data it is not possible to decide whether the very “school-syntonic” attitudes are non-reflected or even unconscious. The causal process of school selection seems to be very individually formed by rationales (Labor market, money) on the one hand and positive former experiences (at one’s university or in personal therapy) on the other. Most important there seems to be a concordance or fit between one’s own epistemological style and the one epitomized by a specific school or institute. The qualitative analysis also replicated the findings of Poznanski and McLennan (2003) that experiences of one’s personal therapy are only influential for psychodynamic or psychoanalytic school choices. CBT candidates rather emphasized the influence of university lectures.

High scores of the candidates’ self-rated therapeutic competence, independent of school type, stand in contrast to reports about self-rated competence of experienced psychotherapists. At least this is true for the PA candidates. In a representative survey sample Will (2006) demonstrated that 65% of the participating German psychoanalysts expressed doubts about their therapeutic competence. One structural problem in PA training is the typical long duration of the supervise cases; candidates may only bring one or possibly two supervised long-term treatments to an end during their training, and this may result in feelings of insecurity. Furthermore, especially PA training regimes have been criticized of being infantilizing (Wiegang-Grefe & Schuhmacher, 2006) and destroying the candidates’ own creativity (Kernberg, 1996). This led to the expectation that PA candidates would differ in their amount of self-doubt, competence and work involvement from other schools, but this was not supported in this study. In fact, PA candidates reported similar Healing and Stress scores as CBT candidates. Only the PT candidates differed from the other schools reporting significantly higher Stress.

As in the studies of Sandell et al. (2004) and Klug et al. (2008), the attitudes of PT candidates occupy a position in between those of CBT and PA candidates. Only when Insight is concerned, PT candidates tend to take a more psychoanalytic stance. The higher amount of challenging practice, that is, higher Stress, might be a result of—or result in—more “eclectic” attitude-profiles, endorsing both CBT- and PA-typical attitudes. In their qualitative answers PT candidates explicitly valued that the psychodynamic approach, as defined by the national German psychotherapy guidelines, integrates aspects of different theoretical orientations

(psychoanalytic, cognitive-behavioral and others). This obviously allows them greater flexibility in their psychotherapeutic work but also bears the danger of weaker school identification and insecurities during training. Furthermore, the fact that PT has been "invented" by the national psychotherapy guidelines as a therapy of its own, with no long tradition of its own, may also contribute to less differentiated attitudes among PT candidates.

In comparison with the results of the DPCCQ for beginners with less than 1,5 years of therapeutic experience (Orlinsky & Ronnestad, 2005, p. 285) our sample shows higher stressful but at the same time higher healing involvement. It may be that, during training, practice patterns are positive (effective or challenging) mainly due to the effects of supervision, personal therapy and beginner's enthusiasm. In such case practice patterns may shift again to more distressing forms of working experience after termination of training. This remains to be explored.

In a recent study Sandell et al. (2007) reported that Kindness and Supportiveness was related to positive outcome in psychoanalysis and psychodynamic therapy. In our sample therapeutic confidence (Stress and Healing) is related to school-specific attitudes in a complex way. Supportiveness is only correlated with Healing in the PA and CBT group while Kindness and Insight seem to be important factors for Healing in the PT group. If candidates base their therapeutic style on atypical school-attitudes they have higher Stress-scores (PA candidates on Adjustment, CBT candidates on Neutrality).

Gender effects concerning therapeutic confidence have not been reported previously. In our sample, female candidates had lower Self-doubt, higher Healing and lower Stress. This finding might be considered in the light of the perennial discussion about gender differences in therapeutic efficacy (Beutler et al., 1994, 2004). Possibly, both in terms of therapist efficacy, self-confidence, and self-assurance, therapeutic work is partly dependent on strengths that are typically regarded as female-related (e.g., relationship orientation). To what extent the finding, also or alternatively, may be due to the low number of men in our sample is impossible to determine.

Besides the substantial non-response rate, a critical limitation of this study was the cross-sectional design. Unforeseen, it turned out that time in training was significantly different between schools, thus confounding the two principal independent variables. Obviously, given such a situation, a longitudinal design is necessary to see changes in attitudes and practice patterns. We hope to be able to solicit institutes and their candidates to participate in such a study.

Literatur

Ambühl, H., Orlinsky, D., & SPR-Collaborative-Research-Network. (1997). Zum Einfluss der theoretischen Orientierung auf die psychotherapeutische Praxis. *Psychotherapeut, 42*, 290-298.

Athur, A. R. (2001). Personality, epistemology and psychotherapists' choice of theoretical model: a review and analysis. *European Journal of Psychotherapy, Counselling and Health, 4*, 45-64.

