Therapists and their patients: Similarities and differences in attitudes between four psychotherapy orientations in Sweden

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Alas, our theory is too poor for experience.

ALBERT EINSTEIN

No, no! Experience is too rich for our theory.

NIELS BOHR

Abstract

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The aim of this thesis was to illuminate the possibilities and obstacles for therapists of different orientations to communicate and cooperate better. Data was collected using a questionnaire named VEP-Q. Similarities and differences in attitudes between licensed psychotherapists of four orientations - working with adults in individual therapy - were surveyed. In all 416 therapists, defining themselves as a psychodynamic (PDT), cognitive (CT), cognitive behavioral (CBT), or integrative eclectic (IE) therapist, were compared. In addition a client version of the VEP-Q was developed and distributed to patients of a subsample of these therapists. **Study I** describes similarities and differences between the therapists regarding (1) background factors, (2) focus in psychotherapy, (3) attitudes towards psychotherapy as art/craftsmanship, (4) scientific outlook, (5) what characterizes a good psychotherapist, and (6) how psychotherapy ought to be pursued. The therapists had very similar attitudes about the therapeutic relationship and rather similar attitudes about which effects psychotherapy ought to obtain. The greatest differences were related to psychotherapeutic techniques and views on scientific issues. In **Study II**, a factor analysis regarding items about how psychotherapy ought to be pursued was conducted, resulting in three scales; a PDT, a CBT and a common factor (CF) scale. In addition to theoretical orientation, variables such as gender and basic professional training influenced how respondents answered the VEP-Q. In **Study III**, the aim was to investigate if psychotherapists misjudge other orientations following a pattern from group psychology: overrating positive aspects in their own group and having prejudiced attitudes towards other groups. The study showed that psychotherapists can correctly evaluate therapists of their own orientation, but exaggerated the differences between their own and other orientations in a prejudiced way. In **Study IV**, patients' preferences about how psychotherapy ought to be pursued were compared on a PDT, a CBT and a CF scale. The patients had rather similar preferences irrespective of their therapists' orientation or which theoretical orientation they themselves preferred. The patients' preferences were also stable after having been in psychotherapy for at least ten sessions. However, clients with a PDT therapist considered the PDT scale as more important than clients in other orientations did, and women rated the CF scale as more important than men did. The clients' preferences were also compared with the therapists'. While the clients' ratings centered around the scales' midpoint, the therapists' ratings differed more, and they often had higher ratings on the scales than the clients did.

The general conclusion is that important differences between theoretical orientations in psychotherapy remain, but the extent of these differences are exaggerated, and the phenomena of ingroup/outgroup thinking among psychotherapists is one explanation for this exaggeration.

Key words: psychotherapy, theoretical orientation, psychotherapist attitudes, client attitudes, questionnaires, prejudice, preferences, integrative psychotherapy

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Populärvetenskaplig svensk sammanfattning

Psykoterapi har kommit att bli en alltmer självklar det av samhället, i vart fall det västerländska. Även om olika former av försök till hjälp med psykiska svårigheter förmodligen alltid varit en del av mänsklig verksamhet, så har den moderna psykoterapin sina rötter hos Sigmund Freud. Med tiden har dock andra former av psykoterapi utvecklats. Den humanistiska psykoterapin, med personer som Carl Rogers och Rollo May som några av de mest kända företrädarna, kan sägas vare den första formen av alternativ terapitradition, vilken utvecklades från 1940-talet och framåt. Men andra psykologiska teorier hade utvecklats tidigare, till exempel vad som kallas för behaviorism. Det var dock inte förrän i slutet av 1950-talet som psykoterapi grundad på behaviorismen utvecklades. Strax efteråt uppkom också en ny form av terapi för depression, utvecklad av Aaron Beck, som kom att kallas för kognitiv terapi. Efter att under lång tid setts som något ganska udda har psykoterapi under de senaste decennierna fått allt större respekt och ett ökat erkännande som en behandlingsmetod för psykiska svårigheter.

Det har också skett en professionalisering av psykoterapeutisk verksamhet genom att bedrivande av psykoterapi inom sjukvårdens ram har blivit en verksamhet som enbart får bedrivas av legitimerade yrkesutövare. För psykologer leder psykologutbildningen till en legitimation där psykologen får bedriva psykoterapi som en del av sitt yrkesansvar. Men genom att en särskild psykoterapeututbildning också har uppkommit, kan även personer med andra grundyrken än psykolog vidareutbilda sig till psykoterapeut. Psykoterapiutbildningen består av två steg. Den första kallas för en grundläggande psykoterapiutbildning, och en person med denna utbildning får bedriva psykoterapi under handledning av en legitimerad psykoterapeut. Det finns också en 3-årig vidareutbildning som leder till legitimation som psykoterapeut. Från början fanns det i Sverige bara en psykodynamiskt inriktad utbildning till psykoterapeut, men med tiden har fler inriktningar tillkommit. Sedan 1999 registrerar Socialstyrelsen psykoterapeut-legitimationen med en av följande sju inriktningar: psykoanalytisk/psykodynamisk individualpsykoterapi, kognitiv psykoterapi, beteendeterapi, kognitiv beteendeterapi, barn- och ungdomspsykoterapi, familjeterapi och gruppsykoterapi.

Eftersom vissa av dessa inriktningar rör formen för hur terapin ska bedrivas (till exempel familjeterapi och gruppterapi) är det lätt att förstå att dessa kan skilja sig åt från de andra inriktningarna. Men när det gäller de terapiformer som oftast handlar om psykoterapi för en enskild individ är det svårare att förstå vad som skiljer inriktningarna åt. Svårast kan det vara att förstå hur det kan finnas olika inriktningar för kognitiv terapi, beteendeterapi och kognitiv beteendeterapi, eftersom dessa former verkar så besläktade med varandra. Uppdelningen i olika inriktningar kan väcka undran över vad det finns för likheter och skillnader mellan inriktningarna. Ytterst reser uppdelningen frågan om det är motiverat med så

många olika inriktningar, eller om det snarare är historiska skäl till uppdelningen. Uppdelningen i "skolor" beträffande psykoterapeuter med olika teoretisk inriktning är bakgrunden till denna avhandlings uppkomst, vars yttersta syfte är att se om det går att sprida ljus över frågan om det kan vara motiverat med så många olika legitimationsgrundande inriktningar för individualpsykoterapi med vuxna.

Tanken har varit att försöka förtydliga vad det finns för möjligheter och hinder för de olika psykoterapiinriktningarna att kommunicera och samarbeta bättre med varandra. För att kunna bedöma detta har en kartläggning skett av viktiga mönster av likheter och skillnader mellan inriktningarna. Främst har intresset riktats mot att undersöka vad de olika inriktningarna har för syn på vad som är värdefulla inslag i psykoterapi. Men även hur de olika inriktningarna ser på vad som kännetecknar en bra psykoterapeut har undersökts. Ett annat inslag har varit att undersöka vad terapeuter tror om andra terapeuter när det gäller hur psykoterapi bör bedrivas, dels terapeuter generellt i den egna inriktningen, dels terapeuter av andra inriktningar. Därutöver har det också undersökts hur patienter som går hos terapeuter med olika inriktningar, ser på en del av de frågor som terapeuterna har fått.

Som framgår av uppräkningen av vilka inriktningar som socialstyrelsen utfärdar legitimation för så finns inte den humanistiskt/existentiella/upplevelseorienterade terapin med. Det beror på att den av socialstyrelsen inte bedömts att ha ett tillräckligt vetenskapligt underlag. Det är också relativt få personer i Sverige som idag betecknar sig enbart som beteendeterapeuter, därför har inte heller den inriktningen undersökts i avhandlingen. Däremot finns det terapeuter som har gått en utbildning med en viss teoretisk inriktning, men som inte längre anser sig bedriva terapin i enlighet med den inriktning man en gång utbildat sig i. Istället låter man sig inspireras av olika inriktningar. Sådana terapeuter brukar kallas för eklektiska eller integrativa, och även den gruppen har undersökts.

För att få ett underlag för att beskriva likheter och skillnader mellan inriktningarna skickades en enkät *Värdefulla inslag i psykoterapi och legitimationsinriktning* till 931 legitimerade psykoterapeuter. När de som inte längre arbetade som psykoterapeut, de som inte var individualterapeuter, och de som inte hade en tydlig identitet i en viss inriktning var bortsållade, återstod 416 terapeuter med en tydlig inriktning: psykodynamisk (PDT), kognitiv (KT), kognitivt beteendeterapeutisk (KBT), samt integrativt/eklektisk (IE) terapi. Det är mellan dessa fyra grupper som jämförelser har gjorts.

I avhandlingen ges först en bakgrund till temat likheter och skillnader mellan olika terapiinriktningar, och därefter presenteras fyra delarbeten med följande innehåll.

I **Studie I** beskrivs likheter och skillnader avseende terapeuternas: (1) bakgrundsfaktorer; (2) fokus i terapi; (3) syn på psykoterapi som vetenskap respektive konst/hantverk; (4) vetenskapliga grundsyn; (5) attityder till vad som

kännetecknar en bra terapeut; samt (6) attityder till hur psykoterapi bör bedrivas. När det gällde bakgrundsfaktorer var KBT terapeuter oftare psykologer och män, jämfört med de andra inriktningarna. Det fanns stora likheter mellan inriktningarna när det gällde att fokusera terapin på sambandet mellan patientens tankar, känslor och beteende, samt på den terapeutiska relationen. Terapeuterna hade också en väldigt likartad syn på vikten av att den terapeutiska relationen kännetecknas av ett bra samarbetsklimat mellan patient och terapeut, att patienten känner sig förstådd av terapeuten och känner stöd och värme från terapeutens sida. Det fanns även en ganska likartad syn på vilka resultat psykoterapin bör uppnå, såsom att patienten lär sig acceptera sina känslor och får en mer positiv självbild. När det gällde synen på vad som kännetecknar en bra psykoterapeut fanns de största skillnaderna mellan KBT-terapeuter och terapeuter med de andra inriktningarna. De största skillnaderna mellan terapeuter av olika inriktning fanns inom områdena vetenskaplig grundsyn och hur viktiga olika psykoterapeutiska tekniker är. PDT-terapeuter hade oftast en så kallat hermeneutisk vetenskapssyn medan KT- och KBT-terapeuter oftare hade en så kallat empirisk/positivistisk vetenskapssyn. Det var dock inte helt lätt att bedöma vikten av denna skillnad eftersom det bland PDT-, IE- och KT-terapeuter var vanligt att anse att dessa olika syner på vetenskap gick att förena. De allra största skillnaderna rörde för det första värdet av att patienten får så kallade hemuppgifter mellan terapisessionerna. Detta hade KT- och KBT-terapeuter en mycket hög värdering av, medan PDT-terapeuter hade en klart låg värdering av att ge patienter hemuppgifter. Den andra riktigt stora skillnaden rör det som brukar kallas att patienten utvecklar en överföringsrelation till terapeuten. Detta ansåg PDT-terapeuter var mycket viktigt, medan KT- och KBT-terapeuter hade en klart låg värdering av att patienten utvecklar en överföringsrelation till terapeuten.

I **Studie II** gjordes en så kallad faktoranalys av de 17 frågor som handlade om hur psykoterapi bör bedrivas. Syftet med faktoranalysen var att underlätta kommande analyser genom att föra samman de 17 frågorna till ett fåtal skalor. Resultatet av faktoranalysen blev tre skalor. En av dessa kallades för PDT-skalan och rymde en hög värdering av överföring och koppling i terapin till patients uppväxt. En andra faktor handlade bland annat om att det är viktigt med mål för terapin, att använda hemuppgifter och att patientens symtom minskar, och denna skala kallades för KBT-skalan. En tredje faktor benämndes CF-skalan efter det engelska uttrycket Common Factors. Denna skala rymde sådant som terapeuter av olika inriktningar värderade högt såsom att patienten känner sig förstådd och accepterad av terapeuten, att terapeuten har ett varmt och stödjande sätt, att patienten får ökad självkännedom, och att terapeuten intresserar sig för patientens nusituation. Det fanns skillnader mellan inriktningarna på PDT- och KBT-skalan, men inte på CF-skalan. Kvinnliga terapeuter, oavsett inriktning, värderade CF skalan högre än vad män gjorde.

I **Studie III** var syftet att undersöka om psykoterapeuter tenderar att missbedöma hur andra terapeuter ser på terapi eller om de kan bedöma detta tämligen bra.

Terapeuter visade sig vara bra på att bedöma andra terapeuter med samma teoretiska inriktning som de själva hade. Däremot missbedömde man andra inriktningar enligt ett klassiskt mönster om hur konkurrerande grupper kan fungera. Terapeuterna tenderade att överdriva skillnaden mellan den egna gruppen och de andra grupperna, genom att på ett lite fördomsfullt sätt underskatta i vilken grad det som de själva tycker är värdefullt i terapi också förekommer i andra grupper, och överskatta i vilken grad det som de själva tycker är värdefullt finns inom den egna terapeutiska inriktningen.

I **Studie IV** analyserades vad patienter i terapi anser borde vara viktigt i psykoterapin, det som kan kallas för hur deras preferenser ser ut. Också här användes tre skalor; en PDT en KBT och en CF skala. Patienterna hade oftast, oavsett inriktning på den terapi de själva gick i, likartade preferenser på de tre skalorna, Dock värderades PDT-skalan högre av patienter i PDT-terapi än av andra patienter. Preferenserna förändrades inte heller efter terapin. De kvinnliga patienterna värderade i likhet med terapeuterna CF-skalan högre än vad männen gjorde. I denna studie gjordes också en jämförelse mellan patienternas preferenser och terapeuters preferenser, på nämnda tre skalor. Det visade sig att de stora skillnaderna inte låg mellan de olika terapeutiska inriktningarna. Istället gick de mellan patienterna som grupp å ena sidan och å andra sidan terapeuterna som grupp. Patienterna skattade, oavsett vilken inriktning patienten gick i, PDT- och KBT-skalorna runt medelvärdet, samt CF-skalan något högre. Terapeuterna däremot hade mer bestämda uppfattningar, och värderade "sin egen" skala (PDT resp. KBT) högre än vad patienterna i samma inriktning gjorde. KT- och KBT-terapeuter värderade alltså KBT-aspekter klart högre än vad patienter i KT och KBT gjorde, medan PDT-terapeuter värderade inriktningen på patientens barndom högre än vad patienter i PDT gjorde. Terapeuterna hade också, oavsett teoretisk inriktning, en högre värdering av de gemensamma faktorernas betydelse jämfört med patienterna.

