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Therapists' therapies: The relation between training therapy and patient change in long-term psychotherapy and psychoanalysis

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Abstract
Patients' development across stages in long-term psychodynamic psychotherapy or psychoanalysis was studied in relation to various parameters of their therapists' training, or personal, therapies. The change variable was symptom distress, the General Symptom Index, according to the Symptom Checklist-90. A series of latent class regression analyses revealed that one class of therapists (16% of the sample) whose patients had the least change in treatment, and in fact had nonsignificant deterioration, was significantly overrepresented by psychotherapists with long psychoanalyses for their training therapies. Alternative interpretations of the findings are discussed.

Among so-called psychodynamic psychotherapists, the therapists' personal therapy[1] is considered of primary importance in his or her professional training and development (Koepp & Vaeth-Szusdziara, 1996). In its bylaws, the European Federation for Psychoanalytic Psychotherapy in Health and Related Public Services (EFPP), among its minimal training standards for qualification of psychoanalytic psychotherapy practitioners in the public sector, proposes "personal psychoanalysis or individual psychoanalytic therapy of an intensity not less than three times a week for four years, in sessions of at least 45 minutes" (EFPP, 1995, p. 5). The standards of the International Psychoanalytical Association for the training analyses of its candidates are even more demanding in terms of session frequency. Underlying such requirements is, of course, the assumption that training therapy is essential for therapists to be able to perform their task to the benefit of their patients or that the therapists will be able to perform their task more effectively with a training therapy than without one. One would assume that this might come about in at least five ways, all of which are presumably essential in the training of any modality of psychotherapy (Aponte, 1994; Macran & Shapiro, 1998; Simenauer, 1984). First, the training therapy helps the becoming therapists to free themselves, as far as possible, from such neurotic mechanisms that otherwise would affect their handling of the treatments in a negative way (the therapeutic function). Second, it provides an opportunity for the becoming therapists to internalize and identify with a fully trained therapist's technique and therapeutic attitude (the modeling function). Third, it offers becoming therapists an opportunity to familiarize themselves with the role and experience of being a patient (the empathic function). Fourth, if successful, it may strengthen the therapists' conviction in the validity of the approach (the persuasive function). Fifth, it offers becoming therapists, concretely and in vivo, the manifestations of abstract concepts that are introduced to them in theoretical seminars (the theoretical function).

In contrast to the insistence on the importance, even the necessity, of the training therapy in psychoanalytically oriented training, many behavioral therapists appear to view training therapy as not necessary, unless, of course, the becoming therapist needs it for personal reasons, as another patient (Laireiter, 1998). Among psychiatrists, opinions differ (Daly, 1998). In Sweden, psychiatric residents protested against the inclusion of a training therapy in the requirements for specialist status, and a negative attitude change among psychiatric residents has been noted in the United States (Weintraub, Dixon, Kohlhepp, & Woolery, 1999).

Research on training therapy has been thoroughly reviewed by Macran and Shapiro (1998) and

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A. Macaskill (1999).[2] The field has been dominated by clinical accounts and surveys of the personal needs for training therapy, its feasibility and prevalence, and therapists' personal evaluations (Brady, Guy, & Norcross, 1995; Bridges, 1993; Holzman, Searight, & Hughes, 1996; N D. Macaskill & Macaskill, 1992; Mackey & Mackey, 1993, 1994; McEwan & Duncan, 1993; Norman & Rosvall, 1994; Patterson & Utesch, 1991; Trijsburg, 1996, 1998; Trijsburg, Duivenvoorden, Stronks, & Schagen, 1994; Zwanikken, 1990).

Although the training therapy may serve several important functions in the training of therapists, its ultimate purpose is certainly to help improve the treatment of their patients. The extent to which this is fulfilled is an underresearched issue. N. D. Macaskill (1988) was able to identify not more than six studies on the association between training therapy experiences and patient treatment outcome, and Macran and Shapiro (1998) could add only one or two. Macran and Shapiro concluded that "whilst the majority of therapists feel that they have benefited professionally from personal therapy there is very little empirical evidence that it has any measurable effect on client outcome" (p. 13), and Macaskill drew essentially the same conclusion. Thus, most studies have reported nonsignificant associations between various parameters of training therapy experience and of therapist competence or treatment results (Holt & Luborsky, 1958; Katz, Lorr, & Rubenstein, 1958; McNair, Lorr, & Callahan, 1963; McNair, Lorr, Young, Roth, & Boyd, 1964; Strupp, Fox, & Lessler, 1969). Only one (Greenspan & Kulish, 1985) has reported a positive association between therapists' training therapy and retention of patients, in contrast to the rather contrasting finding of McNair et al. (1963). Also, on the positive side, Kernberg (1973) mentioned training therapy as one aspect of experience among the more successful therapists in the Menninger Project. On the other hand, one study has reported a negative association with global improvement among the inconsistent associations with different outcome measures in a small sample (Garfield & Bergin, 1971). In a sample suffering from heavy attrition, Wheeler (1991) found a negative correlation between therapeutic alliance ratings from therapist and client alike and training therapy experience among counselors. It is in the nature of things, however, that spuriousness and confounding are more the rule than the exception, because training therapy is a condition that is difficult to manipulate on any randomization basis, and most findings have emerged out of survey designs. It is also noteworthy that all but a few of the studies are more than 25 years old. Partly on the basis of the lack of positive evidence of benefits to patients, A. Macaskill (1999) suggested that training therapy should not be a training requirement. Considering the inconsistency of findings, however, it seems far too early to consider the case closed.

In a previous study within the Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPP) on the role of the level of experience of psychotherapists, length of training therapy was found to be negatively related to patient change (Sandell, Carlsson, et al., 2002). The current study aims to explore in further depth the associations between the length and type of therapists' training therapies and the benefits of psychoanalytic therapy for their patients. This was possible using data from therapists and patients in a panel study of patients in various phases of subsidized long-term psychotherapeutic treatments in Sweden. For accounts of the background of the project, readers are referred to Blomberg, Lazar, and Sandell (2001) and Sandell, Blomberg, and Lazar (1997).

