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THERAPIST ATTITUDES AND PATIENT OUTCOMES: I. DEVELOPMENT AND VALIDATION OF THE THERAPEUTIC ATTITUDES SCALES (TASC-2)

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The aims of the study were to develop and standardize, using a random sample of licensed psychotherapists in Sweden, an instrument to explore therapeutic attitudes. Nine factors were extracted and cross-validated from Therapeutic Identity, a comprehensive questionnaire. The factor scales predicted with considerable accuracy self-designated theoretical orientations of the therapists and were associated with therapists' level of experience. A cluster analysis of the therapists on the basis of the factor scales revealed interesting variations, particularly within the psychodynamic and eclectic parts of the spectrum of therapeutic attitudes.

During the history of psychotherapy research, several scholars have devised inventories to assess therapists' values and beliefs in therapeutic matters. These therapeutic attitudes, as we call them, may reflect the backdrop against which the relationship evolves, the interventions are staged, and the patient responds. This tradition was probably initiated by Fiedler (1950a, 1950b) and continued by, among others, Sundland (1977; Sundland & Barker, 1962), Wallach and Strupp (1964), McNair and Lorr, (1964), Fey and Rice (Fey, 1958; Rice, Fey, & Kepecs, 1972; Rice, Gurman, & Razin, 1974), Weissman, Goldschmid, and Stein (1971), Wogan and Norcross (1983, 1985), and the Collaborative Research Network within the Society for Psychotherapy Research (SPR), initiated by Orlinsky (Ambühl, Orlinsky, & SPR Collaborative Research Network, 1997; Orlinsky et al., 1999). Typically, therapists of different theoretical persuasions are surveyed by questionnaires and compared on a number of dimensions, often derived by factor analytic procedures. Following Fiedler, differences in theoretical orientation are frequently compared with levels of therapeutic experience in terms of explained variance in therapeutic attitudes.

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Different instruments tend to suggest different conclusions. Those focusing on relationship dimensions tend to favor the importance of experience, whereas those focusing on therapeutic goals and technical aspects tend to favor the importance of theoretical orientation. This conclusion of Pope (1977) found support in the 1997 study by Ambühl et al. One lesson from previous research, thus, is that the exploration of therapeutic attitudes has to be multidimensional and wide in scope to reflect theoretical as well as experience-based convictions. Basic philosophical assumptions of ontological and epistemological nature (Vasco & Dryden, 1994; Vasco, Garcia-Marques, & Dryden, 1993) may be as influential in differentiating among psychotherapists as ideas about the goals of psychotherapy (Ambühl et al., 1997), technical preferences (Wogan & Norcross, 1983, 1985), and relationship ideals (Fiedler, 1950a, 1950b).

Apart from the SPR Common Core Questionnaire (CCQ; Orlinsky et al., 1999), which only distantly explores what we define as therapeutic attitudes, there has been no instrument surveying therapeutic attitudes available in Swedish. The purpose of the current study was to develop and standardize such an instrument in the Swedish language to later relate therapeutic attitudes to other variables. The fulfillment of the latter purpose will be reported in a forthcoming article. Based on preliminary analyses, an initial and somewhat different set of scales has been presented by Grant and Sandell (2004) as the Therapeutic Attitudes Scales (TASC). The scales offered here as TASC-2 have been refined and redefined on the basis of the further analyses reported here.

Method

The Questionnaire

The 15-page questionnaire, Therapeutic Identity (henceforth called ThId[1]) contained about 150 items, divided in six sections. The first three sections assessed (a) demographics and academic and professional training (age; gender; graduate education; psychotherapeutic training for licensing purposes; auxiliary psychotherapeutic training more than 1 year; formal supervisory training; academic training or professional training outside psychology or psychotherapy; membership in professional associations); (b) professional experience (duration of psychotherapy practice; clinical experience in different settings; accumulated case load in different categorizations; supervision taken or given in the past 12 months); (c) personal therapy or training analysis (number of rounds; kind of therapy; frequencies; durations); (d) allegiance to four major schools of psychotherapy—psychoanalytic, cognitive, behavioral, and eclectic—using a set of four items, with ratings ranging from 0 (*not at all*) to 4 (*very strong*). A fifth, open alternative was also available for the respondent to use with discretion, and a yes–no question was included after the psychoanalytic item to interrogate whether the therapist's psychoanalytic allegiance was differentiated on different schools. The items in these sections were designed specifically for the project or adopted from the CCQ (Orlinsky et al., 1999).