Sammanfattningsvis visar avhandlingen att skillnaderna mellan terapeuter av olika terapiinriktningar ofta var mindre än vad som kunde förväntas av teoretiska skäl, samtidigt som vi på vissa områden fann betydande skillnader. Det fanns en samsyn i att det går att skilja ut gemensamma faktorer i terapi, främst avseende den terapeutiska relationen, och att dessa är viktigare än de mer metodspecifika faktorerna (PDT-, KT- & I/E-terapeuter), eller i vart fall lika viktiga (KBT-terapeuter). Vi fann också en ganska stor samsyn när det gäller vilka mål som psykoterapi bör ha. Samtidigt fanns det betydande skillnader när det gäller PDT och KT/KBT vad gäller hur psykoterapi ska bedrivas. Mellan KT- och KBT-terapeuter var den största skillnaden synen på vad som kännetecknar en bra psykoterapeut. Här hade KT-terapeuter mer gemensamt med PDT-terapeuter än med KBT-terapeuter, även om det fanns inslag som var gemensamma för alla inriktningar även när det gäller synen på terapeuten. Terapeuter av samtliga

inriktningar tenderar dock att överdriva skillnaderna mellan den egna och andras inriktningar, även om IE terapeuter är minst benägna för att göra detta.

Sammantaget kan resultaten summeras som att det finns faktiska skillnader mellan terapiinriktningarna som kan innebära svårigheter att kommunicera med varandra och samarbeta. Men det finns också påtagliga likheter som innebär möjligheter till ökat samarbete. Ett hinder för detta är dock att terapeuter redan är uppdelade i olika teoretiska inriktningar. Detta skapar i sig avstånd och en tendens till ”vi och dom” tänkande, vilket får till följd en tendens att överdriva skillnaderna mellan den egna inriktningen och terapeuter av andra inriktningar. Däremot är det svårt att motivera förekomsten av olika teoretiska inriktningar utifrån hur patienternas preferenser ser ut avseende vad terapin bör innehålla.

Med utgångspunkt i den forskning som presenteras i denna avhandling finns det därför anledning att tro två saker inför framtiden. Det ena är att ett ökat närmande mellan olika terapiinriktningar kommer att ske, till att börja med främst mellan KT och KBT inriktningarna, men på sikt även mellan dessa inriktningar och PDT. Det andra är att olika teoretiska inriktningar kommer att leva kvar under lång tid, som ett resultat både av faktiska skillnader och gruppsykologiska processer.

Om denna prognos är riktig är att det ur såväl vetenskaplig som praktisk synpunkt olyckligt när olika psykoterapiinriktningar ställs mot varandra "i sin helhet". Det vore önskvärt om diskussionen om evidensbaserad psykoterapi fokuserade på vilka inslag i psykoterapi som forskningen påvisat som mest effektiva, och hur användandet av dessa inslag kan öka. En sådan diskussion skulle sannolikt ha större möjligheter att utveckla framgångsrikt psykoterapeutiskt arbete inom samtliga inriktningar, än nuvarande diskussion rörande huruvida inriktning A har mer evidens för sin behandling än inriktning B. En annan implikation av resultaten kan vara att det ur samhällelig synpunkt är angeläget att iaktta försiktighet med att ta till sig någon specifik skolbildnings syn på psykoterapiområdet, eftersom dessa har en bias för att övervärdera den egna inriktningen.

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Göteborg, April 2010

Billy Larsson

List of publications

This thesis consists of a summary and the following four studies, referred to in the text by their Roman numerals:

I. Larsson, B. P. M., Kaldo, V., & Broberg, A. G. (2009). Similarities and differences between practitioners of psychotherapy in Sweden: A comparison of attitudes between psychodynamic, cognitive, cognitive–behavioral, and integrative therapists. *Journal of Psychotherapy Integration*, *19*(1), 34-66.

II. Larsson, B. P. M., Kaldo, V., & Broberg, A. G. (in press). Theoretical orientation and therapists' attitudes to important components of therapy: A study based on the 'Valuable Elements in Psychotherapy' Questionnaire. *Cognitive Behaviour Therapy*.

III. Larsson, B. P. M., & Broberg, A. G. (2010). What psychotherapists with different theoretical orientations think about each other: The role of prejudice. Manuscript submitted for publication.

IV. Larsson, B. P. M., Kaldo, V., & Broberg, A. G. (2010). Similarities and differences in preferences between Swedish clients in four different psychotherapies: An explorative and prospective study. Unpublished manuscript

Contents

Background, aims, and outline

Psychology is commonly thought of as a new science, but an old subject (Leahey, 2001; Thomson, 1968). In this view, before the appearance of scientific psychology we already had two kinds of psychological theories: philosophical ones and those embedded in folk psychology. Although the word "psychology" only appeared in the 1600s, in practical terms folk psychology—the tendency of human beings to create theories of mind and behavior—may be older even than *homo sapiens*, which makes it at least 100,000 years old (Leahey, 2001). Psychology as a science, on the other hand, developed in the late 19th century, as a result of the scientific claims from experimental psychology and Freudian psychoanalysis.

The same duality of older folk wisdom versus modern science is probably true for psychotherapy. The term "psychotherapy" was used for the first time in 1887 (Leahey, 2001) when a psychotherapeutic clinic was founded in Amsterdam, and the term was rapidly adopted by both writers and the public (Ellenberger, 1970). Nevertheless, psychotherapy as an activity seems to be very old. According to Henri Ellenberger (1974), primitive healing has its roots in prehistoric times, and there is a direct continuity from exorcism to magnetism, from magnetism to hypnosis, and from hypnosis to newer dynamic therapies. Ellenberger also claims that the oldest known representation of a healer is a picture in a cave in France, believed to have been painted about 15,000 BC; based on findings from more recently discovered caves, shamanism is now thought to have been depicted more than 30,000 years ago (Berg, 2005). Moreover, Jerome Frank (Frank & Frank, 1991) claims that the fundamental ingredients have been the same for all kinds of psychotherapy, irrespective of whether the therapy is old or contemporary, or whether the healer is a shaman, a priest, or a scientifically educated psychotherapist.

Although psychotherapy in various forms has a long history, the history of professional psychotherapy in Sweden is rather short. Freud's psychoanalysis was introduced to Swedish physicians by Poul Bjerre in 1911, and a Finnish-Swedish psychoanalytical society was constituted in 1934 (Johansson, 1999); behavior therapy was introduced in the late 1960s, and a behavior therapy association founded in 1971 (Öst, 1996); and cognitive therapy was introduced in the early 1980s, and a Swedish association for cognitive therapy established in 1986 (Törneke, 2005). Thus, during a large part of the 20th century, Sweden had only a few hundred people working professionally with psychotherapy, but since the 1980s this has changed dramatically.

University-level psychotherapy education was started in Sweden 1978 (Högskoleverket, 2007). This training was conducted in two stages, allowing many professionals in caring vocations, such as psychologists, psychiatrists, priests, and

nurses, to gain some basic training in psychotherapy. Since 1985/86, a further three-year, half-time program leading to a license from the National Board of Health and Welfare has been available to those with the basic training. In 1991 there were 1,602 licensed psychotherapists in Sweden; in 1995 Sweden had 2,610 licensed psychotherapists (Socialstyrelsen, 1996); in 2004 there were 4,517 (Westling, 2004); and in 2010 there were 5,729 licensed psychotherapists in Sweden (P. Wahlstedt, personal communication, March 30, 2010). In the beginning, psychotherapy education was totally dominated by psychoanalytically oriented therapy (Socialstyrelsen, 1990), but this changed rather soon. Now there are study programs with various approaches to psychotherapy, so a psychotherapist who wants to work individually with adults earns a license in one of four theoretical schools: psychodynamic, cognitive, behavioral, or cognitive-behavioral. This division raises questions about the similarities and differences between the various schools of psychotherapy, especially whether this division is valuable or whether it exaggerates differences and underestimates what psychotherapists have in common.

The dividing of psychotherapy into different theoretical orientations has also recently been challenged by many new psychotherapies that blend elements from different orientations. Especially in the treatment of personality disorders, this integrative feature seems prominent, and perhaps even necessary, in the creation of successful treatments. It is also worth noting that cognitive-behavioral therapy (CBT), while not particularly new anymore, is itself an integration of two orientations, and this integration made it possible to design treatments for more diagnoses and perhaps also to design more effective treatments. Newer "third wave" psychotherapies in the CBT tradition (Hayes, 2004), such as acceptance and commitment therapy (ACT) (Hayes, Strosahl, & Wilson, 1999), dialectical behavior therapy (DBT) (Linehan, 1993), and mindfulness-based cognitive therapy (MBCT) (Segal, Williams, & Teasdale, 2002), have all integrated elements from other areas, especially from meditation traditions, but sometimes also from the experiential school.

Schema therapy (ST), another highly integrative therapy with roots in CT, includes elements from Gestalt therapy and emphasizes the patient's childhood to a degree that is associated more with psychodynamic therapy than with traditional cognitive therapy (Young, 1999; Young, Klosko, & Weishaar, 2003). Mentalization-based therapy (MBT), developed by two English psychoanalysts, Anthony Bateman and Peter Fonagy, aims to help borderline patients improve mentalization, or the ability to reflect upon their own mental states and consider how their behavior may be perceived and interpreted by others. MBT is similar to cognitive therapy in some particular aspects of treatment, for example in identifying the patient's primary beliefs (named schemas in CT), but also on a more general, theoretical level, including shared positive attitudes towards manualisation of therapy, discussing

diagnoses with patients, and using terms such as psychoeducation (Bateman & Fonagy, 2004, 2006).

Affect phobia therapy (APT) has its origin in short-term dynamic psychotherapy. While APT contains psychodynamic themes such as the resolution of conflicts, the main theme in this therapy is the stepwise exposure to feelings, a process the authors describe as systematic desensitization, using a term from behavior therapy (McCullough & Andrews, 2001; McCullough et al., 2003). In APT psychotherapy sessions are videotaped and used as homework, together with interventions from cognitive, behavior, Gestalt, and experiential therapies and from self psychology. This means that the integration in this therapy is so extensive that it is nearly impossible to characterize it as belonging to specific school of psychotherapy based on either its content or the theory behind it. Instead it is its historical roots that make it possible to classify APT as a psychodynamic treatment. The focus on affect in APT is explicit in its name, and in 2000 Samoilov and Goldfried predicted that the "decade of affect" in CBT would come in the beginning of the 21st century (Samoilov & Goldfried, 2000). A development in that direction has in fact occurred, partly since an increased focus on emotion is common in many of the newer third wave therapies (Leahy, 2007). So in the short term, a likely development is the continued blending of elements from different schools of psychotherapy. This tendency to use components from different traditions suggests that "clinical wisdom" exists in several orientations, irrespective of the extent of evidence for any individual orientation.

Finally, the appearance of interpersonal psychotherapy (IPT) shows that it is possible to create new kinds of psychotherapy without belonging to one established theoretical orientation. Originally IPT was developed as a treatment for depression, and it is a recommended treatment for at least depression and bulimia (Roth & Fonagy, 2005). While researchers sometimes evaluate IPT together with short-term psychodynamic psychotherapy (STPP), for example in Blagys and Hilsenroth's reviews (2000; 2002), advocates of IPT underline that it is a distinctive psychotherapy independent of any particular theoretical school (Lipsitz, 2009; Markowitz, Svartberg, & Swartz, 1998).

The conclusion that can be drawn from this quick overview is that it is becoming increasingly more difficult to say what psychotherapies within a particular school have in common, beyond their historical roots and a positive view of the school's founders. As a consequence, it seems increasingly interesting to know how psychotherapists of different orientations agree or differ in their views of how psychotherapy ought to be pursued, as well as in what ways their actual practices resemble or contrast with each other. Although some attempts in this direction have been made by Sandell and coworkers (Sandell, Carlsson, Schubert, Broberg, & Blomberg, 2002; Sandell et al., 2004), these questions have not been the subject of much research in Sweden.

Thus, this thesis is an attempt to examine some features of the field of psychotherapy for individual adults as it is taught and practiced in Sweden today. The thesis comprises three main parts: (1) the introduction**,** which provides a historical overview of the major schools and trends in psychotherapy; an analysis of similarities between the various schools; a proposal towards a common language in psychotherapy; and the application of some relevant academic and psychological theories to the schools of psychotherapy; (2) a summary of four supporting empirical studies undertaken to explore the similarities and differences between current schools of psychotherapy in Sweden; and (3) a general discussion of the trends towards or away from convergence in theory, language, and therapy in the major schools and their implications for future psychotherapy training and practice in Sweden.

Introduction

To understand the present, as well as to influence the future to any extent, it is necessary to understand the historical development from which the present situation has arisen. Therefore, one aim of this introduction is to give an overview of the similarities and differences between the most common schools of psychotherapy, with special attention to three topics: (1) the ingredients that are thought to make psychotherapy effective, (2) the extent to which these supposedly effective ingredients are used exclusively by therapists in only one school or shared by several schools of psychotherapy, and finally, (3) rather than the obvious and defining theoretical differences, the possibly overlooked similarities of the theories and therapies of the various schools.

The first two sections of the introduction review opinions and beliefs written about these topics, first by the pioneers of the different psychotherapy schools, and then from contemporary clinicians. The third section reviews psychotherapy research relevant to the theme of similarities and differences between psychotherapists of diverse orientations. Following these reviews of founding theories, current thought, and empirical findings, the next sections of the introduction describe how more effective communication between the theoretical orientations could be facilitated by the development of a common language in psychotherapy and what conclusions can be drawn from the empirical research on this topic. The final section expands the reviews, proposals, and research conclusions by including other theoretical perspectives, beginning with the possibly integrative influence of academic psychology on theories about psychotherapy. Furthermore, in an effort to understand phenomena within theoretical schools in psychotherapy, these orientations are regarded as groups, and viewed according to how groups generally

function. Therefore, the introduction to the empirical work ends with some general observations about group psychology and attitudes and how these apply to the various schools of psychotherapy. The concept of attitude is interesting since attitudes within groups are a way to understand the processes that underlie the various theoretical orientations within the field of psychotherapy.

The founders of the schools

Psychodynamic therapy—Sigmund Freud

Sigmund Freud not only developed many theories, but also regarded himself as a scientist. The view of Freud as a scientist was often criticized at the end of the 20th century (Cioffi, 1998; Esterson, 1993; Webster, 1995), but Freud's own opinion will not be questioned here, because irrespective of whether or not his work meets scientific standards, he laid the foundation of modern psychotherapy. Psychoanalysis was made famous as the "talking cure," although this label is ascribed to the patient, Anna O, who was treated not by Freud himself, but by his colleague Joseph Breuer (Freud & Breuer, 1895). Viewed from the longer historical perspective, a talking cure was, of course, not new as a psychotherapeutic tool, but in the early history of psychoanalysis, somatic treatments were so popular that Freud's announcement of this special form of treatment was interesting news.

Freud described similarities and differences between psychoanalysis and other treatments in *On Psychotherapy* (Freud, 1905), and returned to the subject in *Introductory Lectures on Psycho-Analysis* (Freud, 1916-17). Recognizing that psychotherapy had a long history, he wrote, "Let me remind you that psychotherapy is in no way a modern method of treatment. On the contrary, it is the most ancient form of therapy in medicine." (1905, p. 258).