Method

Design

The design has been extensively described by Blomberg et al. (2001) and Sandell et al. (2000). It was a quasi-experimental, partly cross-sectional, partly longitudinal design based on a postal three-wave panel survey on patients in psychotherapy or psychoanalysis and a survey on their therapists.

Procedure

A sample of 756 persons in subsidized treatment or on the waiting list for such subsidization was selected to ensure that it consisted of people who had terminated their treatments, people who were currently in treatment, and people who had not yet started treatment.

A questionnaire, including a number of self-rating scales, was distributed to these 756 persons in 1994 and again in 1995 and 1996 to all who had responded the first year. The return rates of 78%, 86% and 89%, respectively, produced a panel of 445 persons (59%).

With three possible treatment states (pretreatment, in treatment, posttreatment) and three panel waves, it was possible to establish an ordinal scale with nine successive steps, corresponding to stages in treatment: three before treatment, three during treatment, and three after treatment. We located each patient in the panel each year on this scale, referred to as the stage scale. Twelve patients never commenced treatment. They were excluded from further analyses, and this reduced the stage scale to eight steps.

In 1995 a questionnaire was distributed to the 294 therapists with patients in the sample. After four reminders, 209 (71%) had returned their questionnaires. Given attrition among patients as well as therapists, data from both the patient and the therapist were available for 327 cases with 167 therapists. This was slightly more than would be expected by chance ($756 \times 0.59 \times 0.71 = 317$).

The basic model for our analyses was to use nonparametric latent class (LC) analysis to cluster the therapists on the basis of their patients' repeated self-ratings across the stage scale. Parameters of the training therapies were then explored in relation to the cluster variable.

Therapists

All therapists were licensed by the National Board of Health and Social Welfare. Of the therapists who had provided data and whose patients had provided data as well, 127 (76%) were women and 40 (24%) were men. Their mean age was 54.2 years ($SD = 6.4$). The majority were psychologists (77%), and 10% were social workers. Therapist training was psychoanalytic (6%), university degree (15%), various equivalent private institutes with different orientations (71%), and child psychotherapeutic (9%). Sixty percent had supervisory training. The mean number of years working as a psychotherapist after licensing was 10 ($SD = 4$) and before licensing (under supervision) 11 years ($SD = 4.5$).

Of the therapists, 95% claimed to be "rather strongly" or "strongly" oriented toward a psychoanalytic or psychodynamic theoretical position; 16% claimed (also) to share "strongly" or "rather strongly" an eclectic position.

The median number of rounds of training therapy was 2. Mean total duration of training therapy was 10 years ($SD = 4$), and mean total number of sessions (dose) was 1,012 ($SD = 592$). In terms of duration of training therapy, 46% had psychoanalysis as their longest therapy, 40% individual psychotherapy, and 6% group therapy. In terms of dose, 59% had psychoanalysis as their most extensive therapy, 33% psychotherapy, and 4% group therapy. The rest had been in other unspecified or unidentifiable kinds of therapy.

Patients

The typical patient in the 327 cases sample was a woman (77%), single (58%) or divorced (20%), with children (53%). The majority (78%) had at least some university education and typically worked in the health care, education, or social sector. The mean age was 38.9 years ($SD = 8.3$). Of the 327 patients, 264 were receiving psychotherapy, 53 were receiving psychoanalysis, and 10 were receiving "low-dose" therapies.

On the basis of the referrals, psychotherapy was defined as once- or twice-weekly treatment with a licensed psychotherapist and psychoanalysis as three-to-five-times-a-week treatment with a fully trained psychoanalyst, who was a member of either of the two psychoanalytic societies in Sweden belonging to the International Psychoanalytical Association. Both kinds were planned to be long term, according to the referrals, and all were individual treatments. Low-dose therapies were defined as other treatments that fit neither of the previous definitions (e.g., brief therapy, low-frequency supportive therapy, family therapy, group therapy). These treatments typically took place while the patient was on a waiting list for the therapy to which she or he was referred. The treatments were not manualized or standardized with respect to duration, session frequency, technique, and so on.

To simplify our analyses of interactions between therapists' and patients' therapies, we excluded all therapists with group therapy or unspecified therapies as their main therapy and all patients with low-dose therapies. The modalities tested were, thus, patients' and therapists' psychoanalyses and individual psychotherapies.

We also excluded 16 cases to make the patients' main type of therapy constant for each therapist. These cases were selected to minimize the loss of cases. Because there was some overlap among the exclusion criteria, eventually 264 cases with 143 therapists remained in our sample. The distribution of the therapists and patients on modalities of treatment is given in Table I.

Assessment procedures

The Well-Being Questionnaire was designed to explore patients' symptoms, social relations, and morale. The following standard self-rating scales were included: The Symptom Checklist-90 (SCL-90; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974), Social Adjustment Scale (SAS; Weissman &

Table I. Number of patients/number of therapists by modality of patient's therapy × modality of therapist's training therapy.

	Patient's therapy		
Therapist's therapy	Psychotherapy	Psychoanalysis	*N*
Individual psychotherapy	109/65	9/4	118/69
Psychoanalysis	113/56	33/18	146/74
N	222/121	42/22	264/143

Bothwell, 1976; Weissman, Prusoff, Thompson, Harding, & Myers, 1978, in a revised version to suit Swedish users in the 1990s), and Sense of Coherence Scale (SOCS; Antonovsky, 1987). Principal-components analyses of the three mean scores across all items showed, in each wave, that a single component accounted for at least 82% of the total variance and that the so-called General Symptom Index (GSI; the mean score across all 90 items) of the SCL-90 had the largest loading: $>.89$. We concluded that the GSI adequately reflected general well-being and decided to present the results on the GSI only. The internal consistency estimates for the GSI in the three waves varied between .83 and .96. The GSI was analyzed in its square root form (GSIsqrt) to counteract its tendencies to curvilinearity (Sandell, Blomberg, & Lazar, 2002).

Statistical analyses

Nonparametric LC regression modeling with repeated measures (Vermunt & van Dijk, 2001) was used to analyze the GSIsqrt. Nonparametric LC models are less subject to biases because of violations of conventional assumptions about linearity, normality, homoscedasticity, independence, and homogeneity. An LC model introduces a latent nominal variable for classes or clusters. This class variable serves as a moderator in interaction with one or several observed predictors. Typically, LC regression analysis does four things simultaneously: (a) identifies LCs; (b) estimates regression models for each class; (c) tests covariates to predict class membership; and (d) assigns cases to classes. When the dependent variable is a repeated measure, LC regression may be seen as a case of multilevel modeling.