Sections e and f of the ThId had three sets of items to explore the therapists' therapeutic attitudes (Grant & Sandell, 2004). The first of these sections had two sets of items. One of them (e:1) had 33 items to rate belief in the curative value of

[1]The Therapeutic Identity (ThId) questionnaire is available in English, Spanish, German, and Swedish editions from Rolf Sandell.

a number of ingredients of psychotherapy (e.g., Helping the patient avoid anxiety-provoking situations). The items were rated on 5-point, Likert-type scales, ranging from 0 (*does not help at all*) to 4 (*helps a lot*). The items were collected from various sources: experiences of the authors, suggestions from colleagues, theoretical literature, and earlier instruments (Rice et al., 1974; Sundland & Barker, 1962; Wallach & Strupp, 1964; Weissman et al., 1971)

The second set in this section (e:2) had another 31 items to describe manner of conducting psychotherapy in general (e.g., "I do not answer personal questions from the patient"). These items were also rated on 5-point scales, from 0 (*do not agree at all*) to 4 (*agree very much*). Again, the items were of our own design on the basis of experience, suggestions from colleagues, theoretical literature, or adaptations and translations of items from earlier instruments (Rice et al., 1974; Sundland & Barker, 1962; Wallach & Strupp, 1964; Weissman et al., 1971).

The following section (f:1) contained 16 items relating to more basic assumptions about the nature of psychotherapy and the nature of the human mind ("What are your general beliefs about the human mind and about psychotherapy?"). The items were inspired by Hjelle and Ziegler (1981), Sundland and Barker (1962), and Wallach and Strupp (1964). The rating scales were continuous bipolar scales; each of the poles offered a completion of the item stem (e.g., "Psychotherapy may be described . . . as a science—as a form of art"). The respondents were instructed to indicate their agreement on the continuum by a cross mark. Five-step scores were derived by partitioning the line in five equal parts.

Finally, as the second part of this final section, a number of open-ended questions on the respondents' subjectively felt strengths and difficulties as a therapist, in part taken from the CCQ (Orlinsky et al., 1999), concluded the ThId.

Participants

National sample. In fall 1995 the ThId was mailed to a random sample of 325 psychotherapists throughout Sweden. All were licensed by the National Board of Health and Welfare, and the sampling was done on the basis of its roster. After three reminders, 227 had responded (70%). Among the nonrespondents, there was significant overrepresentation of therapists in the higher age categories, of which some returned their questionnaires with comments that they had retired from regular professional activity and, therefore, refrained from answering the questions.

A fuller account of the background of the therapists is offered by Sandell et al. (2002). The majority of the respondents were female (68%), between 50 and 54 years of age (39%), and psychologists (62%). If we consider the training that was the basis for the therapists' license, the vast majority (69%) graduated from a training institute with a psychodynamic orientation either in a university setting or at extra-university training sites. Twelve percent had family therapy training, irrespective of theoretical orientation, and 5% had formal psychoanalytic training at one of the two institutes in Sweden. Not more than 4% had training in cognitive, behavioral, or cognitive–behavioral therapy. More than half (55%) had additional training in more specific psychotherapeutic approaches after their licensing (e.g., hypnotherapy, symbolic drama), and 43% had formal training as supervisors.

The average length of practice as a therapist was as long as 17 years, longer before licensing (M=10.7, SD=6.5) than after (M=6.6, SD=4.2). The mean number of years providing psychotherapy in outpatient psychiatry was 8.9 (SD=7.8) years; inpatient psychiatry, 2.6 (SD=5.1) years; and private practice, 5.5 (SD=6.5) years.

More than half of the therapists (57%) had an accumulated case load of more than 50 patients over the years. More than half (54%) had been in regular supervision during the past 12 months, and more than half (53%) had supervised colleagues regularly in the last year. Personal therapy is compulsory for a therapist license in Sweden, and the average therapist had been in personal therapy more than twice, for a total of almost 8 years (M=7.9, SD=3.6), most frequently in individual psychodynamic psychotherapy (61%) or psychoanalysis (21%).

Cross-validation sample. To cross-validate several analyses, primarily the factor analytic findings, we also used data from therapists participating in the Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPP). The pool was 294 therapists and analysts who had patients in that project. All were licensed by the National Board of Health and Social Welfare and living in the Stockholm area. These therapists were predominantly of psychodynamic or eclectic orientations, and some were fully trained psychoanalysts, members of either of the two psychoanalytic societies in Sweden. The ThId was distributed to all STOPPP therapists at the same time as the national sample. After four reminders, 209 (71%) had returned their questionnaires. Analyses of the attrition showed no systematic sources of nonresponse. This sample is henceforth called the treatment provider sample (or provider sample).

Results

Beliefs About Curative Ingredients

The 33 items in Section e:1 of the ThId were initially subjected to a principal-components analysis. Eight components had eigenvalues >1 and accounted for 48.1% of the total variance. With 33 items, however, the eigenvalue >1 criterion was considered too liberal because a component or factor may then account for as little as 3% of the total variance. Three components had eigenvalues >2. We undertook a series of exploratory factor analyses with various methods and criteria for extraction, including the scree test. After cross-validating the solution in the treatment provider sample, we concluded that three components were stable and interpretable. The scree test also supported the three-factor option. After varimax rotation of the principal components, the squared loadings accounted for 41.4% of the total variance. The highest loading items (>|.40|) for each factor are displayed in Table 1, with the associated internal consistencies of the factorwise means of the items. Three items had no loadings >|.40| on any factor. As cross-validation indexes, we also display the across-items correlations with the loadings in the provider sample.