According to Freud, the reason why old forms of psychotherapy, as well as his own new "scientific psychotherapy," could be effective was the common factor between them, namely the patient's relationship to the physician. Freud emphasized that a consequence of this relationship is that all physicians continually practice psychotherapy "even when [they] have no intention of doing so and are not aware of it." (Freud, 1905, p. 258) Freud noted further in his remark concerning psychoneuroses in particular, that it "is not a modern dictum but an old saying of physicians that these diseases are not cured by the drug but by the physician, that is, by the personality of the physician, inasmuch as through it he exerts mental influence." (1905, p. 259). Freud goes as far as to maintain that it is justifiable for the physician to obtain command of this factor, to use it, and to strengthen it; "This and nothing else is what scientific psychotherapy proposes." (1905, p. 259)

Freud valued different kinds of psychotherapy mainly because of the influence of Hippolyte Bernheim and the Nancy School (Ellenberger, 1970). Freud (1917) described treatments of that school, which were often hypnotic, as suggestive therapies and recognized that they could be effective. However, psychoanalysis, according to Freud, was different. He used the analogy of suggestive therapies acting like cosmetics, while psychoanalysis acted like surgery. In contrast to suggestive therapies, psychoanalysis could overcome the patient's resistance and get close to what had really happened to the patient. This was made possible by the patient's transference of feelings from the past towards the psychoanalyst. As a result of this difference between psychoanalysis and earlier treatments, Freud regarded psychoanalytic treatment as more effective than merely suggestive psychotherapies, and he maintained that psychoanalysis in had a more lasting effect.

Freud saw similarities to other treatments only when he made comparisons to older forms. When he made comparisons with newer treatments such as those developed by Jung and Adler, for example, he emphasized the differences (Freud, 1918). This was presumably a reaction to the fact that the developers of those treatments had first admired Freud and then become critical of his theories and therapies. During Freud's lifetime behaviorism was a kind of academic psychology and seldom a psychotherapy, so comparisons with behaviorism were not particularly appropriate. Although Freud was interested in science, the theories he referred to were mostly those he had acquired during his education in the 19th century, such as evolutionary theories and sexology (Sulloway, 1979). He was not particularly interested in contemporary academic psychology during the 20th century, preferring instead to develop his own theories in many areas.

In summary, Freud maintained that: (1) different forms of psychotherapy can be effective, (2) the common factor in effective therapies is the relationship between the therapist and the patient, and (3) psychoanalytic therapy differs from other forms of psychotherapy because it includes transference reactions from the patient towards the therapist, and this transference enables psychoanalysis to get a better result than other forms of psychotherapy. While Freud had some interest in academic theories, he was most interested in developing his own kind of theoretical system.

Behavior therapy—B. F. Skinner and Joseph Wolpe

Behavior therapy has its roots in the behaviorism of Watson and Skinner, though neither of them worked as clinicians. Skinner wrote about psychotherapy at a time when psychoanalysis was the major approach taken in psychotherapy (Skinner, 1953). His main interest was to show how psychoanalytic theories could be drafted in the terminology he had developed, but he also presented critical views on

psychoanalysis. In particular, Skinner was interested in applying his theory to psychoanalytic therapy. According to Skinner, the patient's difficulties result from punishment or the fear of punishment. The effective therapist, therefore, acts as a non-punishing audience and avoids criticizing the patient in any way. If criticized by the patient, the therapist avoids any signs of counter-aggression. As the therapist's role as a non-punishing audience is established, behavior that has hitherto been repressed begins to appear in the repertoire of the patient. This behavior, which was previously punished, can now disappear by extinction, and the patient will then feel less wrong, less guilty, or less sinful.

Skinner was also of the opinion that some positive effect came from the patient's expectations of relief from an aversive condition. Although he had psychoanalysis in mind when he wrote about psychotherapy, the view Skinner presents is so general that it could also be valid for other psychotherapies.

From Watson's time to the 1950s a large number of behavioral principles were identified in the laboratories where behaviorism was developed. However, it was not until the late 1950s and early 1960s that those basic theories were explored with regard to their therapeutic applications. The people who first did this sometimes called themselves "behavior modifiers." Soon, however, one of Skinner's students settled on the term "behavior therapy," and a rapid development of this kind of psychotherapy ensued (Douger & Hayes, 2000). One of the earliest clinical books from this time, and the most influential, is Joseph Wolpe's *Psychotherapy by Reciprocal Inhibition* (Wolpe, 1958).

Wolpe wanted to explain reciprocal inhibition, which he claimed had a central role in psychotherapy, although he acknowledged that cures from neuroses can be obtained by all kind of therapists. He reviewed research evidence for this opinion and concluded that the various procedures that different therapists regard as vital to success are not vital at all; the effective factor must be something common to all therapeutic situations. The only common feature, according to Wolpe, is that the patient confidentially reveals and talks about his difficulties to a person he or she believes to have the knowledge, skill, and desire to help. In his discussion of abreaction, Wolpe returns to the importance of the therapeutic relationship. He claims that it is only when the patient can feel the therapist's sympathetic acceptance of him, that beneficial abreaction can occur.

A summary of the early standpoints taken by the precursors of behavior therapy has much in common with the summary of Freud's opinions. Both Skinner and Wolpe recognized that various kinds of therapy can be effective and that the therapeutic relationship is the most important factor in psychotherapy. In addition, Wolpe claimed that therapy founded in the tradition of behaviorism will have some of its own methods, which could enrich the psychotherapeutic field. When Skinner tried to explain phenomena in psychoanalysis with behaviorist terminology, he was

strikingly modern and showed an interest in what would later be called theoretical integration.

Humanistic-experiential psychotherapy—Carl Rogers

It has been suggested that the origin of humanistic psychotherapies can be dated to December 11, 1940, when Carl Rogers gave a speech critical of many of the psychotherapy methods of the time (Cain, 2002). Rogers has been famous for formulating, in a somewhat outdated scientific language, what he called the six necessary and sufficient conditions for personality change, both in psychotherapy and in other situations (Rogers, 1957). Three of the six conditions concerned the therapist, who should (1) be congruent and integrated in the relationship, (2) experience unconditional positive regard for the patient, and (3) experience and communicate empathic understanding to the patient.

Rogers emphasized that those six conditions were relevant not only for his own form of psychotherapy, but for all forms. If other kinds of psychotherapy were effective, whether or not they used special methods, the essential ingredients would nevertheless be those same six conditions. For example, if the analysis of dreams or hypnosis were remedial, it was because the therapist used those methods to express unconditional positive regard and empathic understanding to the patient. The opposite was true as well. All kinds of techniques could be used, but with a lack of empathy, they would be ineffective. This was also true for the client-centered psychotherapy Rogers had developed himself, which was specialized to use those six conditions. Client-centered therapy also had its own specific techniques such as "reflecting feelings," but Rogers acknowledged that those techniques were not a necessary ingredient in psychotherapy. Even "reflecting feelings" could be used in an effective or ineffective way, depending on the therapist, according to Rogers.

Thus, Rogers also saw great similarities between the different forms of psychotherapy. They could all be effective or ineffective depending on the therapist's personal skills. If psychotherapy was effective, the effective ingredients were the same. Different kinds of therapists used different methods to do the same thing.

Cognitive psychotherapy–Aaron Beck

Aaron Beck is the founder of cognitive psychotherapy. Admittedly, rational-emotive therapy (RET), was formulated by Albert Ellis in the late 1950s (Ellis, 1962), just before Beck started to develop cognitive therapy, and to some extent Beck was influenced by Ellis when he started to develop his approach to psychotherapy. However, Beck's original theory of depression was founded in his

clinical experiences, while at the same time many of his therapeutic techniques were directly borrowed from behavior therapy (Clark, Beck, & Alford, 1999).

Beck has written extensively about the similarities between cognitive therapy and other forms of psychotherapy, especially in his presentation of research from Rogers and Traux (Beck, 1976), indicating that a successful outcome is facilitated if the therapist shows genuine warmth, acceptance, and accurate empathy.

When Beck and coworkers wrote about cognitive therapy for depression (Beck, Rush, Shaw, & Emery, 1979), they described the therapeutic interaction as characterized by basic trust, and they emphasized the importance of rapport. They portrayed the cognitive psychotherapist in the following way: "The aspiring *cognitive therapist* must be, first, a good *psychotherapist*. He must possess necessary characteristics such as the capacity to respond to the patient in the atmosphere of a human relationship—with concern, acceptance and sympathy. No matter how proficient he is in the technical application of cognitive strategies, he will be severely hampered if he is not adequately endowed with these essential interpersonal characteristics." (Beck et al., 1979, p. 25). The authors also raise a word of caution. Cognitive and behavioral techniques can, especially to the neophyte therapist, seem deceptively simple. The danger with this is that the therapist may relate to the patient as one computer to another, rather than as one person to another, and may then be regarded by the patient as mechanical and manipulative. Instead, techniques are intended to be applied in a tactful, therapeutic, and human manner by a fallible person—the therapist.

The desirable characteristics of the therapist, according to Beck and coworkers (1979), are warmth, accurate empathy, and genuineness. It is in the manner, tone of voice, and way of phrasing words that the therapist generally conveys acceptance and warmth to the patient. Accurate empathy facilitates therapeutic collaboration, and the genuineness of the therapist must mix diplomacy with honesty. In contrast to Rogers' formulation of the necessary and sufficient conditions in therapy, Beck and co-workers believe that these personal characteristics "are necessary but not sufficient to produce an optimum therapeutic effect." (Beck et al., 1979, p. 45). Although Beck emphasized the therapist's personal skills, he has also written that the "same therapeutic program used by different therapists does not differ substantially from one to the other," (Beck, 1976, p. 333) which suggests that he would support the use of manuals in therapy to increase the similarities among therapists.

Beck has also noted that the therapeutic situation has a quieting effect on hyperactivity that may be the result of the therapist's empathy and acceptance, specific relaxation instructions, or explicitly stated verbal approval (Beck, 1970). "Cognitive and behavior therapies probably require the same subtle therapeutic

atmosphere that has been described explicitly in the context of psychodynamic therapy." (Beck et al., 1979, p. 50).

Beck has written about the relationship between cognitive therapy and behavior therapy (Beck, 1970), and he has also compared cognitive therapy with psychoanalysis (Beck, 1976). Describing many similarities between cognitive and behavior therapists, he notes that both are more active in the therapeutic interview than other therapists; they focus on overt symptoms or behavior problems; they do not draw substantially on reconstruction of childhood experience; and they share the assumption that therapy can be effective without insight regarding the origin of the symptom (Beck, 1970). The similarities of cognitive therapy and psychoanalysis he points out are that both are insight therapies in the sense that they are interested in introspective data from the patient. They also attempt to produce structural change by modifying the patient's thinking, and they depend on "working through" intra-psychic problems (Beck, 1976).

Thus, Beck's expresses several opinions of psychotherapy. He claims that different forms of psychotherapy can be effective and he emphasizes the personal qualities of the psychotherapist in a Rogerian way. At the same time, he maintains that cognitive methods of psychotherapy can make therapy more effective. Although he underlines the importance of the relationship and the therapist's personal skills, he also proposes that the use of manuals in cognitive therapy will minimize differences between different cognitive therapists.

Conclusions about the founders

Some conclusions can be drawn from this review of the founders in psychotherapy. Freud, Skinner, Wolpe, Rogers, and Beck all believed that different forms of psychotherapy can be effective, and that the principal explanation of this is the therapeutic relationship. Freud, Skinner, Wolpe, and Beck also have in common the belief that one or more specific ingredients make their own kind of psychotherapy more effective than others. Rogers, on the other hand, does not claim he has specific effective ingredients. Instead, he considers differences in effectiveness between psychotherapists to be the result of differences in their own skills in using the common factors of change in psychotherapy.

Recent clinical trends

Psychodynamic therapy

Obviously, many clinical trends in psychoanalysis have arisen since the time of Freud. Not all of them can be examined in detail within the scope of this thesis, but because some of the more important developments—the British object relations theory and Heinz Kohut's self psychology—are well-known in Sweden, these trends will be scrutinized here. Although object relations theory is no longer new, it deserves attention because it is still influential; Kohut's work beginning in the 1970s, on the other hand, seems to be the last separate and important orientation of psychodynamic psychotherapy to have emerged. Interpersonal therapy (IPT) cannot be considered a new psychodynamic orientation, because while some of its theoretical underpinnings are in the psychodynamic tradition, it is a separate form of psychotherapy entirely, rather than a form of psychodynamic therapy (Gotlib & Schraedley, 2000). The most recent and important psychodynamic therapies, however, a group of short-term psychodynamic psychotherapies, will also be considered.

Object relations theorists mostly criticize the traditional Freudian view of the development of the child and the Freudian therapeutic approach and show little interest in other psychotherapeutic schools than psychoanalysis. However, one of the leading advocates of object relations theory, Harry Guntrip, has made several interesting comments regarding other kinds of psychotherapy, the first of which resembles an updated version of Freud's distinction between suggestive therapies and psychoanalysis. Guntrip also distinguishes between symptom-relieving treatment and psychotherapy. He thinks that the extensive mental ill-health in society is a reason to be grateful for any symptom-relieving treatment that can be proven to be helpful, such as behavior therapy, drugs, or electric convulsive treatment (ECT), but that psychotherapy, in the contrast, aims at something more fundamental: long-term stabilizing change in the total personality (Guntrip, 1968).

Some years later, Guntrip was more positive towards behavior therapy (Guntrip, 1972). First, he considers behavior therapy techniques valuable for suppressing symptoms, and finds desensitization the psychologically most interesting technique. Aversion therapy he cites as the most questionable method, "though there are cases in which I would not rule it out." (Guntrip, 1972, p. 276). Second and perhaps most interesting, Guntrip maintains that psychoanalysis can be seen "as a highly personal process of desensitization of childhood fears of bad parents and/or traumatic situations, liberating personal growth potentials." (Guntrip, ibid., p. 276). Third, Guntrip regards the study of "habit" and "repertoires of behavior patterns" in everyday living as an important result of behaviorism and something that psychoanalysis has failed adequately to take into account. Fourth, Guntrip notes that behaviorists look beyond symptoms, searching for causes and reasons, and this

puts behaviorism and psychoanalysis on common ground. However, according to Guntrip, behaviorists have still not recognized that the causes and reasons may be found in a traumatic childhood and emerge in dreams and symptoms. As is evident from this, Guntrip recognizes both the worth of some of the techniques in behavior therapy and the possibility of explaining phenomena in psychoanalysis using behaviorist theory.

In addition, Guntrip brings up research in the Rogerian tradition about the impact of the therapeutic relationship in psychotherapy with schizophrenics. This supports, Guntrip claims, the fundamental assumption on which psychoanalytic treatment rests, namely that a reliable and insight-promoting personal relationship can be therapeutic (Guntrip, 1971).

