European Journal of Psychotherapy & Counselling

Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t713698217

Therapeutic attitudes and practice patterns among psychotherapy trainees in Germany

Svenja Taubner[a]; Horst Kächele[b]; Annette Visbeck[c]; Andreas Rapp[c]; Rolf Sandell[d]
[a] University Kassel, Kassel, Germany [b] University Ulm, Germany [c] University of Bremen, Bremen, Germany [d] Linköping University, Stockholm, Sweden

Online publication date: 14 December 2010

To cite this Article Taubner, Svenja , Kächele, Horst , Visbeck, Annette , Rapp, Andreas and Sandell, Rolf(2010) 'Therapeutic attitudes and practice patterns among psychotherapy trainees in Germany', European Journal of Psychotherapy & Counselling, 12: 4, 361 — 381
To link to this Article: DOI: 10.1080/13642537.2010.530085
URL: http://dx.doi.org/10.1080/13642537.2010.530085

European Journal of Psychotherapy and Counselling
Vol. 12, No. 4, December 2010, 361–381

Routledge
Taylor & Francis Group

Therapeutic attitudes and practice patterns among psychotherapy trainees in Germany

Svenja Taubner[a]*, Horst Kächele[b], Annette Visbeck[d], Andreas Rapp[d] and Rolf Sandell[c]

[a]*University Kassel, Arnold-Bode-Str. 10, 34109, Kassel, Germany;* [b]*University Ulm, Am Hochsträß 8, 89081 Ulm, Germany;* [c]*Linköping University, Fredrikshovsgatan 3A, SE-115 23, Stockholm, Sweden;* [d]*University of Bremen, Bremen, Germany*

(*Received 26 January 2010; final version received 2 October 2010*)

Aim: This study aims to explore if and how values and attitudes from trainees of different psychotherapeutic schools vary during training. Another aim has been to evaluate the extent of their therapeutic self-confidence during training. Methods: In a cross-sectional study, 171 trainees in German institutes with different theoretical orientations (Psychoanalysis – PA, Psychodynamic Therapy – PT and Cognitive Behavioral Therapy – CBT) participated. Results are reported for two questionnaires: Therapeutic-Attitudes-Candidate-Version (ThAT-CV) and Work-Involvement-Scales (WIS). Results: Therapeutic attitudes showed significant differences between trainees with different theoretical orientations but no significant difference between different levels of training within the same school. Whereas the PA and CBT trainees endorsed contrasting attitude profiles, the PT group displayed less differentiated attitudes in between those contrasts. Most trainees experienced their psychotherapeutic practice as challenging, and Stressful Involvement in therapy sessions was lower with more years in training. Female trainees reported more Healing Involvement and felt more competent in general than their male colleagues. Self-reported competence was higher the more congruent the trainees' attitudes with their school's theoretical orientation. Conclusions: The ThAT-CV discriminates significantly between trainees 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 and change little thereafter. Less differentiated attitudes may explain PT-trainees' higher levels of Stressful Involvement.

Keywords: psychotherapy training; subjective confidence; therapeutic attitudes; theoretical orientation

*Corresponding author. Email: Svenja.taubner@uni-kassel.de

ISSN 1364–2537 print/ISSN 1469–5901 online

DOI: 10.1080/13642537.2010.530085
http://www.informaworld.com

Introduction

Much remains to be known about the effects of psychotherapeutic training (Ronnestad & Ladany, 2006). This study aims to explore how trainees' values and attitudes vary depending on the theoretical orientation of their institutes. How homogeneous, in terms of values and attitudes, are the therapeutic schools and do they differ in this respect? Is training a process of the student's gradual accommodation to the values and frame of reference of the specific orientation or is the specific therapeutic school selected on the basis of the student's existing values and theoretical frame of reference? Furthermore, we want to evaluate how effective trainees feel as therapists and to what extent their level of self-confidence is correlated with their level of training.