The items that loaded heavily on the first factor indicate various strategies, tactics, and interventions to promote the patient's coping with everyday life by means of deliberate control over and coping with outer and inner pressures. In apparent contrast, the second factor subsumed items indicating an assortment of strategies, tactics, and interventions that are rather classic examples of psychodynamic attempts to uncover, clarify, and interpret what is assumed hidden or repressed. What seems to be particularly emphasized is work on development-conditioned contributions to pathogenesis in the form of repetition compulsion and early trauma and early transference. If we consider this a strategy to confront and uncover problems, the strategy

TABLE 1. Curative Factors ("What Do You Think Contributes to Long-Term and Stable Therapeutic Change?")[a]

Factor	I. Adjustment	II. Insight	III. Kindness
e:1:10. Giving the patient concrete goals	.76		
e:1:12. Working for the patient's adjustment to prevailing social circumstances	.68		
e:1:1. Stimulating the patient to think about his problems in more positive ways	.64		
e:1:9. Helping the patient to avoid repeating old mistakes	.62		
e:1:13. Helping the patient avoid anxiety-provoking situations	.58		
e:1:25. Working with the patient's symptoms	.56		
e:1:6. Giving the patient concrete advice	.55		
e:1:26. Helping the patient adapt or adjust to his/her symptoms	.55		
e:1:29. Helping the patient become reality-oriented	.50		
e:1:2. Helping the patient control his/her emotions	.50		
e:1:11. Letting the therapist take the initiative and lead the sessions	.48		
e:1:8. Educating the patient about his/her symptoms and psychic problems	.45		
e:1:5. Helping the patient forget painful experiences	.44		
e:1:22. Helping the patient see the connections between his/her problems and childhood		.68	
e:1:28. Working with the patient's defenses		.68	
e:1:17. Helping the patient understand that old reactions and relations are being repeated with the therapist		.67	
e:1:16. Helping the patient understand that old behavior and relations are being repeated		.66	
e 1:32. Bringing the patient's sexuality to the fore		.66	
e:1:33. Helping the patient remember and confront possible sexual abuse		.64	
e:1:18. Supporting the patient in the therapy to reflect on early painful experiences		.61	
e:1:30. Interpreting the patient's body language		.60	
e:1:19. Giving the patient the opportunity to work with his/her dreams		.59	
e:1:4. Working with the patient's childhood memories		.58	
e:1:14. Helping the patient clarify his/her feelings		.54	
e:1:31. Letting the patient act out his/her feelings (catharsis)		.46	
e1:21. Being a warm and kind therapist			.76
e:1:24. Making the patient feel well liked by the therapist			.76
e:1:3. Consideration and good care-taking			.64
e:1:23. Supporting and encouraging the patient	.52[b]		.60
e:1:20. Letting the patient get things off his/her chest			.58
Trace (%)	16.8	15.3	9.3
Correlation with treatment provider sample	.92	.85	.86
Internal consistency (α)	.83	.87	.82

[a]Eigenvalues >2; items with loadings >|.40| after principal–components extraction and varimax rotation; 41.4% of total variance explained.

[b]The item was not included in the subscale.

implied by the first factor might perhaps be considered as adjustment to circumstances. We suggest using these concepts to designate the factors (i.e., *adjustment* for the first factor and *insight* for the second).

The items of the third factor obviously refer to various ingredients of a friendly social relationship rather of the kind that Bordin (1979) may have had in mind in referring to the bond component of therapeutic alliance. We call this subscale *kindness*.

Attitudes Toward Therapeutic Approaches

Nine principal components with eigenvalues >1 accounted for 57.9% of the total variance. Again, it was found, after various exploratory analyses and cross-validation in the provider sample, that only three components with eigenvalues >2 were consistently interpretable. This number was also clearly supported by the scree test. These factors accounted for 32.1% of the total variance. The items with loadings >|.40| after varimax rotation are displayed in Table 2, together with the internal consistencies of the mean scores across the items loading each factor. Six items did not load >|.40| on any factor. As cross-validation indexes, we also display the across-items correlations with the loadings in the provider sample.

The first factor collected a number of tactics of the type usually called *neutrality*. This factor essentially replicates the personal distance factor of Wallach and Strupp (1964) and Wogan and Norcross (1983). It has been suggested as one of the basic dimensions of therapist activity, the ideological (Sundland, 1977) or analytic versus experiential (Sundland & Barker, 1962) dimension.

The second factor involved various ways of the therapist to try to help the patient by ordering, structuring, prompting, questioning, and encouraging the patient. It also involves being explicit about the goals of treatment and not provoking emotional confrontations. The meaning of this factor, which we call *supportiveness*, is highlighted by an item that also loaded, negatively, on neutrality: "If a patient asks, I might agree to talk with one of his/her relatives."