Like the object relations theorists, Kohut's main interest is in explaining the relationship between his self psychology and traditional psychoanalysis, with little interest in other kinds of psychotherapy. Nevertheless, Kohut's theories are of interest here, and one work, *How Does Analysis Cure*? is especially relevant (Kohut, 1984). There are many similarities between the views of Kohut and Rogers (Kahn, 1985). Like Rogers, Kohut also regards empathy as more important than Freud did, and Kohutian psychotherapy has been described as a deliberate combination of supportive and dynamic components (Roth & Fonagy, 2005). On the other hand, at a theoretical level, Kohut stresses that his opinion on change does not differ from Freud's. The cure is achieved by a process of three steps: optimal frustration, non-fulfillment of the need, and substitution of direct need fulfillment with a bond of empathy between the self and the self-object. Kohut's interest in empathy, however, does not seem to make him find more similarities with other forms of psychotherapy, and Kohut does not mention Rogers in any of his writings (Tobin, 1990). Instead, Kohut accentuates the fundamental similarities between his view and that of Freud.

Over the last few decades, short-term psychodynamic psychotherapy (STPP) has gained more attention. Mainly as a result of that, when psychodynamic psychotherapies are mentioned as evidence-based treatments, it is often forms of STPP that are recommended (Abbass, Henderson, Kisely, & Hancock, 2006; Lewis, Dennerstein, & Gibbs, 2008). STPP is of interest here since it has more in common with psychotherapy of other orientations than object relation theory and self psychology have. Because STPPs are a group of loosely related therapies, there are somewhat different ways to describe what they have in common. According to one definition, STPP is an explicitly time-limited therapy with a maximum of 40 sessions, focused on current and past interpersonal relationships, with the therapeutic effects arising from the patient-therapist relationship, which is considered to be the core mechanism of therapeutic change (Lewis, et al., 2008). A subgroup of these therapies, called experiential short-term dynamic psychotherapy (E-STDP) (Osimo, 2002), emphasize the more rapid achievement of results, which

are made possible by a focus on the patient's experiencing of affects (Fosha & Slowiaczek, 1997; McCullough & Andrews, 2001). The historical roots of E-STDP lie in Malan's work and his famous use of triangles to describe the process of psychotherapy. Some other characteristics of these therapies include the therapist's active mirroring of the patient's verbal and non-verbal behavior and the emphasis they place on the real interpersonal relationship between therapist and patient (Osimo, 2002).

This view of the psychotherapeutic process has many similarities with experiential and humanistic psychotherapies. However, since this orientation, in contrast to what has been the tradition in object relation therapy and self psychology, advocates quantitative research to test the efficacy of the therapy, and at least one detailed manual for this kind of therapy has been published (McCullough, et al., 2003), there are similarities with the CBT orientation too. Further, one of the leading advocates of E-STDP, Diana Fosha, has also considered the similarities of E-STDP to some therapies in other orientations and formulated three common principles: (1) a collaborative therapeutic relationship, (2) the patient's experience as the fundamental agent of change, and (3) an understanding of psychological processes in terms of schemas linking affect, cognition, and representations of self, other, and self-other relatedness (Fosha, 2004).

Regarding the more general question of which ingredients make psychotherapy work, the psychodynamic school seems to consider both the therapeutic relationship and psychoanalytical interpretations as effective, just as Freud did, but with an increasing emphasis on the therapeutic relationship. In an overview of empathy in psychoanalysis (Eagle & Wolitzky, 1997), the authors conclude that "there is a division in the psychoanalytic literature between conceptualizing the role of empathy as a direct curative agent or as an 'enabling' factor that permits the operation of the supposed primary therapeutic factors of interpretation and insight." (p. 214). Emphasizing empathy underscores the similarity between psychodynamic psychotherapy and the other schools of psychotherapy, while an emphasis on interpretation accentuates its differences from other schools, since interpretation is often dependent on psychoanalytic theories of child development. It seems clear then that in object relations theory and self psychology, there is an increased emphasis on the therapeutic relationship, and a decreased emphasis on insight.

In the development of psychodynamic theory, much of the debate in psychoanalysis has been meta-theoretical. For example, the French Lacanian orientation could best be described as a meta-theoretical discourse, which aims to base psychoanalysis not in biology but in sciences such as linguistics and mathematics. This orientation, however, has had little clinical relevance, partly because Lacan's most original clinical idea was to shorten the sessions to just a few minutes—an idea with very few imitators (Roudinesco, 1997). Often the meta-theoretical interest in psychoanalytic debate has been directed towards questions such as whether clinical

theory is superior to meta-psychology (Gill & Holzman, 1976; Holt, 1981) and whether psychoanalysis is a hermeneutical science (Steele, 1979), interpreting "the semantics of desire" (Ricour, 1970), or an empirical science (Bowlby, 1979; Eagle, 1984; Eagle, Wolitzky, & Wakefield, 2001). The last-mentioned trend is important because considering psychoanalysis as an empirical science increases its similarities with the other schools of psychotherapy.

If psychoanalysis is an empirical science, then it is possible to evaluate psychoanalysis in the same way as other therapies and theories. One step in this direction has been taken through an increased acceptance in psychoanalysis of the American Psychiatric Association's Diagnostic and Statistical Manual for of the Mental Disorders (DSM) (Gabbard, 2005). As a common diagnostic system, the use of the DSM has facilitated psychotherapy research, and to an ever-increasing extent, both psychodynamic psychotherapists and those working in the object relations tradition are referring to scientific findings (Stricker & Gooen-Piels, 2002). However, it should be noted that simultaneous with the DSM's growing acceptance within the psychodynamic community, psychoanalytical associations have published their own Psychodynamic Diagnostic Manual (PDM), intended to complement both the DSM and WHO's International Classification of Diseases (ICD) (PDM Task Force, 2006).

The view of psychoanalysis as an empirical science is strong in the first volume of *Comprehensive Handbook of Psychotherapy*, devoted to psychodynamic and object relations therapies (Kaslow & Magnavita, 2002). In the final chapter, the volume editor Jeffery Magnavita discusses future trends in contemporary psychodynamics (Magnavita, 2002), describing the struggle to establish an empirically based science of psychodynamics with help from audiovisual technology, empirical findings, treatment manuals, etc. According to Magnavita, future change will be based upon neuroscience and build interdisciplinary bridges between psychodynamic theory and, for example, cognitive science, affective science, developmental science, and evolutionary science. He finishes the chapter by answering two questions. To the first question, whether psychodynamics will continue to provide fertile models to interdisciplinary thought, his answer is yes; to the second question, whether psychodynamic psychotherapy will remain as a separate school, his answer is more tentative. Magnavita sees a likely convergence between all of the most common models of psychotherapy, which will lead to a continual blending of techniques that work and an abandonment of those techniques that fail to prove their effectiveness.

Cognitive-behavioral therapy

Since the beginning of cognitive-behavioral therapy (CBT) in the late 1970s, many new therapies, such as functional analytic psychotherapy(FAP) (Kohlenberg & Tsai, 1987, 1991), dialectical behavior therapy (DBT) (Linehan, 1993), acceptance

and commitment therapy (ACT) (Hayes, et al., 1999), mindfulness-based cognitive therapy (MBCT) for depression (Segal, et al., 2002), and schema therapy (ST) (Young, et al., 2003) have appeared and are regarded as cognitive-behavioral therapies. Many of these therapies are examples of the earlier mentioned "third wave of behavior therapy." The first generation of behavior therapy concentrated on directly changing behavior. The second generation added the changing of thoughts, and the third wave of behavior therapy is directed at changing the function of the thoughts, not their content. At the same time, traditional cognitive therapy has continued to develop with, for example, increased interest in personality disorders (Beck, Freeman, & Davis, 2004) and in the psychotherapeutic relationship (Leahy, 2001). Because so much of the thought in newer forms of cognitive and cognitive-behavioral therapy concerns "thinking about thinking," it has also been described as "meta-cognition." (Wells, 2000).

As a result of this development, and in response to the question of what makes psychotherapy effective, two trends of thought are prominent in contemporary CBT therapies. One maintains that the usual techniques of cognitive therapy are effective, and therefore should be used to treat more—and more complicated—diagnoses. A handbook of interventions for chronic and severe mental disorders presents CBT therapies for diagnoses such as schizophrenia, bipolar disorder, alcohol addiction, and severe personality disorders (Hofmann & Tompson, 2002). The other trend supports the use of new techniques. Examples of this are mindfulness in DBT and the techniques in ACT of "creative hopelessness," "control is the problem," and "cognitive fusion," which helps the patient to become more accepting of his or her thoughts and feelings.

On the question of whether the effective ingredients in CBT psychotherapy are used in other psychotherapies, Marsha Linehan's concept of validation is especially interesting, because it has many similarities with Rogers's concept of empathy, but validation is more extensive (Linehan, 1997). According to Linehan, validation can be considered at six levels: (1) listening and observing; (2) accurately reflecting; (3) articulating the unverbalized; (4) validating sufficient (but not necessarily valid) causes; (5) validating reasonableness in the moment; and (6) treating the person as valid—radical genuineness. The two first levels encompass what is usually defined as empathy. However, Linehan thinks that most therapists actually use all the other levels, although only the first four are usually discussed in the general psychotherapy literature. Linehan considers that in her new concept she has brought together relevant phenomena from other forms of psychotherapy and used them in a more systematic way in DBT than is common in psychotherapy. In this way Linehan both creates bridges to other forms of psychotherapy and gives validation a higher value in her new treatment than is common in other treatments, especially those in the general tradition of CBT.

On the theoretical level, the similarities between CBT and other schools of therapy have increased. According to Beutler and coworkers the concept of dysfunctional cognitions/schemata/behaviors remains at the core of cognitive therapy (Beutler, Harwood, & Caldwell, 2001), however, other concepts now common to many orientations of psychotherapy originated in cognitive therapy in the early 1990s. Examples of these are the role of defensive processes, the emphasis on the exploration of the therapeutic relationship and the patient's interpersonal dynamics, facilitative aspects of affective arousal, and the developmental experiences in the formation of maladaptive schemata (Robins & Hayes, 1993).

Another example of the continued tendency of concepts from cognitive therapy to spread to other schools is the increased emphasis on avoidance. Patients with personality disorders are described as using both cognitive and affective avoidance (Young, 1999), and when Chadwick and coworkers analyzed delusions, voices, and paranoia, they saw these phenomena as defense-avoidance of negative beliefs about the self (Chadwick, Birchwood, & Trower, 1996). In ACT avoidance, especially experiential avoidance, is also very important (Hayes, et al., 1999).

Another interesting trend in CBT is the view of transference. Cognitive therapy shows an ambivalent attitude to the use of terminology common in psychodynamic theory about the interaction between the therapist and the patient. Some use such concepts as "transference interpretation" (Safran & Segal, 1990), "countertransference" (Hayes, et al., 1999), and "resistance," "transference," and "countertransference" (Leahy, 2001). However, some of the leading proponents of cognitive psychotherapy have expressed doubts about this, and do not use expressions like transference and countertransference, to avoid confusion with psychodynamic assumptions (Beck, et al., 2004). Nevertheless, there are two CBT treatments with integrative features, where the patients' transference towards the therapist has a prominent role. In functional analytic therapy, FAP, transference is a necessary feature for this treatment to work at all (Kohlenberg & Tsai, 1991; Tsai et al., 2009), and in the cognitive-behavioral analysis system of psychotherapy (CBASP), which integrates a cognitive-behavioral approach with an interpersonal focus, the construction of transference hypotheses is an important element (McCullough, 2000, 2003).

Humanistic-experiential therapy

Humanistic psychology has evolved into a broad movement whose major strands are client-centered therapy, existential therapy, and Gestalt therapy (Elliott, 2002), but which also includes therapies like psychodrama, transactional analysis, and redecision therapy (Davis Massey, 2002). Many therapies originally described as humanistic have been grouped together under "the experiential umbrella" (Elliott, Greenberg, & Lietaer, 2004) with client-centered, Gestalt, existential, and body-

oriented therapies. All the major schools of humanistic psychotherapies were well established by the mid-1960s (Cain, 2002). In the 2002 preface to a handbook of humanistic psychotherapy, it was estimated that roughly 10% of the psychologists and psychotherapists in the United States were regarded as humanistic (Cain, 2002). Paradoxically, one problem for humanistic psychotherapy seems to be its success, as its more general themes—about the qualities of the therapist as formulated by Rogers and the emphasis on interpersonal relationships—have been incorporated as general aspects of psychotherapy as a whole (Davis Massey, 2002). Consequently, the interest in an orientation restricted only to these ingredients has decreased, and among the clinical psychologists in the USA in 2003 only 1% considered their primary theoretical orientation to be Rogerian and 1% to be existential/Gestalt/humanistic (Norcross, Karpiak, & Santoro, 2005). In addition, it should be noted that a specific technique in the experiential tradition, that of role-play, has been incorporated into cognitive psychotherapy (Freeman, Pretzer, Fleming, & Simon, 2004).

The third volume of *Comprehensive Handbook of Psychotherapy* concerns humanistic, interpersonal, and existential psychology (Massey & Davis Massey, 2002). Davis Massey describes the psychotherapies in the volume in terms of the third, fourth, and fifth forces in psychotherapy (Davis Massey, 2002), continuing Maslow's labels of psychoanalysis as the first force, behaviorism as the second force, and the humanistic, existential, and phenomenological approaches as the third force. Systemic family therapies, with their emphasis on context, are then regarded as the fourth force, and the integrative perspective as the fifth force. From this description of the different forces, it is obvious that humanistic, interpersonal, and existential psychotherapies have similarities with other approaches. The authors of a research review on experiential psychotherapies also describe characteristics that these therapies have in common with psychotherapy in other orientations (Elliott, et al., 2004). Important themes are the focus on experience in therapy, the therapist's role as an expert on how the patient can handle his or her problems but not on the content of the patient's experience, the therapeutic relationship as potentially curative, and a person-centered view which involves genuine concern and respect for each person.

According to Cain (2002), there have been many interesting developments over the last few decades in humanistic therapy. Cain maintains that perhaps the most fundamental change is the challenge to Rogers' premise of therapeutic nondirectiveness as being too confining for both therapists and patients and not fully in keeping with the fundamental goals of humanistic therapy. Instead a strong case for *process directiveness* has been made. This means that patients often need assistance in understanding how to process their experiences, so humanistic therapists nowadays can, in collaboration with their patients, propose a wide range of methods for processing the patients' experience. The humanistic therapies have also evolved by cross-fertilization within the humanistic family, where each

therapy has benefited from incorporating and integrating some characteristics of other approaches. Furthermore, the concept of empathy has become more complex. Empathy is now seen as not merely "reflection," but instead as a variety of more differentiated responses (Cain, 2002).