Research on the therapist

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

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 of the same theoretical school there is large variation in their therapeutic success (Elkin, 1999), and this variation may be partly mediated by therapists' varying ability (rather than their patients') to contribute to alliance and outcome (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 of observable traits (e.g., age, sex, ethnicity) to therapy outcome 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 others, the values, beliefs, and attitudes pertaining to his or her task. As the therapist brings these to the consulting room, they will likely serve as a backdrop to his or her management of the therapeutic relationship and the therapy process. After a latency of about 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; Orlinsky, et al., 1999) and, somewhat later, by Sandell (Sandell, et al., 2004; Sandell, et al., 2006; Sandell, et al., 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 Arthur, 2001; Heffler & Sandell, 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 are 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 also validated for German psychotherapists (Klug, Henrich, Kächele, Sandell, & Huber, 2008). The authors replicated the findings of Sandell et al. (2004) on a sample of 451 German licensed therapists of psychoanalytic, psychodynamic and cognitive-behavioral schools. Almost all subscales discriminated significantly between the three groups. Taking the correlations among the subscales into account, 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 to a sample of 167 therapists from the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (STOPPP) Sandell et al. (2006; Sandell, et al., 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 safely 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 and 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 therapists 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 that end, Orlinsky and Ronnestad (2005) created the Work Involvement Scales as a tool for self-reflection. One of the two subscales, Healing Involvement (Healing), refers to therapist qualities like kindness, warmth, and tolerance that engage therapists in effective and constructive work patterns. In contrast, Stressful Involvement (Stress) refers to feelings related to anxiety, boredom, and conflict-avoidance strategies. Especially beginner psychotherapists tend to 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 differences concerning different levels of therapeutic training

Therapeutic training is an intensely engaging and long process, in which the student'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 are likely to jointly influence the student profoundly. Yet, whereas there is some research on the didactic effects of training (Botermans, 1996; Hill & Lent, 2006; Ronnestad & Ladany, 2006), the effects of supervision (Ladany, 2005), and personal therapy (Geller, Norcross & Orlinsky, 2005; Sandell et al., 2002), not much is known how trainings may influence students' therapeutic attitudes and practice patterns. Integrating knowledge from empirical research and developmental psychology, Skovholt and Ronnestad (1992) proposed eight stages of therapists' and counselors' development. The first two stages can be applied to trainees: In the first, conventional stage the untrained psychotherapists tend to rely on their lay theories for helping others. In the second stage, professional training, trainees are described as enthusiastic, yet anxious and insecure and thus easily influenced by their teachers. Empirical research, mainly qualitative analysis on small groups, has indeed demonstrated that novice trainees are concerned with their therapeutic efficacy, anxious in their new role, self-critical, and filled with self-doubt, for instance not being able to connect to a patient or cope with difficult clinical situations (Bischoff, Barton, Thober & Hawley, 2002; Hill, Knox & Schlosser, 2007; Howard, Inman & Altman, 2006; Williams, Judge, Hill & Hoffman, 1997). In sum, novice trainees have to deal with very different aspects of development. On the one hand there are external training and learning requirements to increase one's psychotherapeutic competence and on

the other hand there are internal challenges in developing a psychotherapeutic identity (Hill et al., 2007). In the present study the internal challenges of novice and advanced trainees are operationalized in terms of therapeutic attitudes as measured by the TASC-2 scales and practice-patterns as measured by the WIS-scales. Neither the TASC-2 scales nor the WIS-scales have been applied to psychotherapy trainees yet.

There are several competing hypotheses about how therapeutic attitudes may differ 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 trainees in different schools will become more similar with increasing years in training. Another hypothesis is that students will gradually accommodate to the prevailing attitudes of their respective school and thus become gradually less similar across schools. Still another hypothesis is that trainees' attitudes are preformed and serve as one basis for their selection of a school. In that case, there should be no attitudinal differences between trainees at different levels. 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 trainees' feelings of competence and self-efficacy differ during different levels of training and whether these differ among trainees in different schools. Specifically, we hypothesize that students, 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, trainees 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 be higher in the advanced group of students.