The third factor is somewhat problematic both in terms of interpretability and internal consistency. After some hesitation we decided to keep the factor for two reasons. First, the same component was clearly identified in the treatment provider sample; the 10 highest loading items were identical in the national sample and the treatment provider sample, and of the 8 highest loading items in each sample 6 were common to both, which indicates a significant salient variables similarity index ($p < .01$; Cattell & Baggaley, 1960). The loadings correlated $r = .57$, $p = .01$, across items. Second, the scree test clearly supported a third factor. This indicates that the factor was not a chance occurrence. The low internal consistency is partly an effect of the small variance in the factor scores. The items seem mainly to reflect weak self-confidence, with experiences of limitations, doubts, obstacles, and difficulties. We choose to call the factor *self-doubt*.

Basic Assumption and Beliefs About Psychotherapy

The 16 items were initially subjected to a principal-components analysis. Five components had eigenvalues >1 and accounted for 54.8% of the total variance, and two had eigenvalues >2. After a series of exploratory runs with various methods and criteria for extraction, running the scree test, as well as comparing the components with those found in the outcome sample, we concluded that three factors were stable and interpretable. These accounted for 40.4% of the variance. Items

TABLE 2. Therapeutic Style Factors ("What Are You Like as a Therapist?")[a]

Factor	I. Neutrality	II. Supportiveness	III. Self-doubt
e:2:8. I keep my personal opinions and circumstances completely outside the therapy.	.67		
e:2:4. I do not answer personal questions from the patient.	.67		
e:2:3. I do not express my own feelings in the sessions.	.63		
e:2:5. My verbal interventions are brief and concise.	.59		
e:2:11. I am more neutral than personal in therapy.	.59		
e:2:17. My countertransference is an important instrument in my work.	.54		
e:2:6. If a patient asks, I might agree to talk with one of his/her relatives .	−.51[b]	.40[c]	
e:2:22. Keeping the therapeutic frame is fundamental in my work.	.50		
e:2:13. I want the patient to develop strong feelings in the therapy.	.50		
e:2:29. I avoid physical contact with the patient.	.48		
e:2:19. I often put questions to the patient.		.62	
e:2:26. I always communicate the therapeutic goals to the patient in the beginning of a therapy.		.61	
e:2:27. I always make the therapeutic goals explicit to myself during a therapy.		.61	
e:2:16. It is important to order and structure the material.		.60	
e:2:10. I have a positive attitude towards extra sessions.		.55	
e:2:21. It is important to convey hope to the patient.		.52	
e:2:1. I am active in sessions.		.48	
e:2:12. I do not want the patient to develop strong feelings towards me as a person.		.46	
e:2:15. It is important to show my empathy with the patient's problems.		.45	
e:2:28. I do best with patients who are similar to myself.			.62
e:2:25. My involvement with the patient's life goals is an obstacle to therapeutic work.			.53
e:2:24. I doubt my own ability to contain the patient's feelings.			.50
e:2:7. I do not allow long periods of silence during the therapy session.			.49
e:2:2. I find it difficult to deal with the patient's aggression.			.44
e:2:18. I easily frustrate the patient.			.44
Trace (%)	12.7	11.9	7.5
Correlation with treatment provider sample	.87	.88	.57
Internal consistency (α)	.77	.75	.50

[a]Eigenvalues >2; items with loadings >|.40| after principal–components extraction and varimax rotation; 32.0% of total variance explained.

[b]The item has reversed score in the subscale.

[c]The item was not included in the subscale.

TABLE 3. Basic Assumptions Factors[a]

	I. Irrationality	II. Artistry	III. Pessimism
f:3:1. By nature, man is . . . rational/irrational.	.79		
f:4:1. Human behavior is governed . . . by free will/by uncontrollable factors.	.71		
f:4:2. Human behavior is governed . . . by external, objective factors/internal, subjective factors.	.63		
f:2:6. Psychotherapeutic work is governed by . . . conscious processes/unconscious processes.	.57		
f:1:1. Psychotherapy may be described . . . as a form of art/as a science.		−.68[b]	
f:1:2. Psychotherapy may be described . . . as a craft/as free creative work.		.61	
f:2:3. Psychotherapeutic work is governed by . . . relativistic views/absolute convictions.		−.56[b]	
f:2:1. Therapeutic work is governed . . . by training/by personality.		.53	
f:2:2. Psychotherapeutic work is governed by . . . intuition/systematic thinking.		−.53[b]	
f:7:1. The underlying principles of human behavior are . . . completely understandable/not at all understandable.			.67
f:8:1. Humans may develop . . . infinitely/not at all.			.66
f:2:4. Psychotherapeutic work is governed by the idea . . . that everything may be understood/that not everything may be understood.			.61
f:5:1. Personality is formed by . . . heredity/environment.			−.57[b]
f:6:1. Personality is fundamentally . . . changeable/unchangeable.			.56
Trace (%)	14.3	13.4	12.7
Correlation with treatment provider sample	.90	.92	.92
Internal consistency (α)	.67	.57	.57

[a]Eigenvalues >1; items with loadings >|.40| after principal–components extraction and varimax rotation; 40.4% of total variance explained.