Davis Massey (2002) claims that in the future, the humanistic, interpersonal, and existential psychotherapies will contribute to a widening scope of science and to bridging the eastern and western frames of reference. The latter ambition also holds true for DBT and ACT in the CBT orientation. Finally, this tradition insists on the value of evidence from psychotherapy research, and advocates of humanistic psychology, using meta-analyses of psychotherapy outcome studies, have concluded that humanistic therapies are equally as effective as cognitive-behavioral and other forms of psychotherapy (Elliott, 2002; Elliott, et al., 2004).

To conclude, the developments in this tradition indicate that Rogers' original view of psychotherapy is valuable but insufficient. Rogers' insight regarding the importance of the therapeutic relationship has been preserved, but the role of experience has been accentuated, and changes such as process directiveness have emerged, which increase the similarities of this school with the other schools of psychotherapy.

Integrative psychotherapy

According to a Swedish study, in 1995, 24% of the psychotherapists in Sweden regarded themselves as eclectics (Sandell, et al., 2004). In the United States the eclectic/integrative approach to psychotherapy is the most common orientation today, and has been so for many decades (Norcross, et al., 2005). In 1983, proponents of this orientation organized as the Society for the Exploration of Psychotherapy Integration (SEPI). This is an interdisciplinary organization of professionals interested in approaches to psychotherapy that are not limited by a single orientation. SEPI publishes *Journal of Psychotherapy Integration*, and this approach to psychotherapy was presented in *Handbook of Psychotherapy Integration*, first in 1992 and then in a second edition in 2005 (Norcross & Goldfried, 2005; Norcross & Goldfried, 1992). However, this orientation has a longer history than the dates of these publications would imply. About 70 years ago Saul Rosenzweig presented his explanation of how diverse methods in psychotherapy could be successful: although they looked different, they had the same effective factors in common, such as catharsis and the therapist's personality (Rosenzweig, 1936). Rosenzweig's opinion is still of great relevance, and his now-famous article is one of the earliest roots of the integrative movement.

As common factors, those components usually counted are those considered to be the effective ingredients behind positive outcomes in different kinds of

psychotherapy. For example, Weinberger mentions five possible common factors: the therapeutic relationship, expectations, confronting problems, mastery, and attribution of outcome (Weinberger, 1995).

The interest in common factors is important not only for integrative psychotherapists, but in psychotherapy research as well. According to Lambert and Ogles, common factors account for a substantial amount of improvement attained in psychotherapy (Lambert & Ogles, 2004). Results from psychotherapy research, showing how critical common factors could be, also contributed to the rise of the integrative movement in psychotherapy (Norcross & Newman, 1992).

Besides common factors, the integrative movement is interested in three other kinds of integration: the use of effective techniques from different orientations, so-called eclectical integration (Lazarus, 1967); theoretical integration, where two or more therapies are integrated at a conceptual level (Norcross, 2005); and finally, assimilative integration, which entails a firm grounding in one system of psychotherapy, coupled with a willingness to incorporate practices and views from other orientations (Messer, 1992). Despite their shared interests in the questions raised by considering these four general types of integration, however, proponents of the integrative movement share relatively little in terms of their particular answers. The movement does not have a shared opinion as to which the common factors are, for example, nor their relative importance in psychotherapy. Neither has the integrative movement a common target regarding theoretical integration. Some of the integrationists believe it is possible to create a general "transtheoretical" theory (Prochaska & Norcross, 2003). Others think that "assimilative integration" is the only reasonable target. The lack of a common view is not seen as a problem, however, as it is due to the fact that the aim of the integrative movement is to explore the questions raised here, not to give a definite answer to the question of whether or not integration in psychotherapy is possible (Goldfried & Newman, 1992).

Interestingly, in addition to the organized integrative movement, there are integrative trends within the established schools of psychotherapy, which are themselves examples of "assimilative integration". Practitioners of both cognitive (Alford & Beck, 1997; Safran & Segal, 1990) and cognitive-behavior therapies (Beutler, et al., 2001; Castonguay, Newman, Borkovec, Holtforth, & Maramba, 2005), present these therapies as appropriate examples of integrative attempts in psychotherapy. When the psychodynamic therapist Paul Wachtel published *Psychoanalysis and Behavior Therapy: Towards an Integration* in 1977, this was an important and early contribution to bringing psychoanalysis and behavior therapy closer to each other (Wachtel, 1977), and Wachtel later became a prominent figure in the integrative movement. More recent attempts to integrate psychodynamic therapies have been made by Anthony Ryle, who developed Cognitive Analytic Therapy (CAT) through introducing cognitive techniques into

his originally psychodynamic therapy (Ryle, 1995; Ryle & Kerr, 2002), and Stricker and Gold, who have described "assimilative psychodynamic psychotherapy" (Stricker & Gold, 2005). Object relation theory has also been used in integrative attempts in psychotherapy (Säfvestad Nolan & Nolan, 2002).

Conclusions about clinical trends

The conclusions from this overview of recent clinical trends seem obvious. The different schools of psychotherapy have influenced each other, and as a result they have become more similar. Similarities across schools exist in both the practice of psychotherapy and its theoretical constructs. The field of psychotherapy has undergone an interesting and impressive development during the last decades, but despite the many similarities between the various schools, differences in theories and practices still remain.

The view of psychotherapy from empirical science

The effectiveness of psychotherapy

More than 50 years ago, Hans Eysenck, in the first published review of the effect of psychotherapy (Eysenck, 1952), concluded that the available evidence failed to show that psychotherapy had any positive effect, provoking several objections and heated debate (Luborsky, 1954; Strupp, 1963). The view that psychotherapy is not effective is now outdated in science, mainly because the many meta-analytic studies published since 1977 have consistently shown that psychotherapy usually has beneficial effects. The current debate for more than a decade has instead centered on the cause of this positive effect, asking the primary question: Is one psychotherapy superior to others? (Lambert, 2001).

To answer this question, the traditional efficacy study that compares one form of psychotherapy with placebo or some other form of psychotherapy has been supplemented by meta-analyses, quantitative studies that attempt to summarize the results from many comparative studies by converting their results to an effect sizes that may themselves be compared.

The most well-known overview of psychotherapy research is *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (Lambert, 2004). A chapter devoted to the efficacy and effectiveness of psychotherapy considers traditional studies as well as meta-analyses (Lambert & Ogles, 2004), while Bruce Wampold's *The Great Psychotherapy Debate* is mainly an overview of meta-analyses (Wampold, 2001), which he has recently updated in a briefer account of his view

(Wampold, 2010). There are interesting differences between Lambert and Ogles's conclusions and Wampold's.

Wampold asserts two main points of view, critical of common opinions about psychotherapy: first, that there is no diversity in outcome between different forms of psychotherapy (the so-called "Dodo bird verdict"), and second, that representatives of different schools of psychotherapy usually have a "medical model" of psychotherapy, while he considers a "contextual model" more appropriate.

Whether specific ingredients in psychotherapy really have additional effects is not easy to determine, but based on reviews of psychotherapy outcome research, Lambert quantified the contributions of different factors to the effect of psychotherapy: extra-therapeutic change accounted for 40% of the improvement, common factors 30%, techniques 15%, and expectancy 15% (Lambert, 1992). These findings were criticized by Wampold (2001), primarily because Lambert used no statistical procedures, a point Lambert himself was aware of. Instead, Wampold claims that at least 70% of effects cannot be attributed to any specific cause and specific effects account for, at most, only 8% of improvement. However, Lambert asserts that his findings are still correct, and they are supported by new research (Lambert & Barley, 2002). It should be noted that, irrespective of whether Lambert or Wampold is right, both share the opinion that common factors are more important than specific techniques are.

Although Wampold recognizes the possibility that specific techniques could have an impact, even if it is a small one, when he compares different psychotherapy methods, he concludes that there are no differences between the effects of different treatments. This finding is common in the meta-analytic approach, ever since Smith and Glass presented the first meta-analysis (Smith & Glass, 1977). Admittedly, meta-analyses have often shown small differences in favor of cognitive and behavior therapies, but those effects have been explained by methodological factors such as differences in study criteria and even investigator bias (Lambert & Ogles, 2004). However, despite their agreement about the relative importance of general over specific factors, Lambert and Ogles' conclusions still differ from Wampold's. According to them, in meta-analyses of comparative effectiveness there is a strong tendency towards no differences, counterbalanced by indications that, under some circumstances, certain methods (generally cognitive-behavioral, especially regarding anxiety disorders) or modes (family therapy) are superior. In the final chapter of the Handbook, the authors point to slower relapse in schizophrenia and conduct disorder in adolescents as examples of family therapy having a superior effect (Lambert, Garfield, & Bergin, 2004).

In Wampold's analysis of meta-analyses of the treatment of anxiety, he concludes that there are no differences in effectiveness for different treatments, although he

admits that the comparisons are often between various cognitive treatments. Instead, he emphasizes that differences in effectiveness are shown, not between different treatments, but between psychotherapists from different orientations. When Lambert and Ogles (2004) summarize the research about differences in outcome between therapies, they too underline the importance of differences between therapists, however, they argue that differences in effectiveness between therapists likely reflect not only differences in personal qualities, but variations in technical skills as well. The research suggests that differences also exist when treatment manuals are used. Lambert and Ogles conclude that it is possible that too much energy is devoted to studies of technique, and that studying interaction effects (therapist × technique × patient) would be more appropriate. They also suggest that real differences in outcome between different kinds of psychotherapies may be difficult to discover, because the small sample size in many of the studies results in a lack of statistical power, which could mask real differences in outcome (Hill & Lambert, 2004; Lambert & Ogles, 2004).

In Wampold's more philosophical second point; that a contextual model for psychotherapy is preferable to a medical model, he asserts that the medical model assumes that (1) a patient has a disorder or problem and is presented to a therapist with a particular theoretical orientation; (2) the therapist provides an explanation for the disorder; (3) the therapist provides a rationale for change; (4) a treatment is offered that contains specific therapeutic ingredients that are characteristic of the therapist's theoretical orientation; and (5) the specific therapeutic ingredients are wholly or greatly responsible for the patient's progress. The medical model, in Wampold's view, therefore assumes that specific effects will be overwhelmingly larger than general effects. Wampold refer to Freud, Beck, and others as proponents of the medical view, but sees a medical model in many ways even in Rogers' approach.

As an alternative, and one instance of the contextual model, Wampold calls attention to Jerome Frank's view of psychotherapy (Frank & Frank, 1991). In this model specific ingredients are necessary, but it is not important which ingredients they are, as long as they are a part of, and function in support of, a psychological theory that offers a kind of myth in which the therapist can have faith and that gives the patient a sense of alliance with the healer.

Notably, Wampold does not back up his opinion with any citations that Freud, Beck, or any other important figure in psychotherapy regarded the specific ingredients as the most important ingredients in their psychotherapy. In fact, as has been mentioned earlier, contrary to Wampold's argument, Freud, Wolpe, and Beck considered the relationship to the therapist as very important, and while they believed their special methods to have additional effects, they don't seem to have expressed any opinion as to whether the common or the specific ingredients are the most important for the effectiveness of psychotherapy. Frank also recognized the

possibility of differences in outcome between different therapy methods (Frank, 1979; Frank & Frank, 1991), so even Frank does not seem to be a supporter of a contextual model in Wampold's sense. Therefore it seems reasonable to conclude that Wampold exaggerates both the differences between the founders of psychotherapy and the value they placed on their own specific factors compared with factors common to all psychotherapies.

In summary, it is well-documented that psychotherapy is usually an effective treatment. There may be differences in effectiveness that favor cognitive-behavioral therapy for some disorders, but whether or not this is true, therapists of different orientations can be effective, and important differences still exist between therapists, irrespective of their theoretical orientations. However, more empirical evidence is needed to measure both the relative importance of common factors whether specific techniques have possible additional benefits.

Effective elements in psychotherapy

The attempts of the American Psychological Association's Division 12 Task Force to survey empirically supported treatments (ESTs) (Chambless et al., 1998; Chambless et al., 1996) have received a great deal of criticism (Elliott, 1998), primarily because of the uncertainty surrounding whether or not treatments actually differ in their effects, while considerable differences in results between therapists with the same orientation have been shown, even when the therapists are competent in their particular method and have supervision (Luborsky, McLellan, Diguer, Woody, & Seligman, 1997). As a response to the critique of the attempt to define and present ESTs, another APA division was charged with identifying empirically supported relationships (ESRs). The results are presented in *Psychotherapy Relationships that Work: Therapist Contribution and Responsiveness to Patients* (Norcross, 2002).

The book divides general elements of the therapeutic relationship into two groups: demonstrably effective elements, and promising and probably effective elements. Four elements are classified as effective: (1) the alliance, (2) cohesion in group psychotherapy, (3) empathy, and (4) goal consensus and collaboration. Seven elements are classified as promising: (1) positive regard; (2) congruence; (3) feedback; (4) repairing alliance ruptures; (5) self-disclosure; (6) the management of countertransference; and (7) relational interpretations. While several other possible common factors have been suggested (Goldfried, 1995; Lambert & Ogles, 2004; Weinberger, 1995), these 11 have the best foundation in the research to date.

Norcross has also summarized the research on common factors that are effective in psychotherapy and has in addition listed seven common factors from the research literature that have been shown to be ineffective at best (Norcross, 2010): (1) a

confrontational style; (2) a negative and critical process; (3) the therapist's assumptions about the patient taking precedence over inquiry; (4) focus on the therapist's instead of the patient's perspective; (5) rigidity; (6) ostrich-like behavior towards signs of alliance ruptures; and (7) the "procrustean bed"—tailoring the patient to the therapy, rather than the therapy to the unique needs of the patient.

Because psychotherapists vary in their effectiveness, researchers have become interested in identifying the personal qualities are that contribute to the differences in outcome.

Effective psychotherapists

Research summaries about therapist variables are plentiful (Asay & Lambert, 2002; Bachelor & Horvath, 1999; Beutler et al., 2004; Lambert & Barley, 2002; Teyber & McClure, 2000). A common theme for the overviews is an attempt to distinguish the qualities of effective versus less effective psychotherapists. One study shows that empathy is the most distinguishing variable of an effective therapist (Lafferty, Beutler, & Crago, 1989), another that effective therapists show more warmth, affirmation, and understanding, and less blaming, attacking, and rejecting (Najavits & Strupp, 1994). According to Beutler and coworkers (2004), "friendly behaviors" are associated with positive outcome. Frequent in patient-therapist dyads with poor outcome was a pattern of dominance-submission, where the therapists had low levels of positivity/friendliness and high levels of hostility and the relationship was characterized by criticism of the patient by both parties. Excellent psychodynamic, humanistic, and learning therapists also seem to possess attributes such as self-integration, anxiety management, conceptualizing skills, empathy, and self-insight to a greater extent than therapists in general (Van Wagoner, Hayes, Gelso, & Diemer, 1991).