Using the Latent GOLD 3.0 software (Garson, 2001; Vermunt & Magidson, 2003), we analyzed the GSIsqrt with therapists as the units of analysis. Thus, all therapists were classified on the basis of their patients' repeated GSIsqrt scores across the stage scale, and a regression model was estimated for each class of therapists. Such a model for each class condenses the development of the therapists' patients in terms of a regression coefficient, representing these patients' average rate of change across stages, and an intercept, representing their mean pretreatment state as measured by the GSIsqrt. We then explored the associations between this classification of the therapists and various parameters of their training therapies in progressively more complex interactions. All variables except the GSIsqrt were treated as categorical ordinal variables.

Hypothesis

The general hypothesis tested was that there is a systematic heterogeneity among the therapists in their patients' development across the stage scale and that this heterogeneity is partly accounted for by parameters of the therapists' training therapies, possibly in interaction with the patients' therapies.

Results

Preliminary tests of the design

The change rate of the GSIsqrt in the entire sample of therapists was estimated as -0.046 ($p<.001$), with an intercept of 0.99 ($p<.001$).

To be able to interpret the regression in terms of patients' change as a function of stages in treatment, it is of vital importance that the stage scale was not confounded with other variables. For instance, if for some reason the distribution of therapists' training therapy (or any other therapist factor) is unequal among cases in earlier and later stages of treatment, different levels of the GSIsqrt for early and late stages might as well be produced by that therapist factor. Similarly, of course, a skewed distribution of patient diagnoses or other patient characteristics over the stages of treatment might easily produce differences that would be erroneously taken as treatment effects. Thus, the independence of the stage scale in relation to other factors is a critical assumption that should be tested as far as possible. We, therefore, explored the associations between the stage scale and a number of variables pertaining to the therapists, the patients, and the treatments. Testing more than 30 variables for their correlations with the stage scale, we found only one with a near-significant correlation: patients' number of previous treatments in psychiatric open care ($r=-.10$, $p=.055$). We concluded that our stage scale was free of obvious strong confounds.

Classification of therapists

In an initial run, LC models with increasing numbers of classes were compared. The Bayesian information criterion (BIC), based on the log-likelihood and considering the degrees of freedom, was used to determine the number of classes. As seen in Table II, the BIC was at its minimum with the five-class model, and this model was, therefore, chosen for further analysis. The classification accounted for 46% of the total variance. The differences between the classes were significant both when the intercepts and when the slopes were concerned (Wald's $W^2=1597.16$, $p<.001$, and $W^2=76.82$, $p<.001$, respectively). The sizes and estimated β parameters

Table II. Test results for therapist classes.

Regression model	LL	BIC (LL)	No. parameters	R^2
Class 1	−246.93	508.75	3	.05
Class 2	−174.54	383.81	7	.34
Class 3	−147.73	350.04	11	.41
Class 4	−127.92	330.28	15	.44
Class 5	−109.90	314.09	19	.46
Class 6	−102.62	319.38	23	.47

Note. $N = 143$ therapists; 792 observations. LL = log-likelihood; BIC = Bayesian information criterion based on log-likelihood.

for the five classes are given in Table III. The mean self-ratings of the patients of these therapists across the stages scale are displayed in Figure 1. Two reference lines are shown, one representing the mean in a normal group (Blomberg et al., 2001) and the other indicating the case criterion suggested by Derogatis and Lazarus (1994) to provide the best split between likely clinical cases and noncases.

Regarding the intercepts, one of the classes of therapists (Class 4) had patients starting from a very high level of symptom distress, whereas the patients of another class of therapists (Class 5) were well beneath the mean in the normal group already when they started treatment. The other three—and larger—classes started their therapies around the level of the caseness criterion, two (Classes 1 and 3) somewhat above, and one (Class 2) slightly below.

The patients in three of the therapist classes improved at a low to moderate rate across the stages, whereas those in the largest class (Class 1) showed considerable improvement. Especially interesting is Class 3, with 16% of the therapists, whose patients actually had a positive slope. This means that they deteriorated from a rather high level of distress to begin with (0.91) to even more distressed levels as their treatments progressed. Although this deterioration was not statistically significant ($z = 1.41$, $p < .20$, two-tailed), we focused our further analyses on this particular class. Inspection of Figure 1 reveals a more intriguing pattern of development among these therapists' patients than mere linear change. There was a slight worsening as treatment began, then respectable improvement during treatment, but a striking deteriorating trend after termination.

Associations with class membership

The LC variable in effect serves as a moderator that influences the GSIsqrt in interaction with the stage variable (Magidson & Vermunt, 2002). We now explore the extent to which parameters of the therapists' training analyses were associated with the class variable. Our first test was of the main effect of the modality of the therapists' training therapies: (individual) psychotherapy or psychoanalysis. The overall association was not significant ($W^2 = 7.11$, $p = .13$). However, when the γ parameters were transformed to easy-to-understand partial conditional probabilities (for a certain modality given a certain class), these parameter estimates showed that the therapists in Class 3 were more than three times as likely to have been in psychoanalysis as in psychotherapy for their training therapies (.77 vs. .23). These parameters were significant ($z = |1.99|$, $p < .05$).

We proceeded to test whether the two-way interaction between the modalities of the training therapies and the patients' therapies might be associated with class membership. The introduction of this covariate organized the classification somewhat differently than before (Table IV). The previous Classes 3 and 4 remained essentially unchanged, although the previous Class 3 had now become Class 4 (and the previous Class 4 had become Class 5). Again, the Wald statistic failed to reach significance. However, in Class 4, there was a .68 partial conditional probability for a therapist to have been in psychoanalysis and have patients in psychotherapy. This was at least three times more likely than the equally frequent combination of psychotherapy cases with therapists who had had psychotherapy as their main therapy. The probabilities for the combinations of therapists' and patients' treatments, given a certain class, are shown in Table IV.