[b]The item score is reversed in the subscale.

with loadings >|.40| on any factor after varimax rotation are displayed in Table 3 along with the internal consistencies. Two items did not load >|.40| on any factor. As cross-validation indexes, we also display the across-items correlations with the loadings in the provider sample.

The items loading on the first factor contain words like *irrational, subjective, unconscious*, and *uncontrollable*. Obviously, the issue here is the therapist's view of the human nature in one fundamental respect: To what extent are humans in conscious control of themselves? The factor is consequently called *irrationality*. The scale had low internal consistency.

The issue reflected in the second factor is whether psychotherapy is an art or a set of learnable skills. To the extent that one considers it an art, one will believe in the indispensable values of therapist talent, intuition, and inspiration. At the same time, intellectual understanding of theoretical principles and training of concrete

skills will be looked on as insufficient educational means. We have reversed the scoring of the items in this factor and call it *artistry*. The internal consistency was again quite low.

The third factor appears to reflect attitudes of both ontological and epistemological character. Basically, the division is between an optimistic belief in the possibilities of development, change, and understanding versus a rather more pessimistic fatalism. We call the factor *pessimism*. As with the previous scales, internal consistency was low.

Interrelations Among the Subscales

Factor loadings <|.40| contribute to correlations between the subscales. Instead of giving these low loadings in the tables, we offer the correlations among the subscales in Table 4. They appear to cluster the scales in three groups. Adjustment, supportiveness, and kindness formed one group, insight and neutrality a second, and both clusters were fairly cohesive, with intercorrelations >.4. The variables in the one group, in general, were negatively correlated with those in the other. Artistry and irrationality correlated more strongly (.34) with each other than with any other scale and may, therefore, be considered a third group. Pessimism and self-doubt had only weak correlations with the other variables.

Relations Between Therapeutic Attitudes and Demographic Characteristics

The significant associations between the primary factors and therapist gender or age were few and quite weak, either one accounting for less than 5% of the variance in therapeutic attitudes. Sex had a weakly significant multivariate effect, $F(9, 205) = 1.99$, $p = .04$; female therapists had slightly higher scores on neutrality and insight.

Relations Between Therapeutic Attitudes and Theoretical Orientation

The four self-rating scales of theoretical orientation (Section d; psychoanalytic, cognitive, cognitive–behavioral, and eclectic) were correlated with the nine therapeutic attitude scales in a canonical correlation analysis. Instead of a detailed account for canonical correlations and loadings to support the general validity of the scales, we only report the main findings. The four canonical variates jointly accounted for 72.2% of the variance in both sets together. The first canonical correlation was .710, $\chi^2(36, N = 224) = 203.73$; the second .362, $\chi^2(24, N = 224) = 52.24$, both ps < .01. Generally important in contributing to the multivariate canonical correlations were adjustment (bivariate $r = .47$ with behavioral and .43 with cognitive orientations), insight (bivariate $r = .41$ with psychoanalytic orientation), supportiveness (bivariate $r = .47$ with cognitive, −.41 with psychoanalytic, .40 with behavioral orientations), and artistry (no univariate r > |.20|, probably important as a suppressor).

Relations Between Therapeutic Attitudes and Therapeutic Experience

We also conducted a canonical correlation analysis between the therapeutic attitude factors and a number of experience-related variables that were selected on the basis of a previous study of the dimensionality of therapeutic experience (Sandell et al., 2002): number of years in psychotherapy practice after licensing; supervisor training; psychoanalytic training; total number of sessions of personal therapy; age;

TABLE 4. Correlations Among the Therapeutic Attitudes Subscales

	Adjustment	Supportiveness	Kindness	Neutrality	Insight	Self-doubt	Irrationality	Artistry
Supportiveness	.68**							
Kindness	.47**	.43**						
Neutrality	−.33**	−.25**	−.11					
Insight	−.12	−.10	.21**	.41**				
Self-doubt	.01	.00	.09	.01	.04			
Irrationality	−.31**	−.25**	−.18*	.13	.05	.03		
Artistry	−.11	−.09	.06	−.07	.09	.04	.34**	
Pessimism	.15*	.12	.11	−.08	−.11	.11	.05	.06

*$p < .05$, two-tailed. **$p < .01$, two-tailed.

number of years in psychotherapy practice before licensing; accumulated number of patients in individual psychotherapy; training in behavioral/cognitive–behavioral therapy or cognitive therapy. Again, we only report the strength of the overall relation and some of the bivariate correlations. The eight canonical correlations together accounted for 74.0% of the total variance, and the first canonical correlation was .531, $\chi^2(72, N=222)=150.21$, the second .460, $\chi^2(56, N=222)=92.67$, both $ps<.01$. No therapeutic factor was generally predictive, but adjustment (bivariate correlation=−.34 with psychoanalytic training), insight (bivariate $r=-.28$ with cognitive–behavioral training), supportiveness (bivariate $r=-.33$ with psychoanalytic training, −.32 with length of personal therapy), and artistry (bivariate $r=-.25$ with cognitive/behavioral training) again correlated the strongest with the first canonical variate.