In another study of effective therapists, they were found to be distinguished by being more psychologically minded (as opposed to biologically oriented), and they only rarely used medication, either alone or in combination with psychotherapy (Blatt, Sanislow, Zuroff, & Pilkonis, 1996). Furthermore, they estimated that more, rather than less, therapy would be needed before treatment differences in their patients would be manifested.

None of this contradicts the conclusion from an earlier study of therapist success (Luborsky, McLellan, Woody, O´Brien, & Auerbach, 1985) that "the major agent of effective psychotherapy is the personality of the therapist, particularly the ability to form a warm, supportive relationship" (p. 609), later repeated with slightly different wording: "Thus, basic capacities for human relating—warmth, affirmation, and a minimum of attack and blame—may be at the center of effective psychotherapeutic intervention." (Najavits & Strupp, 1994, p. 121). This view is

strengthened by the fact that psychotherapists themselves, rating lessons from their own psychotherapy, rated the therapist's personal qualities as most important (Bike, Norcross, & Schatz, 2009).

Therapists from all theoretical orientations seem to have similar reactions to conflicts in the therapy relationship, although there are important differences in the extent of these reactions between individuals (Binder & Strupp, 1997). The problem of handling hostility from patients seems to be consistent across therapists, because of "the enormous difficulty that human beings, even highly trained therapists, have in dealing with interpersonal conflict in which they are participants." (ibid, p. 123). In fact, too much accentuation of theoretical elements can be an expression of the therapist's personal difficulties in applying a method of psychotherapy. A study of the effect from training in time-limited dynamic psychotherapy found that therapists with hostile and controlling "introjects" (internalized voices of authority) showed the greatest technical adherence, and those therapists were also largely responsible for a substantial increase in negative and complex communication following the training (Henry, Strupp, Butler, Schacht, & Binder, 1993). In cognitive therapy with depressed patients, therapeutic alliance and patients' emotional experience was related to improvement, but focus on more specific cognitive features such as the link between distorted thoughts and negative emotions was, unexpectedly, correlated with negative outcome (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). This was thought to be because therapists dealt with strains in the alliance by increasing the use of the specific cognitive techniques, but then failed to use those techniques in a flexible way.

Findings like these suggest how important the personal qualities of the therapist are. There is evidence that effective therapists are more willing than less effective therapists to look critically at themselves and to admit when they have made mistakes (Najavits & Strupp, 1994). Furthermore, therapists with negative self-representations—that is, who are self-blaming and neglectful towards themselves—are more likely than therapists with positive self-representations to engage in a countertherapeutic process characterized by subtly hostile and controlling interactions with their patients (Henry & Strupp, 1994). There is not necessarily a contradiction between these findings, since it is possible that a positive self-image facilitates admitting mistakes, while a negative self-image either makes the individual prone to being too self-critical or makes it too difficult to admit any mistakes at all.

To summarize, the ideal therapist seems to be a warm and empathic person, with self-insight, a positive self-image, and capacity for self-critical reflection, who avoids complicated communication with the patient, seldom contradicts the patient, and is more interested in psychotherapy than medication.

Similarities and differences between CBT, CT, and PDT in practice

Practical similarities and differences can exist in at least three ways. First, a phenomenon can appear in only one form of psychotherapy and not at all in other orientations. For example, in theory PDT values the interpretation of dreams, while dreams are of no general theoretical interest in CBT or CT, even though individual advocates of CT have published a book about dreams and CT (Rosner, Lyddon, & Freeman, 2004). It is probable then that interpretation of dreams is usual in PDT therapies but does not occur in CBT or CT. Second, a phenomenon can appear on a more general level in several therapies, but have a different expression in each. For example, one of Weinberger's five common factors in psychotherapy is confrontation or facing the problem (Weinberger, 1995). Motivating the patient to face their problems is a general part of all psychotherapy, but in PDT it seems more important to express fears in the therapeutic relationship, while in CBT it seems more important to confront fears in exposure treatment outside the therapeutic relation. Finally, a phenomenon can be a part of several different treatments, but to varying degrees. For example, the therapeutic relationship seems to be important in several treatments, but has traditionally been more a focus of PDT than of CBT or CT.

In two articles, Blagys and Hilsenroth review literature of comparative psychotherapy, for the distinguishing features of psychodynamic-interpersonal psychotherapy versus cognitive-behavioral therapy. In the first article (Blagys & Hilsenroth, 2000), seven interventions stood out as distinguishing short-term psychodynamic-interpersonal therapy: (1) a focus on affect and the expression of patient's emotions; (2) an exploration of patient's attempts to avoid topics or engage in activities that hinder the progress of therapy; (3) the identification of patterns in the patient's actions, thoughts, feelings, experiences, and relationships; (4) an emphasis on past experiences; (5) a focus on a patient's interpersonal experiences; (6) an emphasis on the therapeutic relationship; and (7) an exploration of the patient's wishes, dreams, or fantasies. In the other article (Blagys & Hilsenroth, 2002), six techniques and interventions were found to distinguish CBT from psychodynamic-interpersonal therapy: (1) use of homework and outside-of-session activities; (2) direction of session activity; (3) teaching of skills used by patients to cope with symptoms; (4) emphasis on patient's future experiences; (5) providing patients with information about their treatment, disorder, or symptoms; and (6) an intrapersonal/cognitive focus.

Those articles are valuable as summaries, but can give an exaggerated view of the differences between CBT and PDT by focusing on what is distinctive for CBT or PDT, but not distinguishing between the various shades of meaning of "distinctive" as discussed above. Although the authors want to contribute to the identification of distinctive versus common factors in treatment, they fail to take into account the

essential difference between interventions that are distinctive in the sense of being unique to one kind of psychotherapy and those that are distinctive in the sense of being more important in one or more, but not all, forms of psychotherapy. Features that are more important or "distinctive" in one kind of treatment than in another can still be "common" or therapeutic in several theoretical orientations, while unique features by definition cannot be a common factor. For example, the use of homework and outside-of-session activities are probably unique for CT and CBT, but the third factor they list for PDT, the identification of patterns in the patient's actions, thoughts, feelings, experiences, and relationships, although perhaps more important in PDT than in CBT, are obviously not unique for PDT.

In another example of this type, an analysis of similarities and differences in clinical practice between CT, CBT, and PDT, two process datasets were used (Wiser, Goldfried, Raue, & Vakoch, 1996). One, called the demonstration dataset, had a prototypic design and contained single sessions with the same patient, with Aaron Beck (CT), Donald Meichenbaum (CBT), and Hans Strupp (PDT) as the therapists. The other dataset, referred to as the change session dataset, contained 18 CBT sessions and 13 PDT sessions with therapists appraised as particularly competent.

When those two datasets were evaluated together there seemed to be more failures to find differences than findings of actual differences between the orientations. No differences were found between CBT and PDT concerning the degree to which they focused on the patients' general thoughts, intentions, and themes in their lives, nor in their focus on offering therapeutic support or psychoeducational information. There were differences, however, between CBT and PDT therapists in the relative importance of one feature over the other. CT practitioners were found to be most attuned to the patient's cognitions about self, world, and future; CBT practitioners were most attuned to behavior and emotions; and PDT practitioners, to patterns and the remote past. CT and CBT therapists also focused less on the patient's past, while PDT therapists focused less on the patient's future than CT and CBT therapists did.

Interestingly, there were many similarities between CBT and PDT, for example their depth of emotional experiencing was equal, and CT differed more from PDT than CBT did. The authors also reviewed a comparative-outcome study and cited another example of how the same theme can be emphasized for different purposes in different schools. In both CBT and PDT the therapists try to challenge the patient's view of reality, however, while in CBT the effect is symptom relief, the reverse is true in PDT. This surprising result was clarified with an analysis of content. The CBT therapists' message was that reality was not as bad as the patient thought: "You are more courageous than you think", while the PDT therapists tried to reveal the patient's own contribution to the problems: "You must have contributed to the breakup of your marriage, too." The authors conclude that

perhaps in PDT the patients have to feel worse before feeling better. This is an example of how a common general theme can have different expressions in different psychotherapies.

Two other studies used an instrument called the Psychotherapy Process Q-set (PQS) to compare similarities and differences between PDT and CBT (Ablon & Jones, 1998; Jones & Pulos, 1993). The instrument was designed to be applied to an audiotaped or videotaped record or a transcript of a single treatment hour. From 100 items, the 10 most characteristic and 10 least characteristic items each for PDT and CBT were ranked. In the first study, three items were identified as most characteristic for both PDT and CBT: (1) the patient's current or recent life situation is emphasized; (2) the patient's self-image is a focus for discussion; and (3) the therapist clarifies, restates, or rephrases the patients' communication. The comparison across the treatment modalities also demonstrated large and important differences. CBT promoted control of negative affect through the use of intellect and rationality combined with vigorous encouragement, support, and reassurance from the therapist. In PDT the emphasis was on the evocation of affect, on bringing troublesome feelings into awareness, and on integrating current difficulties with previous life experience, using the therapist-patient relationship as an agent of change. A factor analysis of the items in PQS resulted in four factors; one of the factors was named psychodynamic technique and another cognitive-behavioral technique. The PDT factor was not only associated with treatment outcome in PDT, it was also correlated with most of the improvement in CBT.

A limitation of this study was that the process factors termed "psychodynamic" and "cognitive-behavioral" were generated from the data set without an external criterion to establish whether the factors did in fact represent these two treatments in the way they were commonly applied. Another study using PQS tried to handle this limitation by developing ideal prototypes of PDT and CBT processes by using panels of expert clinicians representing each approach (Ablon & Jones, 1998). Each expert therapist was asked to rate each of the 100 items on PQS on a scale from one to nine according to how characteristic each item was of their understanding of an ideally conducted course of therapy that adhered to the principles of their theoretical perspective. The emerging prototypes were then applied to actual psychotherapy sessions. One result was that PDT therapists applied a notable amount of CBT strategy in addition to PDT strategies. Another result was that also in this study it was the PDT process and not the CBT process that predicted positive outcome in CBT. The authors conclude that what is supposed to be a CBT treatment may actually contain significant PDT ingredients and vice versa (Ablon & Jones, 1998).

In another study of similarities and differences between PDT and CBT therapists, concerning treatment goals and strategies, each group of therapists responded to case vignettes (Arnow & Castonguay, 1996). Both groups were equally committed

to the use of behavior strategies, as well as to the resolution of interpersonal problems when they were clearly defined in the vignettes. The differences were that PDT therapists indicated a significantly greater interest in pursuing non-symptomatic goals and exploratory strategies across all vignettes, and they were more likely to endorse goals involving interpersonal change in vignettes without evidence of explicit interpersonal difficulties. The authors concluded that they found more overlap between the groups than they anticipated.

Some other studies have focused exclusively on experienced therapists. One studied 22 CBT and 14 psychodynamic-interpersonal, carefully selected, "master therapists" (Goldfried, Raue, & Castonguay, 1998), who were asked to chose clinically significant sessions, and especially clinically significant portions of the sessions, for comparison. The authors then compared both how the therapists of the two orientations acted during the sessions and how the clinically most significant portions of the sessions differed from the non-significant portions. Differences were found between the two orientations. For example, the CBT therapists were more likely to compare or contrast the patient's functioning with the functioning of others, to encourage between-session experience, and to work in a future time frame. By contrast, the psychodynamic-interpersonal therapists were more likely to focus on themselves, to highlight instances of more general themes in the patient's life, and to place more emphasis on emotions during the significant portions of the session. However, in the clinically significant portions of the sessions the clinicians appeared to reflect a blending of both orientations, and the interventions were less pure theoretically compared to manual-based treatment. For example, during the clinically significant portions the therapists of both orientations focused more on the patients' evaluation of their self-worth, their expectations of the future, and their emotions. The therapists of both orientations were also more likely to encourage patients to view things more realistically in these portions. So in this study the similarities between these "master therapists" seemed more extensive than the differences, and the differences between the two orientations consisted of how much they focused on some themes.

A similar view of the role of experience appears in two articles concerning how 65 psychotherapists constructed case formulation and treatment plans in response to six patient vignettes. The investigation analyzed similarities and differences between the therapists based on theoretical orientation (CBT or PDT) and level of experience (novice, experienced, and expert) (Eells & Lombart, 2003), as well as the quality of the case formulations (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005). There were some differences between the two therapy orientations. For example PDT therapists placed more emphasis on factors like coping/defenses and childhood history, and CBT therapists on symptoms and problems. CBT therapists also predicted greater improvements from therapy. However, expert therapists of both orientations had much in common compared to novice and experienced therapists. Regardless of theoretical orientation, the expert therapists demonstrated

overall superiority of case formulations skills. They also viewed the information available in the vignettes as less adequate than did the other therapists, and they recommended longer treatments than both novice and experienced therapists.

In summary, with the exception of the use of homework and outside-of-session activities in CT/CBT, it is hard to find any truly unique characteristics in the empirical literature that distinguish PDT from CT/CBT. To a great extent both orientations are interested in the same phenomena and differ mainly in their emphases. Although the differences are more of degree than of kind, however, differences of degree can be important. Nevertheless, the differences seem to decrease when therapists are more experienced, and therapists of both orientations seem able to adjust to the need of the individual patient.

Patients and theoretical orientations

Patient variables are often regarded as more important for the outcome in psychotherapy than either therapist variables or treatment methods (Beitman & Manring, 2009; Bohart & Tallman, 2010). Consequently, the importance of different patient variables, for example age and severity of symptoms, has been a target for research (Clarkin & Levy, 2004). Patients can, however, differ in several other ways, including personality characteristics and preferences that can have an impact on their need for different kinds of treatments.

Blatt and Felsen (1993) reviewed evidence indicating that anaclitic patients—who are preoccupied with issues of relatedness—are more responsive to interpersonal therapy, while introjective patients—who are more concerned with establishing and maintaining a viable self-concept—seem more responsive to CBT. Larry Beutler, the founder of systematic treatment selection (STS), advocates that different patients ought to have different kinds of psychotherapy because patients with various characteristics respond variously to different psychotherapies. A patient with a internalizing coping style responds better to the insight-oriented treatment elucidated by psychodynamic theorists, while cognitive change methods are more effective for impulsive or externalizing patients, and nondirective and paradoxical interventions are more effective than directive ones among patients with high levels of pre-therapy resistance (Beutler, Consoli, & Lane, 2005; Beutler & Harwood, 2000). Beutler's view, that different patients need different kinds of psychotherapy, does not necessarily imply that different schools of psychotherapy are necessary, because he does not exclude the possibility that the same therapist can employ a variety of strategies proposed by STS (Beutler, et al., 2005). In a review of scientifically supported principles of therapeutic change, he and his co-author showed that such principles emanate from a variety of different theoretical orientations, including psychodynamic, experiential, and cognitive-behavioral therapy (Castonguay & Beutler, 2006). Following in this direction, a manual for

treating victims of mass trauma has been published that integrates techniques from cognitive therapy, behavior therapy, and relationship therapy (Housley & Beutler, 2007).