To explore a still more complex three-way interaction, we then introduced the duration of the training therapy in the analysis. Instead of measuring

Table III. Size, R^2, and β parameters for the five classes of therapists.

	Class				
Variable	1	2	3	4	5
Class size	41%	26%	16%	9%	8%
R^2	0.29	0.09	0.02	0.20	0.07
Intercept	1.16	0.78	0.91	1.37	0.41
Slope (by stages)	−0.095***	−0.034***	0.030	−0.034**	−0.024

Note. $N = 143$ therapists; 792 observations. All intercepts were significantly different from 0 ($p < .001$).
$p < .01$.*$p < .001$.

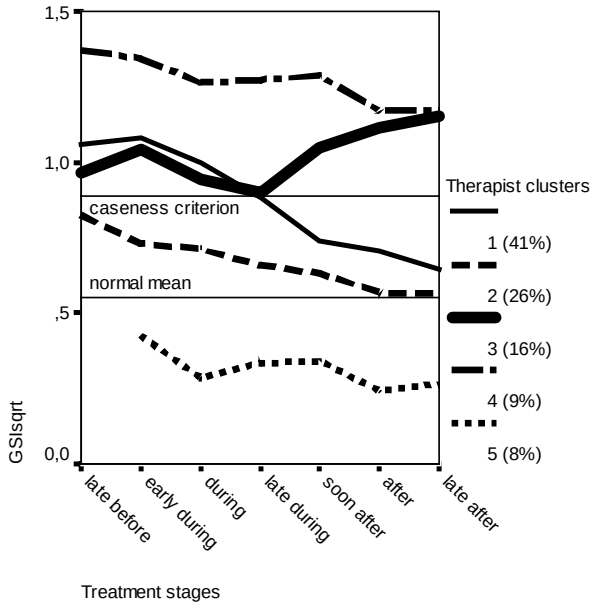

Figure 1. Trajectories on the Symptom Checklist-90 General Symptom Index square root (GSIsqrt) across stages of treatment for cases in five classes of therapists. The reference lines refer to the norm group mean and the caseness criterion ($M+1.28$ norm group SD; Blomberg, Lazar & Sandell, 2001; Derogatis & Lazarus, 1994).

duration in months, we decided to measure it in terms of number of sessions (dose) because that would better differentiate between therapists' psychoanalyses and psychotherapies. Following routine in regression analysis (Cohen & Cohen, 1983; Jaccard, Turrisi, & Wan, 1990), we first generated a three-way interaction term by multiplying the dose variable with the combinations of therapists' and patients' therapies, ordered from 1 to 4 the same way as the two-way interaction combinations in Table IV. This produced 86 categories, and these were reduced to five in a distribution as close to a rectangular one as possible.

When this three-way interaction variable was introduced as a covariate in an LC regression analysis, the classes reorganized themselves essentially in the original fashion (see Table V). Thus, those 16% of the therapists with nonimproving patients again formed Class 3 ($W^2=8.20$, $p=.08$). The γ coefficient linking the three-way interaction to Class 3 membership was 0.0003 ($z=2.51$, $p=.01$, two-tailed). This means that there was a significant positive association between membership in Class 3 and high scores on the three-way interaction variable. Table V presents the probabilities of a certain score on the five-category interaction scale given a certain class. Because the scores formed an almost exactly rectangular distribution, the probabilities are directly comparable. It is evident that, in Class 3, the estimates increase in a curvilinear, positively accelerated order, from .08 to .36. Given a high-enough dose, high scores may be obtained by any combination of Therapist $\times$ Patient Treatment but are most likely with therapists with high-duration psychoanalyses who are treating patients in psychotherapy. To illustrate this, Figure 2 shows the mean trajectories of the psychotherapy cases and the psychoanalysis cases with therapists with different experiences of training therapy: more or less than 10.5 years in individual psychotherapy or psychoanalysis. The first stage, late before treatment, has been deleted because of low frequencies. Noteworthy is the similarity between the Class 3 trajectory in Figure 1 and the trajectory among the psychotherapy cases with therapists with long psychoanalyses as their training therapy.

Table IV. Size, R^2, and β parameters for the five classes of therapists and probability-transformed γ parameters for combinations of modalities of therapists' and patients' treatments.

	Class				
Variable	1	2	3	4	5
Class size	31%	30%	16%	15%	9%
R^2	0.33	0.18	0.12	0.02	0.20
β parameters					
Intercept	1.23	0.92	0.64	0.89	1.37
Slope (by stages)	−0.105***	−0.055***	−0.045***	0.036	−0.034**
Partial conditional ps					
Tpst × Ppst	0.54	0.39	0.65	0.21	0.42
Tpst × Ppsa	0.09	0.00	0.00	0.00	0.00
Tpsa × Ppsa	0.00	0.23	0.21	0.11	0.08
Tpsa × Ppst	0.36	0.38	0.14	0.68	0.50

Note. $N=143$ therapists; 792 observations. All intercepts were significantly different from 0 ($p<.001$). Tpst = therapists' psychotherapy; Ppst = patients' psychotherapy; Tpsa = therapists' psychoanalysis; Ppsa = patients' psychoanalysis.
**$p<.01$. ***$p<.001$.

Table V. Size, R^2, and β parameters for the five classes of therapists and probability-transformed γ parameters for the three-way interaction.

	Class				
Variable	1	2	3	4	5
Class size	40%	28%	16%	9%	8%
R^2	0.321	0.09	0.02	0.19	0.06
β parameters					
Intercept	1.18	0.80	0.91	1.37	0.40
Slope (by stages)	−0.100***	−0.035***	0.031	−0.032*	−0.023
TTx × PTx × Duration of Training Therapy					
Partial conditional ps					
1	0.33	0.15	0.08	0.20	0.47
2	0.21	0.23	0.12	0.24	0.18
3	0.22	0.23	0.18	0.28	0.24
4	0.13	0.19	0.26	0.14	0.02
5	0.10	0.21	0.36	0.15	0.09

Note. $N = 143$ therapists; 792 observations. All intercepts were significantly different from 0 ($p < .001$). TTx = therapist treatment; PTx = patient treatment.
*$p < .05$. ***$p < .001$.