Interaction Between Theoretical Orientation and Therapeutic Experience

Fiedler's (1950a) main conclusion was that, with increasing experience, the therapeutic attitudes became more similar across different theoretical orientations. We tested this by repeating, in two different groups, a multivariate analysis of variance with a classification based on highest self-rated theoretical orientation as the independent variable and the nine therapeutic attitudes scales as dependent variables. One group was a highly experienced group, with supervisor training and more than 8 years of postlicense practice ($M=11.1$; $n=69$). The second group had no supervisor training and less than 5 years postlicense practice ($M=2.3$; $n=57$).

In the more experienced group, the multivariate effect of theoretical orientation was not significant, $F(27, 132)=1.29$, $p=.17$. In the less experienced group, there was a significant multivariate effect, $F(27, 161)=1.75$, $p=.02$. Univariately significant effects were found for adjustment ($p<.01$; behavioral high, psychoanalytic low), supportiveness ($p<.02$, cognitive high, psychoanalytic low), neutrality ($p<.01$; psychoanalytic high, behavioral low), and insight ($p<.01$; psychoanalytic high, cognitive low). The difference between the more and less experienced groups supports Fiedler's findings. However, this may only generalize to the psychoanalytic and the eclectic orientations because the frequencies of therapists with behavioral and cognitive orientations were too low.

Assignment of Theoretical Orientation on the Basis of Therapeutic Attitudes

An interesting issue is the extent to which therapists' self-reported theoretical orientation is congruent with theoretical assignment based on their therapeutic attitudes. We began to explore this question by performing a cluster analysis of therapists on the basis of their scores on the nine therapeutic attitudes factors. Anderberg's (1973) nearest neighbor method was used, and solutions with different numbers of clusters were compared. We found four clusters to offer a reasonable balance between too differentiated and too coarse solutions. The mean z-score profiles of the clusters across the nine therapeutic attitude scales are displayed in Figure 1, along with the percentage of each cluster. It should be noted that the differences between the groups are standardized and thus correspond to effect sizes.

There were two clusters with clearly contrasting profiles, together including more than half of the sample. In relation to each other, one of them (Cluster 2) had quite low scores on adjustment, supportiveness, and kindness, whereas the other

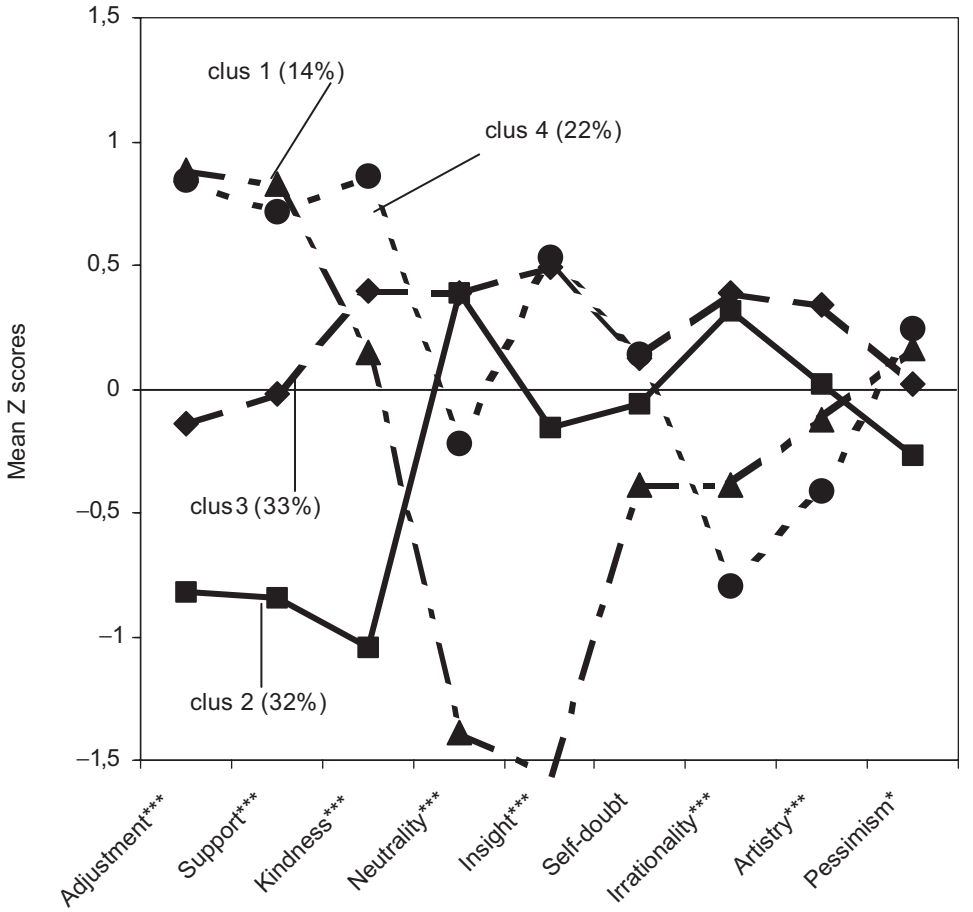

FIGURE 1. Mean cluster profiles (in standard scores) across therapeutic attitudes factors in a national random sample ($N = 227$). *$p < .05$; ***$p < .001$.