Baldwin, S., Wampold, B., & Imel, Z. (2007). Untangeling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75*, 842-852.

Beutler, L., Machado, P., & Neufeldt, S. (1994). Therapist Variables. In S. Garfield & A. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (4 ed., pp. 259-269). New York: Wiley.

Beutler, L., Malik, M., Alimohamed, S., Harwood, T., Talebi, H., Noble, S., et al. (2004). Therapist Variables. In M. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (5 ed., pp. 227-306). New York: Wiley.

Blatt, S., Sanislow, C., Zuroff, D., & Pilkonis, P. (1996). Characteristics of effective therapists: Further analyses of data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 64*, 1276-1284.

Botermans, J. (1996). The training of psychotherapists: Impact of confidence and mastery, self-efficacy, and emotional reactivity. Unpublished doctoral dissertation. Universite´ Catholique de Louvain, Department de Psychologies Clinique

Elkin, I. (1999). A Major Dilemma in Psychotherapy Outcome Research: Disentangling Therapists from Therapies. *Clinical Psychology, 6*, 10-32.

Elkin, I., Falconnier, L., Martinovitch, Z., & Mahoney, C. (2006). Therapist effects in the NIMH Treatment of Depression Collaborative Research Programm. *Psychotherapy Research, 16*, 144-160.

Fey, W. F. (1958). Doctrine and experience: Their influence upon the psychotherapist. *Journal of Consulting Psychology, 22*, 403-409.

Fiedler, F. (1950). Comparisons of therapeutic relationships in psychoanalytic, nondirective, and Adlerian therapy. *Journal of Consulting and Clinical Psychology, 14*, 436-445.

Frommer, J. (1996). *Qualitative Diagnostikforschung*. Berlin: Springer.

Geller, J., Norcross, J., & Orlinsky, D. (2005). *The psychotherapist's own psychotherapy: Patient and clinician perspectives.* New York: Oxford University Press.

Heffler, B., & Sandell, R. (2009). The role of learning style in choosing one's therapeutic orientation. *Psychotherapy Research, 19*, 283-292.

Jüttemann, G. (1990). *Komparative Kasuistik*. Heidelberg: Asanger.

Kernberg, O. (1996). Thirty methods to destroy the creativity of psychoanalytic candidates. *Int J Psychoanal, 77 (Pt 5)*, 1031-1040.

Klug, G., Henrich, G., Kächele, H., Sandell, R., & Huber, D. (2008). Die Therapeutenvariable. Immer noch ein dunkler Kontinent? *Psychotherapeut, 53*, 83-91.

Kolb, D. A. (1984). *Experiential learning. Experiences as a source of learning and development.* New York: Prentice-Hall.

Ladany, N. (2005). Conducting effective clinical supervision. In G. Koocher, J. Norcross & S. Hill (Eds.), *Psychologists' desk reference.* (2nd ed., pp. 682-685). New York: Oxford.

Luborsky, L., Crits-Christoph, P., McLellan, A., Woody, G., Piper, W., Liberman, B., et al. (1986). Do therapists vary much in their success? Findings from four outcome studies. *American Journal of Orthopsychiatry, 56*, 501-521.

Mayring, P. (1983). *Qualitative Inhaltsanalyse*. Weinheim: Beltz.

McNair, D. M., & Lorr, M. (1964). An analysis of professed psychotherapeutic techniques. *Journal of Consulting Psychology, 28*, 265-271.

Okiishi, J., Lambert, M., Eggett, D., Nielsen, L., & Dayton, D. (2006). An analysis of therapist treatment effects: Towards providing feedback to individual therapists on their clients' psychotherapy outcome. *Journal of Clinical Psychology, 62*, 1157-1172.

Okiishi, J., Lambert, M., Nielson, S., & Ogles, B. (2003). Waiting for supershrink: An empirical analysis of therapists effects. *Journal of Clinical Psychology, 10*, 361-373.

Orlinsky, D., Ambühl, A., Ronnestad, M., Davis, J., Gerin, P., & Davis, P. (1999). Development of psychotherapists: Concepts, questions, and methods of a collaborative international study. *Psychotherapy Research, 9*, 127-153.

Orlinsky, D., & Ronnestad, M. (2005). *How psychotherapists develop. A Study of therapeutic work and professional growth.* Washington DC: American Psychological Association Press.

Orlinsky, D. E., Ambühl, H., Ronnestad, M. H., Davis, J., Gerin, P., Davis, M., et al. (1999). Development of psychotherapists: Concepts, questions, and methods of a collaborative international study. . *Psychotherapy Research, 9*, 127-153.