Discussion

The analyses did not show that shorter training therapies are better for the patients than longer training therapies. In fact, a post hoc series of analyses in overlapping 2-year groups of training therapy durations (e.g., 3–4, 4–5, 5–6 years) showed that rate of patient change on the GSIsqrt was at its highest (or best) among the 38 cases with training therapies of 7 or 8 years of duration ($b = -0.081$) and at its lowest (or worst) among the 37 cases with durations of 13 or 14 years ($b = 0.009$). (For 10 cases with training therapy durations of 3 or 4 years $b = -0.036$. Thus, the relation between training therapy duration and patient outcome seems to have been curvilinear.)

Before interpreting the substantial findings, some methodological issues should be discussed. One is the extent to which the length of therapists' therapies was confounded with their professional experience. In fact, length of therapists' therapies accounted for less than 5% of the variance in therapists' age or various parameters of length of experience in the profession and was negatively correlated with all but two (range = −.207–.023). The small share of common variance makes any confounding unlikely. Note also, in contrast to therapists' therapies, that these experience variables were positively related to patient change (Sandell, Carlsson, et al., 2002).

Regarding generalizations, the sample of therapists was not representative for the therapist population in Sweden. Psychoanalysts were overrepresented and behavioral therapists underrepresented, as reflected by the generally long training therapies in this study. The overrepresentation of psychoanalysts primarily reflected an agreement made with the health care authorities to allot 50% of the subsidies to psychoanalytic cases. It is important to realize that the results cannot readily be generalized to therapies and therapists outside the blurry boundaries of psychodynamic treatments. The psychodynamic therapist population is large in Sweden, however. In our national sample of therapists, 82% rated their psychoanalytic orientation as strong or rather strong.

The logic of our analysis was to take a main effect, of the modality of training therapy, as our departure and then test progressively more complex interactions. It is true that repeated such tests increase the Type I error risk, however. However, the three-way interaction (Therapists' Treatments × Patients' Treatments × Duration of Training Therapy) was consistent with the two-way interactions and also revealed exactly the same pattern on the SOCS and the SAS as on the GSIsqrt. Therefore, we are inclined to accept it as nonrandom. Besides the constant possibility of Type I errors, the interaction is open to alternative interpretations.

The most direct interpretation implies the view of training therapy as having a sort of indirect effect on the patient, with the therapist as a mediator. Thus, therapists' training therapy, when it has been a long psychoanalysis, is not very productive for their patients in psychotherapy. This might possibly be the case with therapists' cases at the time of their training therapy and might then be regarded as a kind of carry-over process, but it should be more unlikely when the training therapy is long past. The only way to control for this interpretation is to randomize type and duration of training therapies on therapists, certainly not a practicable procedure.

Another approach to interpretation is to focus on patients' selection of therapists and therapists' selec-

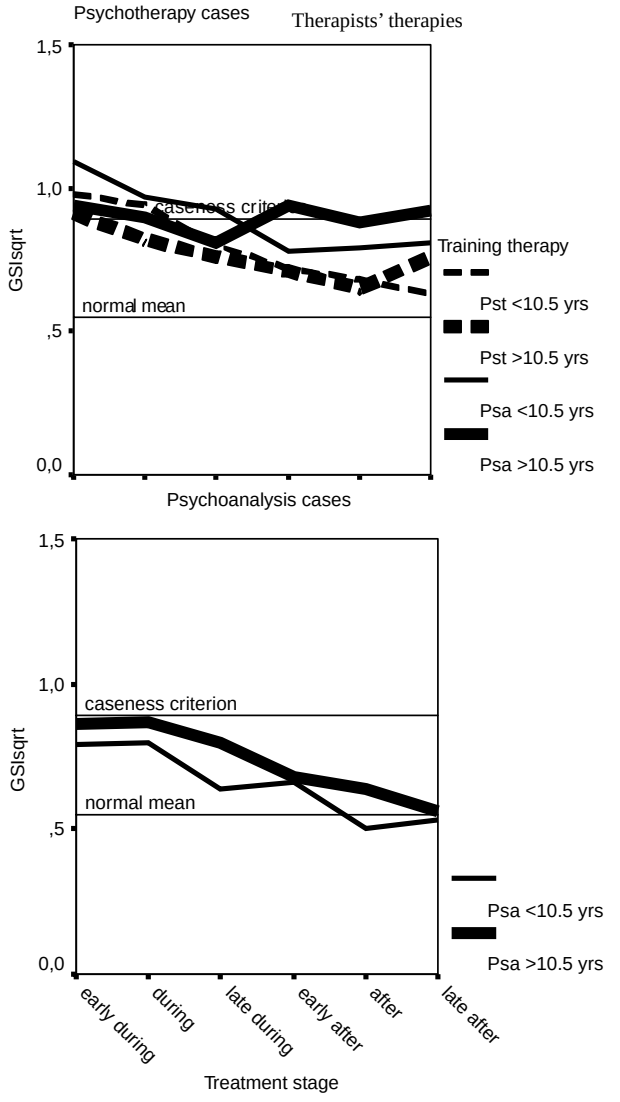

Figure 2. Trajectories on the Symptom Checklist-90 General Symptom Index square root (GSIsqrt) across stages of treatment for cases in psychotherapy (upper panel) and psychoanalysis (lower panel) with therapists with different training therapy experiences. Training therapy durations were dichotomized at their median (10.5 years). Psychoanalysis cases with Pst (lower panel) are not shown because of too few observations ($n_i < 25$). (Pst = individual psychotherapy; Psa = psychoanalysis.)

tion of patients. Thus, particularly difficult patients and therapists with particularly long training therapies might select each other. Although it certainly does not appear that the patients with less change in this study were more distressed from the start of therapy, in terms of symptoms, they may, of course, have offered other and more serious difficulties to their therapists. Thus, for instance, therapists who have been in particularly long and intensive training therapies might believe that, just because of that, they would be able to manage patients whom other therapists, with less extensive training therapies, would consider too difficult to manage and, therefore, avoid. Alternatively, they may feel obliged to take on more difficult cases. This interpretation, however unlikely it may appear, could not be rejected without random assignment of patients to therapists. This was not feasible given the background of this study.