Due to the cross-sectional design of our first study on this matter, we cannot measure changes of attitudes and practice patterns but only describe differences between groups at different levels of training. In a following study we will report longitudinal changes after three years of training.

Method

Participants

Psychotherapeutic training for master level 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 trainees 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 students at institutes representing those theoretical orientations in our study.

Our study design was cross-sectional and naturalistic. The questionnaires were sent to a number of private and university training institutes that were selected randomly from an exhaustive list of institutes. First we contacted institutes and trainee 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 trainees asking them to fill out and return the questionnaires. Participation was voluntary and anonymity was offered to every participant. Those interested in a follow-up interview had the option to submit their names and addresses for future contact. Respondents returned their questionnaires to the first author individually by pre-addressed stamped envelopes. After three reminders through the institutes, 171 filled-out questionnaires were obtained; 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 Work-Involvement-Scales (WIS; Orlinsky & Ronnestad, 2005) is a short self-report form based on the findings from the Common Core Questionnaire (DPCCQ, Orlinsky, et al., 1999). Items are rated from 0 (never) to 5 (very often) or, some of them, 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, Cronbach's α) were 0.74 for Healing and 0.66 for Stress, respectively.

The Therapeutic Attitudes Candidate Version (ThAt-CV; Sandell, Taubner, Rapp, Visbeck & Kächele, 2008) is a version of the ThId for psychotherapist trainees (Sandell et al., 2001). It includes questions on personal background in terms of age and sex, previous training, professional experience, and personal therapy. Other questions referring to the trainee's satisfaction with supervision, theoretical training, personal therapy, as well as with the training as a whole were included using 5-point rating scales ranging from 'not at all' to 'very much'. Furthermore, open questions were included about why the trainee wanted to become a psychotherapist, why the student had chosen the specific theoretical school, and what he or she would like to change in the training regime. As a last item we included a question about how competent as a psychotherapist the trainee felt at the moment, again using a 5-point rating scale ranging from 'not at all' to 'very much'. More questions about the trainees' theoretical orientation were included 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. When the TASC-2 scales were concerned, due to the low reliability of the Self-doubt scale in former studies, five more statements related to self-doubt were included. The scales had the following reliabilities (internal consistency; $k =$ number of items): Adjustment ($k = 13$) 0.82; Supportiveness ($k = 9$) 0.64; Kindness ($k = 5$) 0.70; Neutrality ($k = 10$) 0.66; Insight ($k = 12$) 0.86; Self-doubt ($k = 9$) 0.63; Irrationality ($k = 4$) 0.57; Artistry ($k = 5$) 0.49; Pessimism ($k = 5$) 0.12. 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.

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 that is named 'category'. A category includes at most one single statement of each subject. Therefore, the number of occurrence shows how many students made statements in one category. Here only the results from the following open question will be reported: 'Why did you choose your theoretical orientation?'

Results

The trainees

The distributions of our sample on some background variables are given in Table 1. All participants were in part-time training with duration of at least 5 years. In psychoanalytical training (PA) were 36%, followed by 29%

Table 1. Participants' characteristics.

	School				
	PA	PT	CBT	Total	Between-groups *p*
N (%)	62 (39)	50 (32)	46 (29)	158 (100)	0.268
Sex (%)					
Female	45 (73)	37 (74)	42 (91)	124 (79)	0.042
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)	0.000
Academic training (%)					
Medicine	15 (24)	1 (2)		16 (10)	0.000
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)	0.000
Client type (%)					
Adult	46 (74)	43 (86)	42 (91)	131 (83)	0.095
Child	14 (23)	7 (14)	4 (9)	21 (13)	
Both	1 (2)			1 (1)	
Unknown	1 (2)			5 (3)	

Note: Age differences were tested by *t*-test, all other variables by chi-square.