Poznanski, J., & McLennan, J. (2003). Becoming a psychologist with a particular theoretical orientation to counselling practice. *Australian Psychologist, 38*, 223-226.

Rice, D. G., Fey, W. F., & Kepecs, J. G. (1972). Therapist experience and "style" as factors in co-therapy. *Family Process, 11*, 1-12.

Rice, D. G., Gurman, A. S., & Razin, A. M. (1974). Therapist sex, "style," and theoretical orientation. *Journal of Nervous and Mental Diseases, 159*, 413-421.

Ronnestad, M., & Ladany, N. (2006). The impact of psychotherapy training: Introduction to the special section. *Psychotherapy Research, 16*, 261-267.

Rüger, U., Dahm, A., & Kallinke, D. (2005). *Faber/ Haarstrick. Kommentar Psychotherapie-Richtlinien.* (7th ed.). München, Jena: Urban & Fischer.

Sandell, R., & al., e. (2009). Therapeutic orientation and learning style.

Sandell, R., Broberg, J., Schubert, J., Blomberg, J., & Lazar, A. (2001). Psycho-Therapeutic Identity (ThID). A questionnaire about training, experience, style, and values. Stockholm County Council Institute of Psychotherapy and Department of Behavioural Sciences: Linköping University.

Sandell, R., Carlsson, J., Schubert, J., Broberg, J., Lazar, A., & Blomberg, J. (2002). Varieties of therapeutic experience and their associations with patient outcome. *European Psychotherapy, 3*, 17-35.

Sandell, R., Carlsson, J., Schubert, J., Broberg, J., Lazar, A., & Grant, J. (2004). Therapist attitudes and patients' outcomes. I. Development and validation of the Therapist Attitudes Scales (TASC2). *Psychotherapy Research, 14*, 469-484.

Sandell, R., Lazar, A., Grant, J., Carlsson, J., Schubert, J., & Broberg, J. (2006). Therapist attitudes and patient outcomes. III. A latent class analysis of therapists. *Psychol Psychother, 79*(Pt 4), 629-647.

Sandell, R., Lazar, A., Grant, J., Carlsson, J., Schubert, J., & Broberg, J. (2007). Therapist attitudes and patient outcomes: II. Therapist attitudes influence change during treatment. *Psychotherapy Research, 17*, 196-204.

Sandell, R., Taubner, S., Rapp, A., Visbeck, A., & Kächele, H. (2008). Psycho-Therapeutische Haltung Ausbildungsversion (ThAt-AV). Universität Ulm.

Stehle, S. (2004). Psychotherapeutische Berufstätigkeit. Ergebnisse der DGPT-Therapeutenerhebung. In A. Gerlach, A. Schlösser & A. Springer (Eds.), *Psychoanalyse des Glaubens*. Gießen: Psychosozial-Verlag.

Strauß, B., Barnow, S., Brähler, E., Fegert, J., Fliegel, S., Freyberger, H., et al. (2009). *Forschungsgutachten zur Ausbildung von Psychologischen Psychotherapeuten und Kinder- und Jugendlichenpsychotherapeuten*. Berlin: Bundesministerim für Gesundheit.

Sundland, D. M. (1977). Theoretical orientations of psychotherapists. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy: A handbook of research* (pp. 189-219). New York: Pergamon.

Sundland, D. M., & Barker, E. N. (1962). The orientations of psychotherapists. *Journal of Consulting Psychology, 26*, 201-212.

Tress, W., & Benjamin, L. S. (1989-1991). *INTREX Kurzform*.Unpublished manuscript.

Wallach, M. S., & Strupp, H. H. (1964). Dimensions of psychotherapists´ activity. . *Journal of Consulting Psychology, 28*, 120-125.

Wampold, B. (2001). *The great psychotherapy debate. Models, methods, and findings.* New Jersey: Mahwah.

Weissman, H. N., Goldschmid, M. L., & Stein, D. D. (1971). Psychotherapeutic orientation and training: Their relation to the practices of clinical psychologists. *Journal of Consulting and Clinical Psychology, 37*, 31-37.

Wiegang-Grefe, S., & Schuhmacher, M. (2006). *Strukturelle Gewalt in der psychoanalytischen Ausbildung. Eine empirische Studie zu Hierarchie, Macht und Abhängigkeit.* Gießen: Psychosozial-Verlag.

Will, A. (2006). *Psychoanalytiker - anders als ihr Ruf? Ein empirisches Portrait*. Gießen: Psychosozial-Verlag.

Wogan, M., & Norcross, J. C. (1985). Dimensions of therapeutic skills and techniques: Empirical identification, therapist correlates, and predictive utility. *Psychotherapy Research, 22*, 63-74.