As a third speculative interpretation of our findings, therapists who feel themselves doing not well with their patients may try to cope with this by having more training therapy. This would not seem to help much, however, especially if they themselves have chosen psychoanalysis for their personal treatment and especially if they are doing psychotherapy. A less flattering speculation somewhat along the same line, reflecting on the therapeutic function of the training therapy, is that these therapists themselves have personal problems that psychoanalysis, however long, will not help much to resolve. However, why would this influence their doing psychotherapy but not psychoanalysis?

A complementary interpretation focuses on the therapist's selection of training therapy and its modeling function. On the basis of therapists' long experience with their psychoanalyst's approach, the therapist may identify with it and unwittingly adopt it in working with his or her own patients in psychotherapy. In learning theory terms, this would produce a negative transfer because of the differences between psychoanalysis and psychotherapy. For instance, Grant and Sandell (2004; Sandell et al., 2000) have reported findings suggesting that therapists with classically psychoanalytic attitudes (in terms of, e.g., neutrality and abstinence) are doing worse with their patients in psychotherapy than are therapists with more eclectic therapeutic attitudes. They attributed the inferior results to the therapists' more or less intentional attempts to do "as-if" analyses (i.e., applying psychoanalytic technique under nonpsychoanalytical conditions).

The longer the therapists' psychoanalysis, the stronger is the identification with the psychoanalyst's approach and, if Grant and Sandell are correct, the stronger the negative transfer. Thus, having psychoanalysis as one's training therapy and adopting the classical psychoanalytic attitude of one's analyst—maybe in a nonauthentic and misinterpreted version at that—is suboptimal when oneself is doing psychotherapy. In connection with the previous interpretation, one might speculate that therapists' personal or professional problems might make transfer even more negative in their own psychotherapeutic work when they have selected psychoanalysis for their own treatment.

Fancher (1990) is among the few who have considered the distinction between psychoanalysis and psychoanalytic psychotherapy to be important in

connection with training therapies, and Rawn (1991) seems to be one of the few to formulate the question of whether psychoanalysis is actually the treatment of choice for psychoanalytic psychotherapists. He concluded, however, without much empirical support, that there is no substitute for "a full, thorough training analysis" (p. 57) for psychoanalytic and psychotherapeutic candidates alike. On the basis of the current findings, this appears to be an overstatement. A few other thinkers have questioned the value of extensive training therapy (A. Macaskill, 1999; N. D. Macaskill, 1988; Seligman, 1995; Thomä, 1991a, 1991b, 1992, 1993; Wheeler, 1991). Whereas the current results may support such doubts, they do not show that training therapy as such is unnecessary or even counterproductive for psychoanalytically oriented therapists. Also, one should certainly respect the opinions of many clinicians that their training therapies have been important and valuable to them both personally and professionally (Mahoney, 1997). It is difficult to see how therapists-to-be would otherwise learn how a person might feel being a patient, how experienced therapists "do it," and how theoretical concepts manifest themselves.

Notes

[1] For reasons of convenience of expression, psychoanalysis and psychotherapy are referred to as therapy, and psychoanalysts and psychotherapists as therapists, unless a particular distinction is intended. Likewise, personal therapy and training analysis are called training therapy.

[2] A forthcoming publication (Geller, Norcross, & Orlinsky, in press) was not available to the authors.

References

Antonovsky, A. (1987). *Unraveling the mystery of health*. San Francisco: Jossey-Bass.

Aponte, H. (1994). How personal can training get? *Journal of Marital & Family Therapy*, *2*, 3–15.

Blomberg, J., Lazar, A., & Sandell, R. (2001). Outcome of patients in long-term psychoanalytical treatments. First findings of the Stockholm Outcome of Psychotherapy and Psychoanalysis (STOPP) study. *Psychotherapy Research*, *11*, 361–382.

Brady, J. L., Guy, J. D., & Norcross, J. C. (1995). Managing your own distress: Lessons from psychotherapists healing themselves. In L. Vandecreek & S. Knapp (Eds), *Innovations in clinical practice: A source book* (Vol. 14, pp. 293–306). Sarasota, FL: Professional Resource Press.

Bridges, N. (1993). Clinical dilemmas: Therapists treating therapists. *American Journal of Orthopsychiatry*, *63*, 34–44.

Cohen, J., & Cohen, P. (1983). *Applied multiple regression/correlation analysis for the behavioural sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Daly, K. A. (1998). Attitudes of U.S. psychiatry residencies about personal psychotherapy for psychiatry residents. *Academic Psychiatry*, *22*, 223–228.

Derogatis, L. R., & Lazarus, L. (1994). SCL-90-R, Brief Symptom Inventory, and matching clinical ratings scales. In M. E. Maruish (Ed.), *The use of psychological testing for treatment planning and outcome assessment* (pp. 217–248). Hillsdale, NJ: Erlbaum.

Derogatis, L. R., Lipman, R. S., Rickels, K., Uhlenhuth, E. H., & Covi, L. (1974). The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. *Behavioral Science*, *19*, 1–15.

European Federation for Psychoanalytic Psychotherapy (1995). *Constitution of the European Federation for Psychoanalytic Psychotherapy in Health and Related Public Services*. London: Author.

Fancher, E. (1990). A training analysis for psychoanalytic psychotherapists. *Psychoanalytic Review*, *77*, 41–57.

Garfield, S. L., & Bergin, A. E. (1971). Personal therapy, outcome and some therapist variables. *Psychotherapy: Theory, Research and Practice*, *8*, 251–253.

Garson, G. D. (2001). Software reviews. Latent gold. *Social Science Computer Review*, *19*, 369–378.

Geller, J. D., Norcross, J. C., & Orlinsky, D. E. (in press). *The psychotherapist's own psychotherapy*. Oxford, UK: Oxford University Press.

Grant, J., & Sandell, R. (2004). Close family or mere neighbours? Some empirical data on the differences between psychoanalysis and psychotherapy. In P. Richardson, H. Kächele & C. Renlund (Eds), *Research on psychoanalytic psychotherapy with adults* (pp. 81–108). London: Karnac.

Greenspan, M., & Kulish, N. (1985). Factors in premature termination in long-term psychotherapy. *Psychotherapy*, *22*, 75–82.