(Cluster 4) graphically rather mirrored the first, with particularly high scores on adjustment, supportiveness, kindness, and insight and low scores on irrationality and artistry. Whereas the first absorbed 32% of the therapists, the second comprised 22%.

Cluster 3 had another 33% of the therapists and had higher z scores than 0 on all variables except adjustment and supportiveness. The mean scores were particularly high on neutrality, insight, irrationality, and artistry. Finally, 14% of the therapists were in a cluster (Cluster 1) with high scores on adjustment and supportiveness and extremely low scores on neutrality and insight.

The interpretation of the clusters was based on their associations with the self-designated theoretical orientation of the therapists and with their professional training. Thus, we interpreted Cluster 2 as a clearly psychoanalytic cluster, with significant overrepresentations (Haberman, 1978) of therapists with psychoanalytic training and training in group therapy. It also seemed obvious to interpret Cluster 1 as a behavioral/cognitive–behavioral cluster, with significant overrepresentations of therapists with training in such modalities, and in family therapy. The interpretation of Clusters

3 and 4 was less obvious. On the basis of their profiles and the patterns of over- and underrepresentation in self-designation and training categories, we suggest considering therapists in Cluster 3 as eclectic therapists with a vague psychodynamic inkling. Cluster 4 also appeared to comprise therapists with an eclectic orientation, albeit with a more cognitive perspective.

Discussion

Basically, the current set of attitude factors replicate previous findings of associations with theoretical orientation, therapist gender, and various indicators of therapeutic experience, such as age, personal therapy, and training (e.g., Sundland, 1977; Wogan & Norcross, 1983, 1985), thus supporting the validity of the factors.

Interesting as bivariate associations may be, however, it seems to us that the most interesting findings in the current study came from the clustering of the therapists. The four clusters reveal some interesting findings. First, as has been noted for American samples (Norcross, Prochaska, & Farber, 1993; Wogan & Norcross, 1985), the majority of therapists in Sweden (55%) should be viewed as eclectics, when their attitudes are considered, although not more than 24% designated themselves as such. Indeed, the majority (65%) designated themselves as psychoanalytically oriented. Likewise, there were many more therapists in the cognitive–behavioral and the cognitive eclectic clusters (36%) than there were self-designated cognitive–behaviorists or cognitivists (12%). Although the association on the individual level between self-designation and assignment based on attitudes was fairly strong and significant, as has also been found by Herron, Ginot, and Sitkowski (1987) and Norcross et al. (1993), this suggests that self-designation concepts like behavioral, cognitive, eclectic, psychodynamic, and psychoanalytic remain ambiguous.

Consider, for instance, the terms *eclectic* and *psychoanalytic*. If eclectic refers to an orientation that selects characteristics from different schools, we have found two distinguishable varieties of eclectics in our data: one cluster leaning toward the psychoanalytic strand, the other rather toward the cognitive one. In the former cluster 77% tended to designate themselves as psychoanalytically oriented, yet their attitudes were clearly distinguishable from those of the psychoanalytics proper. For instance, the clusters differed considerably on *insight*. Whereas the dynamic eclectics place great value on it, the psychoanalytics were not as convinced about its value. Many psychodynamic or psychoanalytically oriented psychotherapists tend to emphasize this component in their own position, often referring to work on childhood events and reminiscences. In contrast, contemporary psychoanalysts are not as focused on so-called genetic reconstruction as on the here-and-now. This difference notwithstanding, the critical differences from a technical point of view may be in terms of adjustment, supportiveness, and kindness. These are qualities more characteristic of the behavioral and cognitive–behavioral therapist, which of course is why one cluster is eclectic and the other not.

A particularly interesting factor is self-doubt. It appears to have few precedents in previous research, although Sundland (1977, p. 194) mentions two factors from his 1961 study that may be related: (a) "Activity and involvement of the therapist are desirable/not desirable" and "Therapist feels very secure/admits of some insecurity." An interesting question is to what extent self-doubt is realistic and reasonable. It correlated only weakly with most experience indicators. As conjecture, we believe the factor may reflect the differences between therapists who find it difficult

to manage their involvement and identification with their patients and those who do not. An interesting feature of the factor is that it did not seem to correlate strongly with much else, yet was not a random variable. Obviously, self-doubt may be found in any grouping of therapists. For the time being, it should be taken as an interesting hypothesis to be further investigated.