psychodynamic trainees (PT) and 27% cognitive-behavioral trainees (CBT). The distribution of 22% male and 78% female participants agrees with the psychotherapy trainee population in Germany. At an average a PA student was four years older than a PT trainee and seven years older than a CBT trainee. Also, the PA trainees had been in training the longest, followed by PT and CBT. Students with a medical academic qualification were only present in the PA group (except one in the PT group), which may be due to a stronger willingness of private institutes to cooperate with the study. Medical doctors are typically offered to include PT or CBT training as part of their clinical education in hospitals; some choose additional, more costly, PA training in private institutes. Furthermore, CBT training is in general chosen by psychologists (Strauss et al., 2009).

Respondents also reported on their experiences with personal therapy before training, and this is summarized in Table 2. Only 29 (17%) trainees reported no personal therapy before their psychotherapeutic training, and these were all CBT trainees. Thus, every trainee 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 trainees had most often been in psychoanalysis before training, PT students most often in psychodynamic therapies. This trend to choose to train in the specific orientation that the trainee has already experienced as a patient was not true for the CBT trainees. The majority of those who had been in personal therapy had chosen group therapy rather than CBT. The total amount of personal therapy in Table 2 includes previous psychotherapies as patients as well as

Table 2. Types of participants' personal therapies, number of sessions and experience with patient work (no. PATIENTS).

	School				
	PA	PT	CBT	Total	*p*
N (%)	62 (39)	50 (32)	46 (29)	158 (100)	
Type of personal therapy (%)					
PA	47 (76)	8 (16)	4 (9)	59 (37)	0.000
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)	0.000
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)	0.000

Note: All variables were tested by chi-square.

personal therapy during training. Not surprisingly, mean values were highest for PA trainees and lowest for CBT students.

When experiences with patient work are concerned, in every theoretical orientation only few trainees were total debutants. The majority had treatment experiences with one to five patients, and in contrast to the CBT group few PA and PT trainees had treatment experiences with more than 10 patients. This is likely a matter of the typical treatment durations in CBT and PA or PT. The trainees in our study were mostly focused on psychotherapy with adults (84%); only 26 (15%) students reported treating children.

Were there differences in therapeutic attitudes between trainees 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 trainees in different theoretical schools, $F(16; 268) = 7.53$, $p < 0.001$. All TASC-2 subscales except Self-doubt had significant between-groups variances ($p < 0.01$ for Artistry, $p < 0.001$ for Adjustment, Support, Kindness, Neutrality, Insight, and Irrationality). As shown in Figure 1 and Table 3, CBT and PA students tended to have contrasting attitudes. Whereas CBT trainees valued Adjustment, Support, and Kindness, PA trainees put higher values on Neutrality, Insight, and

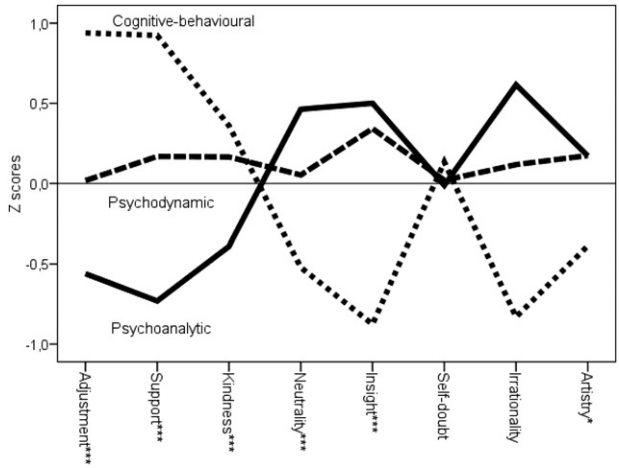

Figure 1. Therapeutic attitudes of CBT, PA and PT-trainees (*** $p<0.001$, ** $p<0.01$).

Table 3. Means (standard errors) by training orientation.