Table 1.
Participants' characteristics

	School				
	PA	PT	CBT	Total	Between-groups p
N (%)	62 (39)	50 (32)	46 (29)	158 (100)	.268
Sex (%)					
Female	45 (73)	37 (74)	42 (91)	124 (79)	.042
Male	17 (27)	13 (26)	4 (9)	34 (21)	
Mean age (SD)	40,4 (6.9)	36,3 (5.8)	33,5 (6.6)	37.1 (7.1)	.000
Academic training (%)					
Medicine	15 (24)	1 (2)		16 (10)	.000
Psychology	36 (58)	40 (80)	45 (98)	121 (77)	
Social Worker	8 (13)	6 (12)		14 (9)	
Other	3 (5)	3 (6)	1 (2)	7 (4)	
Mean no. semesters of training	9,1 (4.9)	6,8 (3.7)	4,7 (3.0)	7.1 (4.4)	.000
Client type (%)					
Adult	46 (74)	43 (86)	42 (91)	131(83)	.000
Child	14 (23)	7 (14)		21 (13)	
Both	1 (2)			1 (1)	
Unknown	1 (2)		4 (9)	5 (3)	

Table 2.

Participants' personal therapies, number of sessions of personal therapy and experience with patient work (no. years)

	School				
	PA	PT	CBT	Total	P
N (%)	62 (39)	50 (32)	46 (29)	158 (100)	
Type or personal therapy (%)					
PA	47 (76)	8 (16)	4 (9)	59 (37)	.000
PT	6 (10)	27 (54)	2 (4)	36 (23)	
CBT	1 (2)	1 (2)	3 (6)	5 (3)	
Group	12 (19)	16 (32)	9 (19)	39 (25)	
Other	7 (11)	13 (26)	3 (6)	28 (18)	
No. sessions in personal therapy					
Mean	596 (327)	224 (194)	127 (137)	347 (323)	.000
Median	550	160	120	220	
No. patients seen					
0	11	12	13		
1-5	35	19	10		
6-10	12	14	6		
>10	4	5	17		
M (SD)	6.2 (2.8)	5.0 (2.3)	5,5 (2.6)	5.1 (2.6)	.000

Table 3.

Stress and Healing means (M) and standard deviations (SD) by time, school, and gender

Candidate group	Healing M (SD)	Stress M (SD)
PA	11.1 (1.1)	5.0 (1.3)
PT	11.0 (1.3)	5.8 (1.5)
CBT	11.0 (1.2)	5.1 (1.5)
Male	10.3 (1.2)	6.0 (1.5)
Female	11.2 (1.1)	5.1 (1.4)
Beginners	10.6 (1.2)	5.7 (1.4)
Intermediate	11.2 (1.1)	5.2 (1.7)
Advanced	11.1 (1.2)	4.9 (1.1)
Novices[a]	9.3 (1.9)	4.5 (1.7)

[a]Novices had less than 1,5 years of experience working as psychotherapists. Data from Orlinsky & Ronnestad 2005, p. 285).

Table 4.

Patterns of therapeutic work experiences during training

		Stressful Involvement	
		low	high
Healing Involvement	high	Effective practice 50 (38%) DPCCQ[a] = 27%	Challenging practice 68 (51%) DPCCQ[a] = 15%
	low	Disengaged practice 1 (1%) DPCCQ[a] = 29%	Distressing practice 14 (11%) DPCCQ[a] = 29%

[a] DPCCQ scores among German psychotherapists with less than 5 years of experience, N=86 (Orlinsky & Ronnestad; 2005, p. 276).

Table 5.

Qualitative categories from the open question: Why did you choose your theoretical orientation?

	PA	PT	VT	RO	Total
	n=47	n=45	n=39	n=12	n=143
Experiences of personal therapy	9	4	1	0	14
Occupational experiences	0	2	0	2	4
University experiences	0	2	6	0	8
I want to allow changes for patients	14	6	5	3	28
Convinced about the school's concepts and efficacy	26	20	19	5	70
Personal fit	10	6	8	4	28
Wish to understand others	12	8	5	4	29
Self-fulfillment	9	4	1	2	16
Therapy as a precious experience	0	4	0	0	4
Curiosity	6	2	0	0	8
Critical towards other schools	9	9	2	1	21
Career perspectives	7	10	14	2	33
Financial reasons	1	2	7	0	10
Can learn competencies	3	12	14	4	33
Occupational aptitude	4	1	2	1	8
Variety of techniques are possible	0	3	3	0	6
Role models in Family	2	0	0	0	2
Coincidence	0	0	2	0	2