Ambühl et al. (1997) concluded that the commonalities among therapists with different theoretical orientations were larger than the differences. Irrespective of orientation, in relation to their patients, many therapists wanted to be accepting, tolerant, warmhearted, friendly, involved, sharing, intuitive, effective, and skillful, and very few wanted to be cold, confused, or unhelpful. But who does not prefer the good to the evil? It is, as always, the variation that contains the information, and there is indeed variation in therapeutic attitudes among therapists. Sundland (1977, p. 216) concluded his review by recommending that specification of therapists' theoretical orientations should be standard. This was a quarter of a century ago and still it is not standard. We offer the TASC-2 scales as one step toward a remedy to this omission.

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Zusammenfassung

Die Zielsetzung der Studie war es, ein Instrument zu entwickeln, um therapeutische Einstellungen zur erkunden. Dazu wurde eine Zufallsstichprobe von in Schweden zugelassenen Therapeuten verwendet. Auf der Grundlage eines umfassenden Fragebogens zur therapeutischen Indentität wurden neun Faktoren extrahiert und kreuzvalidiert. Die faktorisierten Skalen sagten mit ziemlicher Genauigkeit die selbstbestimmte therapeutische Orientierung der Therapeuten voraus und waren verbunden mit dem Niveau des Erfolgs eines Therapeuten. Eine Clusteranalyse der Therapeuten aufgrund der Faktorskalen ergab interessante Variationen insbesondere in bezug auf die psychodynamische und eklektische Einstellung im Spektrum aller therapeutischen Orientierungen.

Résumé

Les objectifs de cette étude étaient de développer et de standardiser, à l'aide d'un échantillon randomisé de psychothérapeutes licenciés en Suède, un instrument pour explorer des attitudes thérapeutiques. Neuf facteurs étaient extraits et cross-validés du questionnaire global de l'Identité Thérapeutique. Les échelles factorielles pouvaient prédire avec une précision considérable les orientations théoriques auto-attribuées par les thérapeutes et étaient associées au niveau d'expérience des thérapeutes. Une analyse cluster des thérapeutes sur la base des échelles factorielles a révélé des variations intéressantes en particulier dans les parties psychodynamiques et éclectiques du spectre d'attitudes thérapeutiques.

Resumen

Los objetivos del estudio fueron el desarrollo y la estandarización (usando una muestra aleatoria de psicoterapeutas matriculados en Suecia), de un instrumento para explorar actitudes terapéuticas. Del cuestionaro comprehensivo de Identidad Terapéutica, se seleccionaron y *cross*-validaron nueve factores. Las escalas factoriales predijeron con una exactitud considerable las orientaciones teóricas autodeclaradas de los terapeutas y se las asoció con el nivel de experiencia de los terapeutas. Un análisis de conjunto (*cluster analysis*) de los terapeutas sobre la base de las escalas factoriales reveló variaciones interesantes, particularmente dentro de las secciones psicodinámica y ecléctica del espectro de actitudes terapéuticas.

Resumo

Os objectivos do estudo consistiam em desenvolver e estandardizar um instrumento para explorar atitudes terapêuticas, usando uma amostra randómica de psicoterapeutas credenciados na Suécia. Foram extraídos nove factores e validados a partir da Identidade Terapêutica, um questionário compreensivo. As escalas dos factores predizem com considerável precisão as auto-denominadas orientações teóricas dos terapeutas e foram associadas com os níveis de experiência dos terapeutas. Uma análise de *clusters* dos terapeutas baseada nas escalas dos factores revelou variações interessantes, particularmente nas partes psicodinámicas e eclécticas do espectro de atitudes terapêuticas.

Sommario
Gli scopi del presente studio sono stati sviluppare e standardizzare, attraverso l'utilizzo di un campione casuale di psicoterapeuti svedesi, uno strumento per valutare le attitudini terapeutiche. Da un questionario, il Therapeutic Identity, sono stati estratti e validati nove fattori . I fattori sono risultati essere predittivi con notevole accuratezza delle scelte di orientamento teorico dei terapeuti e del loro livello d'esperienza. Una cluster analysis dei terapeuti sulla base dei fattori delle scale hanno rivelato interessanti differenze, in particolare per quanto concerne le parti relative alle attitudine per terapeuti psicodinamici ed eclettici.

摘要
本研究旨在以隨機取樣的方式邀請瑞典一群有執照的心理治療師來發展與標準化一套測量治療態度的工具。共萃取出 9 個因素，並且和治療性認同（Therapeutic Identity）問卷加以交叉檢核。這個因素量表可有效預測出治療師自稱的理論取向，且和治療師的工作經驗極有關連。這些治療師以此因素量表為基礎所得出的群聚分析可看出有趣的差異情形，尤其是心理動力學派和折衷學派的治療態度更是有所不同。

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