Attachment theory is becoming more influential in clinical psychology, and research on the links between attachment and psychotherapy deals with adult attachment patterns and process variables, such as alliance, transference, attachment to the therapist, as well as outcome (Slade, 2008). Differences in the patients' adult attachment patterns result in differences in the patients' behavior in therapy. Patients classified as secure were more compliant with treatment, and patients classified as more deactivating were judged by therapists to be poorer at making use of treatment (Daniel, 2006). Some studies have also raised the question of whether patients with different attachment patterns could be more appropriately treated using one kind of theoretical orientation rather than another. For patients who are preoccupied/anxious a more deactivating treatment such as CBT may be more effective, while hyper-activating treatments, such as PDT, could be more useful for dismissive/avoidant patients (Daniel, 2006). However, the few studies about attachment and theoretical orientation have not yet produced any conclusive results (Slade, 2008). In one study, however, of experienced therapists from various orientations who were asked how to help patients with attachment avoidance to overcome their fears of intimacy, their responses showed a similar pattern regardless of the therapist's theoretical orientation (Daly & Mallinckrodt, 2009). It is possible then that the important matching is between the patient and a specific therapist, rather than between a patient and a therapist with a specific theoretical orientation.

Another research area where it may be possible to identify the need for a specific theoretical orientation is in the patients' expectations and preferences. It seems reasonable that preferences for a specific orientation could improve the results. According to Banduras' well-established theory of self-efficacy, efficacy beliefs—expectations of a kind—contribute significantly to the quality of human functioning (Bandura, 2002), and this phenomena could be relevant in psychotherapy. Hope is one kind of positive expectation, and the value of hope is often raised in discussions of how psychotherapy produces its effect (Frank & Frank, 1991). Despite theoretical arguments for the role of positive expectations, empirical results for the importance of a patient receiving treatment that accords with his or her preferences are mixed. In the overview of research on effective psychotherapeutic relationships (Norcross, 2002), different aspects of customizing the therapy relationship to the individual patient are discussed. One such aspect is the patient's expectations and preferences. Three kinds of preferences have been studied: role preferences, type of psychotherapy, and demographic features of the psychotherapist (Arnkoff, Glass, & Shapiro, 2002). It is possible that matching the patient's preferences to the treatment could have a positive influence on the

outcome, however, whether or not this is the case has not yet been shown empirically.

According to the review by Arnkoff, Glass, and Shapiro (2002), it is difficult to find evidence that preferences about role (for example, whether or not the therapist acts as an advisor) are related to outcome in psychotherapy. Results relating preferences and outcome to type of therapy were mixed, but it was more common not to find a significant relationship between preferences and type of therapy than to find one. In some newer studies, the results also are mixed. In a comparison between medical treatment, psychotherapy, and a combination of medication and psychotherapy, the patient's preferences had an interactive effect on outcome (Kocsis et al., 2009). In a study comparing affect-focused body psychotherapy and standard psychiatric out-patient treatment, preferences also had an impact on the outcome (Levy Berg, Sandahl, & Clinton, 2008). However, two other studies, interested in the effect of randomization, found no differences between patients who received the treatment they preferred and the randomized group (Leykin et al., 2007; Van et al., 2009). Research on preferences for demographic features of the psychotherapist and outcome seem to be rare, and Arnkoff and coworkers (2002) reported only one such study, focused on gender preferences. Matching patients with their preferred gender did not have any significant influence on either outcome or dropout rates.

It is possible that matched preferences contribute to outcomes indirectly, as mediators or moderators, for example by reducing dropout or by strengthening the therapeutic alliance. Matched patients' preferences about specific ingredients in psychotherapy—such as talking about childhood or doing out-of-session assignments —could be examples of mediating variables.

Finally, the conclusion from the research reviewed by Arnkoff and coworkers is that because of methodological weaknesses and lack of studies, the only clear advice to practicing therapists regarding the role of patients' expectations and preferences is that it is wise to raise the patient's outcome expectations early in therapy.

Towards a common language and common principles of change

In the theoretical integration of psychotherapy, the ambition is to create a conceptual framework that synthesizes the best elements of two or more approaches to therapy. At its most successful, this could lead to the development of what Ryle requested more than three decades ago (Ryle, 1978): a common language for the psychotherapies. While a common language seems remote, interest in utilizing concepts in a way that transcends differences between the various

schools is clearly increasing. This could be a sign of a development towards what Kuhn called a phase of normal science (Kuhn, 1962) in psychotherapy research. For several decades the concept of the therapeutic alliance has been important in the different schools of psychotherapy, and there are other ideas that could be common concepts too. The examples below are not the only promising concepts, but they show the increasing tendency in psychotherapy towards a more common language, sometimes with new concepts and often with foundations in research. It is worth noting that several of the concepts suggested here are also discussed from a psychoanalytical point of view in Jørgensen' search for common factors in psychotherapy (Jørgensen, 2004).

Barlow and coworkers have proposed a unified protocol for emotional disorders, where emotion regulation, emotional avoidance, and emotional exposure are important concepts (Allen, McHugh, & Barlow, 2008; Barlow, Allen, & Choate, 2004; Ehrenreich, Buzzella, & Barlow, 2007; Fairholme, Boisseau, Ellard, Ehrenreich, & Barlow, 2010). While Barlow's background is in the cognitive-behavioral tradition, these concepts seem to identify general aspects of psychotherapy that other orientations also consider important.

Affect regulation

Affect (or emotion) regulation is an aspect of the more general concept of self-regulation. Since 1990 attention to self-regulation has been increasing in psychology, and it has been proposed as a defining feature of the human species (Forgas, Baumeister, & Tice, 2009). Regulation of emotions is of interest not only clinically, but also generally, for example in child development (Fonagy, Gergely, Jurist, & Target, 2002). Furthermore, social psychological thinking about emotion regulation may be relevant in clinical applications (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Tice, 2009), and the clinical use of the concept is increasing remarkably. Emotion regulation could be regarded as a general aspect of psychotherapy (Greenberg & Vandekerckhove, 2008), and it is gaining attention in several psychotherapies. In DBT, emotion regulation is one of five skills taught in groups (Linehan, 1993; Wheelis, 2009), and the mindfulness and acceptance-based strategies of ACT have been described as alternative emotion-regulation strategies, instead of, for example, suppression (Valdivia-Salas, Sheppard, & Forsyth, 2010). Emotion regulation has been suggested as a transdiagnostic approach to both etiology and treatment (Kring & Sloan, 2010), and some authors have developed an integrative emotion-based treatment called emotion regulation therapy (ERT) (Mennin & Fresco, 2010). Whatever the merits of those approaches, affect regulation will continue to be an important transtheoretical concept in coming years.

Avoidance

Avoidance is a well-established concept in the CBT orientation that has many similarities to the thinking about defenses in PDT, with two main differences. First, the PDT orientation recognizes at least10 different defense mechanisms (Fonagy & Target, 2009), while the CBT orientation focuses mainly on the function of the avoidance; what is avoided, and how to prevent the avoidance, with little interest in different defenses. Second, the PDT tradition links the different defenses to the child's development, while the CBT tradition does not do this. The defense concept is still common in the PDT orientation, however, APT and MBT more closely resemble CBT in their discussion of defenses. APT is interested in what the patient avoids (specific affects), rather than in how this avoidance is effected (different defenses) or how the defenses arise (developmental issues); what the psychodynamic language calls defenses, APT describes as avoidant responses (McCullough, et al., 2003). The founders of MBT content that "Dynamic therapists will inevitably raise a question concerning psychological defences such as displacement, projection, projective identification, disavowal and so on….Within MBT, mentalizing defences is simply identifying the way a person may be avoiding or exaggerating a particular experience in order to make life easier for themselves in some way." (Bateman & Fonagy, 2006, p. 138). The narrower concept of experiential avoidance seem to have been used for the first time as recently as 1994, but the concept has historical roots in the different theoretical orientations (Boulanger, Hayes, & Pistorello, 2010), and Hayes and coworkers (1999) point out that avoidance has been recognized in many therapies, such as behavior therapy, client-centered therapy, Gestalt therapy, and existential therapy. Finally, there is also substantial evidence showing the negative effects of avoidance of private experiences in depression, substance abuse, and sequelae of child abuse (Hayes, Pankey, Gifford, Batten, & Quiñones, 2002), which suggests that this concept may become even more common in psychotherapy in the future.

Exposure

The concept of exposure has strong roots in CBT, but it has also drawn attention in PDT, and it is not uncommon for PDT authors then to cite Freud's recommendation that one sort of patients with agoraphobia go into the street to confront their anxiety and resolve the phobia (Freud, 1919). Paul Wachtel, originally a psychoanalyst and later the originator of the cyclic psychodynamic model, considered the concept of exposure (and avoidance) as an appropriate contribution to the psychodynamic tradition. In his first book in 1977 he used the older concept of systematic desensitization in which the patient is deeply relaxed (Wachtel, 1977). Later he discussed how the newer concept of exposure (where relaxation is no longer a component) can enrich psychodynamic thinking (Wachtel, 2008). However, it is in APT that the use of exposure has been most similar to its use in modern CBT,

where both schools use exposure not only for external threats, but also for internal dangers (McCullough, 2001; McCullough & Andrews, 2001; McCullough, et al., 2003). Research shows that exposure is a well-established technique, at least for anxiety disorders (Woody & Ollendick, 2006), which speaks in favor of exposure's growing use in the future within different orientations.

Insight

The concept of insight in psychotherapy is associated with psychoanalysis and psychodynamic therapy, and these therapies have been criticized for overestimating the value of insight in psychotherapy. It is true that this concept has an important role in the psychodynamic tradition, but somewhat surprisingly, Freud himself used the German term for insight only once (Messer & McWilliams, 2007). Currently insight is not a necessary feature in PDT, and the founders of MBT have been clear that insight is not a primary aim in MBT (Bateman & Fonagy, 2006). In the experiential therapies, the concept of insight has been used with ambivalence, because the insight advocated in this tradition is more awareness of felt bodily experience than understanding of the historical background of the patient's problems (Pascual-Leone & Greenberg, 2007). Thus, proponents for the experiential therapies suggest an integrative model of insight that would apply to three levels of process: awareness, meta-awareness, and conceptual linking (Pascual-Leone & Greenberg, 2007). Advocates of CBT admit that in the beginning of the behavioral therapy tradition insight was dismissed (Grosse Holtforth et al., 2007). However, with the introduction of the cognitive perspective, especially the schema concept, insight is now a part of CBT that could be defined as the acquisition of new understanding (Grosse Holtforth, et al., 2007). Finally, a great majority of a large group of psychotherapy researchers with various theoretical affinities agreed to define insight as a conscious shift in meaning involving new connections (Hill et al., 2007). With this definition, insight seems to be of interest for therapists of different orientations.

Validation

While originally a concept developed in DBT and defined as covering phenomena which occur in all successful psychotherapies (Linehan, 1993, 1997), validation has been recognized as both an underappreciated aspect in psychoanalysis, as well as an appropriate concept to describe the psychoanalytic process (Schechter, 2007). Validation is an aspect of MBT as well, although its use in MBT is not exactly same as in DBT (Bateman & Fonagy, 2006). It seems too early to determine whether the narrower, Rogerian concept of empathy or Linehan's more expansive concept of validation will be used more in the future.

Mentalization

According to the founders of MBT, all therapies promote mentalization, the only specific aspect of MBT is making the enhancement of mentalizing itself the focus of treatment (Bateman & Fonagy, 2006). In line with this, representatives of CBT have described how their therapy also promotes mentalizing (Björgvinsson & Hart, 2006). Mentalization is a concept not only in clinical practice, but also in developmental psychology (Fonagy, et al., 2002). Secure attachment promotes the ability to mentalize, while children with a disorganized attachment pattern have a poor ability to mentalize, and moreover have an increased risk for developing borderline personality disorder as adults (Bateman & Fonagy, 2004). The connection with developmental psychology suggests that mentalization may be of increased clinical importance in the future, since to some extent psychotherapy may aim to help a person develop abilities that were insufficiently developed during childhood. It is then an advantage to use the same concept, mentalization, to describe an ability that may not has been developed to a sufficient degree during childhood and the ability psychotherapy seeks to help the patient to develop in order to gain further skills, such as the ability to engage in intimate relationships.

A tripartite model of the psychotherapeutic relationship

The psychoanalyst Gelso has proposed a scientifically founded tripartite model of the psychotherapeutic relationship, consisting of a working alliance, a real relationship, and a transference relationship (Gelso & Hayes, 1998; Gelso & Samstag, 2008). Emphasizing the component of a real relationship is in accordance with the view of the therapeutic relationship in several orientations. The object relation theorist Guntrip maintained that the therapeutic relationship is due to more than only transference reactions (Guntrip, 1968), and Bowlby wrote that the therapeutic alliance is based on the therapist's function as a secure base for the patient. A transference relationship existed too, but Bowlby also emphasized the role of the therapist as a companion for his patient (Bowlby, 1988). Beck underlined how important it is that the therapist becomes visible as a real person (Beck, et al., 1979), and the role of the therapist as a real person is also discussed in APT (McCullough, et al., 2003). The value of the therapist as a real person is especially important in the humanistic experiential orientation, and is essential in Rogers' view of psychotherapy (Rogers, 1957). Finally, what the PDT tradition labels transference is often the same as what cognitive therapy calls overgeneralization (Rabinovich & Kacen, 2009), and since the phenomenon of transference has been shown scientifically during the last decade (Andersen & Saribay, 2005, 2006), this bodes well for tripartite model becoming a common description of the therapeutic relationship for all theoretical orientations.

Common principles of change

Finally, following the APA's Division 12 Task Force publication of the now famous lists of ESTs and the subsequent task force commissioned in response to the reaction and charged with identifying ESRs (Norcross, 2002), the process continued. A third APA task force looked for empirically based principles of therapeutic change using the insights gained about ESTs and ESRs. They identified characteristics of the participants, aspects of the relationships, and procedures within treatment that were shown to induce positive effects across theoretical models and methods (Castonguay & Beutler, 2006) and formulated rules to express these principles. Sometimes the rule has a close connection to one of the concepts discussed above, for example, the rule for treating anxiety: "Use repeated exposure to the feared situation to reduce the intensity of the fear response" (Woody & Ollendick, 2006) is a direct use of the concept of exposure. Sometimes the rule has a weaker connection to a specific concept, for example the rule for treating depressed patients: "Improve the patient's interpersonal social functioning" (Follette & Greenberg, 2006), states an intermediate aim, but makes no recommendation about which concept might be most useful in fulfilling that aim.