Holt, R. R., & Luborsky, L. (1958). *Personality patterns of psychiatrists. A study of methods for selecting residents* (Vol. I). New York: Basic Books.

Holzman, L. A, Searight, H. R., & Hughes, H. M. (1996). Clinical psychology graduate students and personal psychotherapy: Results of an exploratory survey. *Professional Psychology: Research & Practice*, *27*, 98–101.

Jaccard, J., Turrisi, R., & Wan, C. K. (1990). *Interaction effects in multiple regression*. Newbury Park, CA: Sage.

Katz, M. M., Lorr, M., & Rubinstein, E. A. (1958). Remainer patient attributes and their relation to subsequent improvement in psychotherapy. *Journal of Consulting Psychology*, *22*, 411–413.

Kernberg, O. F. (1973). Summary and conclusions of "Psychotherapy and Psychoanalysis, Final Report of the Menninger Foundation's Psychotherapy Research Project". *International Journal of Psychiatric Medicine*, *11*, 62–77.

Koepp, W., & Vaeth-Szusdziara, R. (1996). Anmerkungen zur Bedeutung der Lehranalyse fuer die praktische, psychotherapeutische Arbeit [Some remarks on the importance of the training analysis for the practice of psychotherapy]. *Psychotherapie Psychosomatik Medizinische Psychologie*, *46*, 43–46.

Laireiter, A.-R. (1998). Self-directed experience and personal therapy: The situation in the German-speaking countries and the "state of the art" of empirical research. In E. Sanavio (Ed.), *Behavior and cognitive therapy today: Essays in honor of Hans J. Eysenck* (pp. 163–179). Oxford, UK: Anonima Romana.

Macaskill, A. (1999). Personal therapy as a training requirement: The lack of supporting evidence. In C. Feltham (Ed.), *Controversies in psychotherapy and counseling* (pp. 142–154). London: Sage.

Macaskill, N. D. (1988). Personal therapy in the training of the psychotherapist: Is it effective? *British Journal of Psychology*, *4*, 219–226.

Macaskill, N. D., & Macaskill, A. (1992). Psychotherapists-in-training evaluate their personal therapy: Results of a UK survey. *British Journal of Psychotherapy*, *9*, 133–138.

Mackey, R. A., & Mackey, E. F. (1993). The value of personal psychotherapy to clinical practice. *Clinical Social Work Journal*, *21*, 97–110.

Mackey, R. A., & Mackey, E. F. (1994). Personal psychotherapy and the development of a professional self. *Families in Society*, *75*, 490–498.

Macran, S., & Shapiro, D. A. (1998). The role of personal therapy for therapists: A review. *British Journal of Medical Psychology*, *71*, 13–25.

Magidson, J., & Vermunt, J. K. (2002). *Latent class models*. Belmont, MA: Statistical Innovations Inc.

Mahoney, M. J. (1997). Psychotherapists' personal problems and self-care patterns. *Professional Psychology: Research & Practice*, *28*, 14–16.

McEwan, J., & Duncan, P. (1993). Personal therapy in the training of psychologists. *Canadian Psychology*, *34*, 186–197.

McNair, D. M., Lorr, M., & Callahan, D. M. (1963). Patient and therapist influences on quitting psychotherapy. *Journal of Consulting Psychology*, *27*, 10–17.

McNair, D. M., Lorr, M., Young, H. H., Roth, I., & Boyd, R. W. (1964). A three-year follow-up of psychotherapy patients. *Journal of Clinical Psychology*, *20*, 258–264.

Norman, J., & Rosvall, S. B. (1994). Help-seeking behavior among mental health practitioners. *Clinical Social Work Journal*, *22*, 449–460.

Patterson, J. E., & Utesch, W. E. (1991). Personal therapy for family therapy graduate students. *Contemporary Family Therapy*, *13*, 333–343.

Rawn, M. L. (1991). Training analysis and training psychotherapy. *Psychoanalytic Psychology*, *8*, 43–57.

Sandell, R., Blomberg, J., & Lazar, A. (1997). When reality doesn't fit the blueprint: Doing research on long-term psychodynamic therapies in a public health service program. *Psychotherapy Research*, *7*, 333–344.

Sandell, R., Blomberg, J., & Lazar, A. (2002). Time matters. On temporal interactions in psychoanalysis and long-term psychotherapy. *Psychotherapy Research*, *12*, 39–58.

Sandell, R., Blomberg, J., Lazar, A., Carlsson, J., Broberg, J, & Schubert, J. (2000). Varieties of long-term outcome among patients in psychoanalysis and long-term psychotherapy. A review of findings in the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (STOPPP). *International Journal of Psychoanalysis*, *81*, 921–942.

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.

Seligman, C. (1995). The therapist as patient in interminable treatment: A parallel process. In M. B. Sussman (Ed.), *A perilous calling: The hazards of psychotherapy practice* (pp. 55–58). New York: Wiley.

Simenauer, E. (1984). Aktuelle Probleme der Lehranalyse [Current problems of training analysis]. *Psyche: Zeitschrift für Psychoanalyse und Ihre Anwendungen*, *38*, 289–306.

Strupp, H. H., Fox, R., & Lessler, K. (1969). *Patients view their psychotherapy*. Baltimore: Johns Hopkins University Press.

Thomä, H. (1991a). Idee und Wirklichkeit der Lehranalyse. Ein Plaedoyer fuer Reformen (I). [Idea and reality of training analysis: A plea for reforms: I]. *Psyche: Zeitschrift für Psychoanalyse und Ihre Anwendungen*, *45*, 385–433.

Thomä, H. (1991b). Idee und Wirklichkeit der Lehranalyse. Ein Plaedoyer für Reformen (II). [The idea and the reality of training analysis: A plea for reform: II]. *Psyche: Zeitschrift für Psychoanalyse und Ihre Anwendungen*, *45*, 481–505.

Thomä, H. (1992). Stellungnahme zum kritischen Kommentar Hermann Belands zu meinem Aufsatz "Idee und Wirklichkeit der Lehranalyse." [Response to the critical comments of Herman Beland on my article "Idea and reality of training analysis"]. *Psychoanalyse: Klinik und Kulturkritik*, *46*, 115–144.