	PA ($n=62$)	PT ($n=49$)	CB ($n=46$)
Adjustment	−0.56 (0.10)	0.02 (0.09)	0.93 (0.13)
Supportiveness	−0.73 (0.10)	0.17 (0.10)	0.92 (0.12)
Kindness	−0.39 (0.12)	0.17 (0.15)	0.36 (0.13)
Neutrality	0.46 (0.11)	0.05 (0.13)	−0.52 (0.14)
Insight	0.50 (0.08)	0.34 (0.11)	−0.88 (0.16)
Self-doubt	−0.01 (0.11)	0.02 (0.11)	0.13 (0.15)
Irrationality	0.62 (0.11)	0.12 (0.12)	−0.83 (0.12)
Artistry	0.17 (0.12)	0.17 (0.13)	−0.38 (0.17)

Irrationality. PT trainees 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. As a measure of heterogeneity a discriminant analysis revealed that 27% of the PA trainees had attitudes that were more characteristic of the PT group, whereas 21% of the PT students had PA type attitudes and 10% CBT type attitudes. In that sense, the CBT trainees were more homogeneous as a group: 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.

Are there differences in therapeutic attitudes between the schools at different levels of training?

The sample of trainees was divided into three groups according to number of semesters in training, early (<5 semesters, before starting supervised practice);

intermediate (5–9 semesters) and late (>9 semesters). A MANOVA on the TASC-2 scales showed no main effect of stage in training, whether multivariately or univariately, F (18; 264) = 1.01, $p = 0.45$. Neither was there any school by stage interaction, F (36; 496) = 0.85, $p = 0.72$, meaning that there was no trend across stages in any group of orientation.

Nevertheless, in the entire trainee sample there were significant correlations between stage in training and all subscales except Artistry ($p < 0.05$). 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 trainees had been longer in training and had higher scores on Neutrality, Insight, and Irrationality, whereas the CBT trainees had spent fewer semesters in training and had higher mean scores on Adjustment, Support, and Kindness.

Trainees' age correlated significantly with time in training ($r = 0.44$, $p < 0.001$). As with stage in training, significant correlations between age and Adjustment, Supportiveness, Kindness, Insight, Irrationality, and Artistry (p's < 0.05) generally disappeared within-schools, as a consequence of the between-schools differences in age. Correspondingly, mean differences between female and male trainees on Supportiveness ($p = 0.01$) and Kindness ($p = 0.03$) reflected the differences between CBT and PA students in sex distributions.

Are there differences in self-confidence as a therapist at different stages of training?

In line with our hypothesis another MANOVA showed a significant main effect of stage in training, F (4; 236) = 2.51, $p = 0.04$, with significantly decreasing Stress scores, F (2; 119) = 7.72, $p = 0.02$, but no clear trend for Healing, F (2; 119) = 3.14, $p = 0.10$. This pattern did not differ among the schools – the school by stage 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, $p = 0.02$, whereas there were no differences on Healing. Thus, PT trainees had significantly higher scores for Stress than the PA group ($p = 0.02$) (See Table 4).

Practice patterns were calculated according to the cut-off-measures suggested by Orlinsky and Ronnestad (2005).[2] Most students experienced their psychotherapeutic practice as challenging. 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 5, which indicates the non-random pattern, χ^2 (1, $N = 133$) = 7.18, $p = 0.01$.

The distributions of practice patterns were roughly equal in the CBT and PA groups, whereas the PT trainees reported relatively more challenging work experiences. These differences were not significant, however ($p = 0.76$).

Table 4. 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)
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 (DPCCQ)[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 5. 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).

Comparing groups at different stages in training, 50% in the advanced group experienced an effective practice pattern and 39% challenging practice. Among the beginners and in the intermediate groups the rank order was reversed, with 29% and 36% effective and 57% and 55% challenging practice, respectively. Again, these differences were not significant ($p = 0.28$).