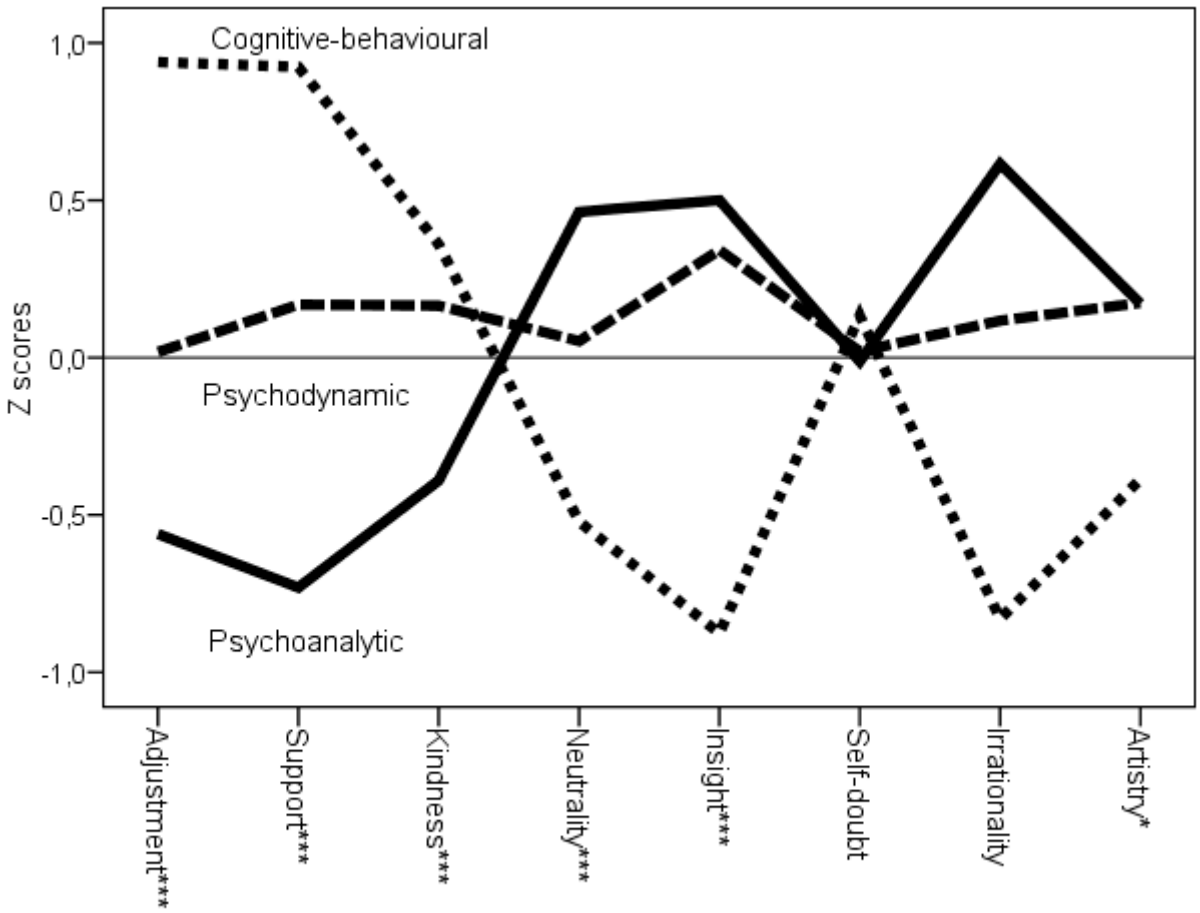
Footnote

[1] PT—as defined by the guidelines—is based on psychoanalytic theory but, in contrast to PA, refrains from using regression or transference processing as therapeutic techniques. Instead PT focuses on working on a patient's current external conflicts. Concerning differential indications as well as therapeutic techniques PA and PT are viewed on a continuum with unclear distinctions (Rüger et al., 2005). For subsidization, the national psychotherapy guidelines define normative frequencies and highest possible durations as follows: for PA 300 hours up to 3 hours a week, for PT 100 hours once a week, for CBT 80 hours once a week.

[2] High healing > 9,55, low healing < 9,55, high stress > 4,75, low stress < 4,75.

Figure caption

Figure 1: Therapeutic attitudes of CBT, PA and PT-candidates (*** p <.001, ** p <.02)


Cognitive-behavioural
Psychodynamic
Psychoanalytic
Z scores
1,0
0,5
0,0
-0,5
-1,0
Adjustment***
Support***
Kindness***
Neutrality***
Insight***
Self-doubt
Irrationality
Artistry*

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