Thomä, H. (1993). Training analysis and psychoanalytic education: Proposals for reform. *Annual of Psychoanalysis*, *21*, 3–75.

Trijsburg, R. W. (1996). Training analysis in the Dutch Society for Psychoanalytic Psychotherapy: A survey of attitudes and feasibility. *Psychoanalytic Psychotherapy*, *10*, 189–205.

Trijsburg, R. W. (1998). De persoon van de psychotherapeut in psychoanalytische behandelingen [The psychotherapist in psychoanalytical treatment]. *Tijdschrift voor Psychotherapie*, *24*, 421–441.

Trijsburg, R. W., Duivenvoorden, H. J., Stronks, D. L., & Schagen, S. (1994). Leertherapie in Nederland [Educational therapy in the Netherlands]. *Tijdschrift voor Psychotherapie*, *20*, 2–30.

Vermunt, J. K., & Magidson, J. (2003). *Latent GOLD®. User's guide*. Belmont, MA: Statistical Innovations Inc.

Vermunt, J. K., & van Dijk, L. A. (2001). A non-parametric random coefficient approach: The latent class regression model. *Multilevel Modelling Newsletter*, *13*, 6–13.

Weintraub, D., Dixon, L., Kohlhepp, E., & Woolery, J. (1999). Residents in personal psychotherapy: A longitudinal and cross-sectional perspective. *Academic Psychiatry*, *23*, 14–19.

Weissman, M. M., & Bothwell, S. (1976). Assessment of social adjustment by patient self-report. *Archives of General Psychiatry*, *33*, 1111–1115.

Weissman, M. M., Prusoff, B. A., Thompson, W. D., Harding, P. S., & Myers, J. K. (1978). Social adjustment by self-report in a community sample and in psychiatric outpatients. *Journal of Nervous and Mental Disease*, *166*, 317–326.

Wheeler, S. (1991). Personal therapy: An essential aspect of counsellor training, or a distraction from focussing on the client? *International Journal for the Advancement of Counselling*, *14*, 193–202.

Zwanikken, G. J. (1990). De leertherapie in de opleiding tot psychiater [Educational therapy in training as a psychiatrist]. *Tijdschrift voor Psychotherapie*, *16*, 284–290.

Zusammenfassung

Die Therapien der Therapeuten: Die Beziehung zwischen Therapeutentraining und der Veränderungen der Patienten bei Langzeitpsychotherapie und Psychoanalyse

Entwicklung der Patienten in verschiedenen Stadien von Langzeittherapie oder Psychoanalyse wurde in Beziehung gesetzt zu verschiedenen Parametern der Ausbildung ihrer Therapeuten bzw. deren persönlicher Therapien. Die Veränderungsvariable war der Symptomstress entsprechend dem allgemeinen Symptomindex nach der Symptomcheckliste-90. Eine Reihe von Regression Analysen mit latenten Klassen zeigte eine Klasse von Therapeuten auf (16% der Stichprobe), deren Patienten die geringsten Veränderungen aber auch keine Verschlechterung aufwiesen. In dieser Klasse waren Psychotherapeuten mit langen Lehranalysen überrepräsentiert. Es werden auch alternative Interpretationen dieser Ergebnisse diskutiert.

Résumé

Les thérapies des thérapeutes : la relation entre la thérapie didactique et le changement chez le patient dans la psychothérapie et psychanalyse de longue durée

Le développement des patients à travers les phases de psychothérapies psychodynamiques ou de psychanalyses de longue durée était étudié en relation à divers paramètres de la thérapie personnelle ou didactique de leurs thérapeutes. La variable de changement était la détresse symptomatique, le General Symptom Index selon la Symptom Checklist-90. Une série d'analyses par la régression par classe latente a révélé qu'une classe de thérapeutes (16% de l'échantillon) dont les patients avaient changé le moins voire se détérioraient de façon non significative était surreprésentée de façon significative par des psychothérapeutes ayant eu de longues psychanalyses comme thérapies didactiques. Des interprétations alternatives des résultats sont discutées.

Resumen

Terapia de terapeutas. La relación entre el tratamiento didáctico y el cambio del paciente en psicoterapia y psicoanálisis a largo plazo

Se estudió el desarrollo de los pacientes a través de etapas en psicoterapia psicodinámica o psicoanálisis a largo plazo, en relación con diversos parámetros del entrenamiento de sus terapeutas o terapias personales. La variable de cambio fue un síntoma de distrés, del ïndice General de Síntomas, de acuerdo con el Symptom Checklist-90. Una serie de análisis de regresión de clase latente reveló que una clase de terapeutas (16% de la muestra), cuyos pacientes habían experimentado el cambio menor en el tratamiento y que, de hecho, no tuvieron deterioro significativo, estuvo significativamente sobrerrepresentada por psicoterapias con psicoanálisis largos en sus terapias didácticas. Se debate sobre interpretaciones alternativas de los hallazgos.

Resumo

As terapias dos terapêutas: A relação entre terapia de treino e a mudança do paciente em psicoterapia de longo prazo e psicanálise

Foi estudada a relação entre o desenvolvimento dos pacientes ao longo dos estádios da psicoterapia psicodinâmica de longo prazo ou psicanálise e os vários parâmetros da terapia, de treino ou pessoal, dos seus terapeutas. A variável de mudança foi a sintomatologia psicopatológica, o Índice de Perturbação Geral da Lista de Sintomas de Derrogatis (SCL-90). Uma série de análises de regressão (La Lent Class Regression) revelou que um grupo de terapeutas (16% da amostra), cujos pacientes tiveram as menores mudanças no tratamento e sem deterioração significativa, estava significativamente sobre-representados por psicoterapeutas com longa experiência de psicanálise para as suas terapias de treino. Serão discutidas interpretações alternativas para os resultados.

摘要

本研究探討長期心理動力治療或是心理分析的案主跨階段的發展與治療師的訓練或個人治療之間的關聯性。改變的變項包括症狀檢核-90 工具的症狀困擾與一般症狀指標。一連串潛在類別回歸分析顯示，有一類治療師(占樣本的 16%)的案主治療改變最少，也沒有明顯的惡化，治療師明顯過度陳述了他們接受長期心理分析作為治療師的訓練。本研究結果的其他可能解釋也被討論。