Analysis of variance (ANOVA) of the Self-doubt scale revealed no significant main or interaction effects, whether of school, stage in training, or candidate gender. However, there were substantial correlations between Self-doubt and the WIS scales, −0.42 with Healing and 0.47 with Stress ($p < 0.001$ for both). Consequently, practice patterns could be clearly differentiated by the level of Self-doubt, $F(3; 128) = 10.59$, $p < 0.001$. Besides the single disengaged candidate, the trainees 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 strength ($p = 0.06$) with practice patterns, in both cases with the lowest scores for trainees with a distressing practice pattern. To test school-specific relations between attitudes and therapeutic self-confidence, correlations were calculated between TASC-2

and WIS-scales for each school separately. For the PA students Stress correlated with Adjustment (0.34) and inversely with Irrationality (−0.31) while Healing correlated with Supportiveness (0.28). PT trainees had higher Healing with higher Insight (0.38) and Kindness (0.44). For CBT trainees there were significant correlations for Healing and Adjustment (0.33) as well as Supportiveness (0.32). Furthermore, Stress correlated with Neutrality (0.46).

As might stand to reason, self-rated competence correlated significantly with Healing (0.42), Stress (−0.30), and Self-doubt (−0.42). The number of students 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'). Neither school, nor age had any unique effect on competence ratings.

'Unconfounding' the variables

No doubt, a host of variables are confounded with the theoretical orientation of the candidates in the different groups. Therefore, the attitudinal differences may not be explained by mere theoretical orientation. To explore the relative contributions of various other background factors but the attitude scales, we explored their interaction using a chi-square automatic interaction detection procedure (SI-CHAID 4.0; Magidson, 2005). Based on the chi-square statistic, controlling for the associations between the variables, SI-CHAID explores, in a stepwise procedure, to what extent they, in combination, may predict membership in the candidate groups. The result is visualized in a tree structure accounting for as much of the between-classes differences as possible, given the associations between the covariates. Unless specified otherwise all references to significant associations use the $p < 0.05$ (two-tailed) level. Besides the TASC-2 scales, except Pessimism, each categorized in five step scales, the following variables were entered: candidate's age and sex, his or her academic degree and additional qualifications, his or her additional psychotherapeutic degrees, present stage in training, experience with patient work, self-rated competence, and practice pattern. Significant main effects by chi-square tests (<0.001 to <0.027) were obtained for all variables except academic and therapeutic qualifications and self-rated competence. Taking the associations between the variables into account, the entire candidate sample was split, first, on their Supportiveness scores, as shown in Figure 2. Candidates low on Supportiveness were further split on Insight, whereas those high on Supportiveness were split on Adjustment. On the next level candidates with sub-maximal scores on Adjustment were split on Insight and, finally, those with higher than minimum scores on Insight were split on their additional psychotherapeutic qualifications, which made a locally significant difference in this particular group. Thus, taking the background variables into account as well, the differences among the candidates in different theoretical schools were basically related to the TASC-2 scales, Supportiveness, Insight, and Adjustment. Whereas the PA candidates were primarily found in the group with low scores on Supportiveness and

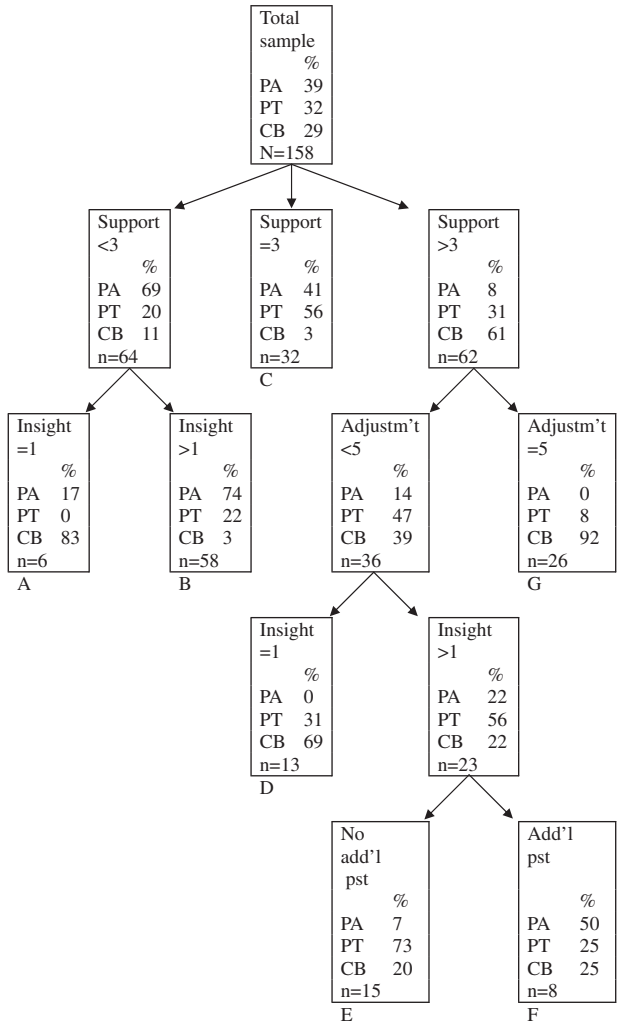

Figure 2. Tree diagram describing significant ($p < 0.05$) splits of the total sample on background factors and attitudes. (Add'l pst and No add'l pst = The candidate has or has not additional, previous psychotherapeutic qualifications).

higher scores (2–5) on Insight (Segment B; 74%), CBT candidates were more heterogeneous, being over-represented among those low on Supportiveness and Insight (Segment A; 83%), or among those high on Supportiveness and Adjustment (Segment G; 92%), or among those high on Supportiveness, sub-maximal (1–4) on Adjustment and low on Insight (Segment D; 69%). Finally, the PT candidates were found, predominantly, on medium levels of Supportiveness (Segment C; 56%), or high on Supportiveness, low on Adjustment, high on Insight, and with no additional psychotherapeutic qualifications (Segment E; 73%).

Table 6. Qualitative categories from the open question: Why did you choose your theoretical orientation?

	PA $n=47$	PT $n=45$	VT $n=39$	RO $n=2$	Total $n=131$
Experiences of personal therapy	9	4	1	0	14
Occupational experiences	0	2	0	2	2
University experiences	0	2	6	0	8
I want to allow changes for patients	14	6	5	3	25
Convinced about the school's concepts and efficacy	26	20	19	5	65
Personal fit	10	6	8	4	24
Wish to understand others	12	8	5	4	25
Self-fulfillment	9	4	1	2	14
Therapy as a precious experience	0	4	0	0	4
Curiosity	6	2	0	0	8
Critical towards other schools	9	9	2	1	20
Career perspectives	7	10	14	2	31
Financial reasons	1	2	7	0	10
Can learn competencies	3	12	14	4	29
Occupational aptitude	4	1	2	1	7
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

'Why did you choose your theoretical orientation?'

One hundred and thirty-one participants answered the question why they had chosen their specific theoretical orientation. Their answers could be assigned to 17 different categories, as shown in Table 6. 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 man (65 instances in all). Twenty-four trainees also felt that there was a 'personal fit' with their school's concepts. Students in the different schools varied in the weighing of financial and labor market reasons for their choice. This was relatively more frequent among CBT trainees (but also PT ones) than among PA trainees. 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.

Discussion

In sum, our results suggest that there are wide attitudinal differences between trainees of different schools. These differences are more or less independent of the obvious background differences that also exist between candidates of different schools. Deviations from the school norms are more frequent among PA and PT trainees. The attitudes do not differ with stage in training in each school. Most trainees 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 students and therapists, Adjustment and Supportiveness are favored by CBT trainees and psychotherapists. The middle-of-the-road position of PT psychotherapists can also be found in our trainee 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. The internal consistency of the subscales irrationality and artistry did not reach the required criterion of Cronbach's α of 0.7, which might reflect that these constructs are not consistently measurable in trainee populations. 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 schools, 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 et al. (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 trainees, whereas the CBT students 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 trainees would be more orthodox in their therapeutic attitudes during training than experienced psychotherapists seems correct.

Since there was no interaction between stage in 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 (CBT versus PT) 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 differences between training stages 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. Consequently, 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 trainees rather emphasized the influence of university lectures.

High scores of the students' 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 trainees. 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 supervised cases; trainees 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 trainees' own creativity (Kernberg, 1996). This led to the expectation that PA trainees would differ in self-doubt, competence and work involvement from other schools, but this was not supported in this study. In fact, PA trainees reported similar Healing and Stress scores as CBT students. Only the PT trainees 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 trainees occupy a position in between those of CBT and PA students. Only when Insight is concerned, PT trainees tend to take a clearer psychoanalytic stance. The higher amount of challenging practice, that is, higher Stress, may be a result of – or result in – more 'eclectic' attitude profiles, endorsing both CBT- and PA-typical attitudes. In their qualitative answers PT trainees 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 German psychotherapy guidelines as a therapy school, with no long tradition of its own, may also contribute to less differentiated attitudes among PT trainees.

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 because of 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 trainees base their therapeutic style on atypical school-attitudes, however, they do tend to have higher Stress scores (PA students on Adjustment, CBT students on Neutrality). Unfortunately, the relation between positive Work Involvement and therapy outcome, which could contribute nicely to this discussion, is yet to be determined.

Besides the substantial non-response rate, a critical limitation to conclusions about change during training on the basis 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 trainees to participate in such a study.

Acknowledgement

Financial support by Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie (DGPT) and Deutsche Psychoanalytische Gesellschaft (DPG) is herewith gratefully acknowledged. We also want to thank the participating institutes for their generous support.

Notes

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.

References

Ambühl, H., Orlinsky, D.E., & 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* (4th ed., pp. 259–269). New York: Wiley.

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

Bischoff, R.J., Barton, M., Thober, J., & Hawley, R. (2002). Events and experiences impacting the development of clinical self confidence: A study of the first year of client contact. *Journal of Marital Family Therapy, 28*(3), 371–382.

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, Université 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 Program. *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.

Hill, C., Knox, S., & Schlosser, L.Z. (2007). Becoming psychotherapists: Experiences of novice trainees in a beginning graduate class. *Psychotherapy Research, 44*, 434–449.

Hill, C., & Lent, R.W. (2006). A narrative and meta-analytic review of helping skills training: Time to revive a dormant area of inquiry. *Psychotherapy Research, 43*, 154–172.

Howard, E.E., Inman, A.G., & Altman, A.N. (2006). Critical incedents among novice counselor trainees. *Counselor Education and Supervision, 46*, 88–102.

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

Kernberg, O. (1996). Thirty methods to destroy the creativity of psychoanalytic candidates. *International Journal of Psychoanalysis, 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., Imbers, S., & Pilkonis, P. (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.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.

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

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., 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 Psychotherapy, 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.

Skovholt, T.M., & Ronnestad, M.H. (1992). *The evolving professional self: Stages and themes in therapist and counselor development*. New York: Wiley.

Stehle, S., Dilg, R., & Kelter, W. (2004). Psychotherapeutische Berufstätigkeit. Ergebnisse der DGPT-Therapeutenerhebung. In A. Gerlach, A. Schlösser, & A. Springer (Eds.), *Psychoanalyse des Glaubens* (pp. 495–514). 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.

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.

Williams, E.N., Judge, A., Hill, C., & Hoffman, M.A. (1997). Experiences of novice therapists in prepracticum: Trainees', clients' and supvervisors' perceptions of therapists' personal reactions and management strategies. *Journal of Counseling Psychology, 44*, 390–399.

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