The search for general principles that can be found in different kinds of psychotherapy, on the one hand, and for a more common language, on the other, can be considered two sides of the same coin. Both encourage increased attention to similarities and differences between schools on a more clinical and experiential level. In other words, when different theoretical orientations begin to use the same language, dialogue will be facilitated, because with common terms it will then be possible to say, "Yes, in our treatment we use exposure [or affect regulation, validation, etc.], but perhaps not exactly in the same way [to the same extent, for the same purpose] as in your kind of psychotherapy. We accentuate this aspect of exposure [affect regulation, validation, etc.] because we expect it will have this beneficial effect. What is your opinion about that based on your perspective?"

Conclusions from empirical research about psychotherapy

From empirical research we know that psychotherapy is usually effective and that there are at least four effective elements unrelated to any particular orientation: the alliance, cohesion in group psychotherapy, empathy, and goal consensus and collaboration. We also know how important the therapist's personal qualities are. Other than those common factors and the personal qualities of the psychotherapist, it is unclear whether any specific ingredients have additional effects. Because of this, continued research into whether some forms of psychotherapy are more effective for some disorders is important and has been proposed in the most well-known surveys of psychotherapy outcome research (Lambert & Ogles, 2004; Roth & Fonagy, 2005). We have also seen that in practice there are many similarities

between PDT and CBT therapists, at least when the therapists are experienced. The role of patients' expectations and preferences in the effectiveness of treatment is still unclear. Finally, the development of a more common language in psychotherapy can facilitate communications between different orientations.

To fully explore the similarities and differences between theoretical orientations, it is necessary, but not sufficient to consider theories and research about psychotherapy. More general academic psychology can have relevance for psychotherapy, and because the orientations tend to be organized as groups, it is also necessary to consider psychological theories about groups, especially theories about attitudes towards other groups.

Other relevant theories

Psychotherapy and academic psychology

In the long term, it is probable that the process of integration in psychotherapy will increase on a more theoretical level, as a result of a more common language. During the last decades leading proponents for the various therapeutic schools have developed more similar views of the need for scientific knowledge, based not only on psychotherapy research, but on academic psychology in general. Freud aimed to create not only a clinical theory, but also a general psychology; while his skeptical attitude towards psychoanalysis's need for academic psychology delayed the integration of psychodynamic theory and academic psychology, an expansion in that direction, leading to psychoanalysis being regarded as an empirical science, seems inevitable (Eagle, 1987; Kandel, 1999; Wakefield, 1992; Westen, 1998).

Integrative attempts can found not only in psychotherapy, but in other branches of psychology, such as developmental (Fonagy & Target, 2003; Green, 2003) and personality psychology (Campbell, 2008; Mayer, 2005). Theories from developmental psychology that are founded on direct observations of children, such as attachment theory and Daniel Sterns' theory of the child's self-development, seem to be increasingly influential among clinicians from different schools of psychotherapy. For several decades the psychodynamic orientation had their own theories of child development, but it is becoming more and more unusual for representatives of the psychodynamic school to refer to clinically founded theories, such as Freud's or Melanie Klein's, to explain normal child development. Recently, different theoretical orientations have shared a positive interest in the same developmental theories. Attachment theory, for example, is a theoretical starting point in MBT, which has psychodynamic roots (Bateman & Fonagy, 2003, 2004), but it is also utilized in ST, which has roots in cognitive therapy (Young, et al., 2003).

Another example of how clinical and developmental psychology can share an interest in the same subjects is the concept of the self. In psychoanalysis interest in the self has increased (Mitchell, 1991; Stolorow, 1995), and the self concept is common both in cognitive psychology (Beck, et al., 2004; Leahy, 2001) and in developmental psychology (Diamond & Marrone, 2003; Stern, 1985).

As a result of the increased influence of academic psychology, when clinicians continue to develop clinical theories, they will rely not only on their clinical experience, but also increasingly on academic psychology to create theories. For instance, Drew Westen has used theories on associative networks, affect regulation, and social cognition, in an attempt to integrate psychodynamic and cognitive-behavioral theory and technique (Westen, 2000). These integrative trends in psychology indicate that psychotherapy may become more and more grounded in research in the future, and less and less based on the theories from the different psychotherapy orientations. Psychotherapy will then become a matter of applying a common empirical science (Grave, 1997).

Group psychology—stereotypes, prejudices, and cooperation

Belonging to a theoretical orientation in psychotherapy means more than having some convictions in common, such as a positive attitude towards the founders; it also means being organized in a group, a group that to some degree competes with other groups. Thus, being a member of a certain psychotherapeutic orientation becomes an aspect of the individual's identity and self-concept: what I am and what I am not (Tajfel, 1981). When social psychological theories about groups are used to understand theoretical orientations in psychotherapy, it is especially interesting to consider social psychological theories about social identity, intergroup conflicts, and cooperation.

Group living is what humans do as a species, and group living offers a bounty of benefits through cooperation and an abundance of costs through social conflict (Buss, 2005). Humans are "ultrasocial" and unlike the vast majority of other species, individuals who are not closely genetically related work cooperatively to achieve common goals (Kurzban & Neuberg, 2005). No wonder then that belonging to a group becomes an important aspect of one´s identity (Brown, 2000). Moreover, belonging to a group tends to lead to an overvaluation of one's own group compared to other groups and to a search for markers of positive distinction for one's own group against other groups, which elevates the individual's self-esteem in the process (Brown, 2000). The result of this basic cognitive categorization process is that group-based attitudes, perceptions, and behavior will arise, dividing the social world into in-groups and out-groups (Brewer, 2007). As a consequence, when belonging to a group becomes important to an individual, he or

she will identify with the in-group and easily develop stereotyped and prejudiced attitudes towards members of out-groups.

A definition of stereotype accepted by most investigators is a set of characteristics ascribed to people on the basis of their group membership (Worchel & Rothgerber, 1997). A stereotype is a form of group belief, although there may also be some individual basis (Worchel & Rothgerber, 1997). A result of using stereotypes is that the out-group is perceived as more homogeneous than the in-group is; we have an idea of the "typical" member of the out-group, while we have a more differentiated view of individuals in our in-group. Stereotypes are primarily negative ("Italians are lazy"), but not necessarily ("Germans work hard"). Prejudices on the other hand are defined as a negative attitude toward a group or members of the group (Stangor, 2009). Group attitudes are a part of social categorization, a natural process that occurs spontaneously in our everyday perception, and there is a kernel of truth in most group beliefs (Stangor, 2009). For example, because there are differences between the genders, gender stereotypes are not entirely misleading (Swim, 1994). Thus, while having a stereotypical view of a group as a whole (overgeneralizing) is normal, it is the application of stereotypes to individuals that is problematic, since no matter how accurate the belief may be concerning the group, it cannot possibly describe every member of the group. Finally, a more general view is that stereotypes are cognitive (schemas), but when affect is added prejudices appear, which then can lead to discrimination (Stangor, 2009).

Most often individuals belonging to different groups have to live together or co-exist under a superior category or umbrella, for example various ethnic groups in a society or political parties in a government. Thus, members of different subgroups have to find ways to cooperate within the larger group, but at the same time they will have stereotyped views and prejudices against other groups, and they may possibly also compete for resources. A consequence of this is the need for theories about how to moderate such conflicts—especially conflicts between countries and ethnical groups—and how to promote cooperation and reduce prejudices (Brewer, 2007). The most common methods are contact under the right conditions, changing social categorization by developing a intergroup schema that accentuate similarities between the groups, and combinations of these methods (Brewer & Gaertner, 2004).

Groups are, of course, not necessarily something negative; on the contrary, participation in a group can facilitate the individual's development of both knowledge and skills when members share specific values and interests. However, groups can have disadvantages, too. One disadvantage is that when a group exaggerates the differences between the in-group and other groups, they lower their chances of cooperating with individuals from the other groups. Another disadvantage is that over-identification with the in-group can lead to a person evaluating phenomena primarily through the lens of the in-group's norms, and not

through objective criteria of value (Mackie & Cooper, 1984). For example, in the field of psychotherapy, members of particular orientations may judge a book, course, or treatment not by whether or not it seems beneficial, but by the orientation of the author or originator.

If these social psychological theories about groups are applied to the different schools of psychotherapy, it becomes clear that their existence as separate entities is based on far more than their holding different theories of change within a psychotherapeutic relationship. They likely hold a number of different attitudes, of which stereotypes and prejudices are two kinds (Stangor, 2009). Examining the relations between theoretical orientations in psychotherapy using group theory leads naturally to an examination of the attitudes between the various orientations. It will be valuable then to close this overview with some general remarks about attitudes and research in psychotherapy.

Attitudes and psychotherapy

Although formal definitions of attitude vary, most contemporary social psychologists agree that the characteristic attribute of an attitude is its evaluative nature. An attitude may then be defined as a disposition to respond favorably or unfavorably to an object, person, institution, or event (Ajzen 2007), or in other words, as a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor (Eagly & Chaiken, 1993).

Research in social psychology on the content of attitudes has been dominated by two perspectives: the three-component model and the expectancy-value model (Maio & Haddock, 2007). According to the three-component model, attitudes express people's feelings, beliefs, and past behaviors regarding the attitude object. In this model the behavior is a part of the attitude and it is possible to have conflicts between beliefs, feelings, and behavior (Maio & Haddock, 2007). Some researchers argue that a danger of the three-component model is that it is too all encompassing; it is better to simply focus on only one of the components. In the expectancy-value model, an attitude is instead considered the sum of all evaluative beliefs regarding the attitude object (Maio & Haddock, 2007).

Irrespective of which model is preferred, like a personality trait, attitude is a hypothetical construct that, being inaccessible to direct observation, must be inferred from measurable responses (Ajzen 2007). Given the nature of the construct, these responses must reflect positive or negative evaluations of the attitude object. Beyond this requirement, however, there is virtually no limitation of the responses that can be considered (Ajzen 2007). Despite some fluctuations in interest in different decades, the concept of attitude has been popular in the social

sciences, and more so in social psychology than in any other academic discipline (Eagly & Chaiken, 1993).

In psychotherapy research, investigations of attitudes are common, too. However, within psychotherapy itself attitudes do not seem to be a subject of general theoretical concern, and in Lambert's *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*, the concept of attitude is not even mentioned in the subject index (Lambert, 2004). Instead its use is restricted to two topics: questions to therapists or patients in very specific areas, for example therapists' attitudes to homework in psychotherapy (Kazantzis, Lampropoulos, & Deane, 2005), their attitudes toward treatment manuals in psychotherapy (Addis & Krasnow, 2000), or patients' pre-therapy interpersonal attitudes (Filak, Abeles, & Norquist, 1986); and in more general instruments such as the Dysfunctional Attitude Scale, the Eating Attitude Test, or the Insight and Treatment Attitudes Questionnaire (Fischer & Corcoran, 2007). Thus, research about attitudes in area of psychotherapy usually aims either to evaluate a particular entity with some degree of favor or disfavor, or to construct a scale for general use; in neither case is there usually any linkage to social psychological theories about attitudes as such.

This historical background and outline of the present situation in psychotherapy was presented as a starting point for considering the following research component of the thesis, to facilitate an understanding of the relevance and interest of the research, and to facilitate a discussion of the results presented below.

Summary of the empirical studies

General aim

In Sweden, training to become a licensed psychotherapist working with adults in individual psychotherapy is offered in one of three orientations: psychodynamic, cognitive, or cognitive-behavioral. Psychotherapists with such training may then either regard themselves as eclectic/integrative or identify themselves with the theoretical orientation they were trained in. The general aim of this thesis is to explore the opportunities and obstacles for members of different schools of psychotherapy to communicate and cooperate more effectively with each other. To make such an evaluation possible, several attitudes and preferences were explored among both practitioners of different orientations and their patients.

Method

Participants

The participants in these studies were one group of psychotherapists from different orientations and one group of their patients. The therapist group was drawn from two samples: one random and representative sample of 676 therapists and one sample of 255 CT and CBT therapists. The additional sample of CT and CBT therapists was included to counter the dominance of PDT in Sweden, which would have led to very few representatives of CT or CBT in the random sample. Both samples had a response rate of 82%. When respondents not working as therapists anymore, or not were working with adults in individual therapy, were removed, 578 therapists remained. Since we wanted to compare therapists with a distinctive identity in one orientation, therapists with an unclear identity as therapists, for example regarding themselves as both psychodynamic and cognitive psychotherapists, were then removed. Finally 416 therapists were included: 161 PDT, 93 CT, 95 CBT, and 67 integrative/eclectic (IE) therapists. Of these 416 therapists, 66 were willing to ask their patients to answer a questionnaire, and in total 290 patients answered this questionnaire. The patients were classified according to the theoretical orientation of their therapists in four groups: a PDT group of 80, a CT group of 93, a CBT group of 57, and an IE group of 60.

The questionnaires

The questionnaire for therapists included 106 items. One section included background variables about the therapists, their preferred focus in therapy, and their attitudes to psychotherapy and science. Another section consisted of 10 items on what defines a good psychotherapist. A third section used 17 items to ask how psychotherapy ought to be pursued, according to the therapist's own view. This section was called "Valuable Elements in Psychotherapy-Questionnaire" (VEP-Q). In the following section in the questionnaire the VEP-Q items were repeated, however, this time the therapists were requested to evaluate how important these items would be in their own orientation in general as well as for therapists in other orientations. The patients were given two questionnaires, one at the beginning of therapy and one towards the end. The first questionnaire included five sections and 70 items, with one 15-item section composed mainly of the VEP-Q items. The second questionnaire also contained the 15 items about how psychotherapy ought to be pursued, according to the patient.

Statistical analyses

In study I, significant differences in the background variables, attitudes to focus in therapy, and attitudes towards science were tested for using chi-square tests for independence for categorical variables such as gender or basic professional training. For the continuous variables, such as number of years since obtaining license, one-way between-group ANOVA was conducted. When significant differences in background variables were found, these variables (gender, length of psychotherapy experience, number of patients, and basic professional training) were used as covariates in one-way ANCOVA tests for factors for being a good psychotherapist and with the VEP-Q items. When the ANOVA/ANCOVAs showed significant differences, the Bonferroni test was used as post hoc test.

In study II (therapists answering the questions) and study IV (patients answering the questions), factor analysis of the VEP-Q items was used to facilitate analysis and improve psychometrical quality. The factor analyses were conducted by principal component analysis with VARIMAX rotation, and for theoretical reasons a three-factor solution was extracted. The factors in both study II and IV were a PDT scale/factor, a CBT scale/factor, and a common factor (CF) scale/factor. The items that were included in the scales for psychotherapists and the factors for patients differed somewhat. Cronbach's alpha was used to measure internal consistency of the scales and was satisfactory for both factor solutions.

In study II, test-retest reliability of the therapist scales was investigated, and the coefficients were above recommended limit. To investigate whether variables other than theoretical orientation influenced attitudes to psychotherapy, a hierarchical regression analysis was conducted on the results from the therapists. In study III, the chi-square test was used to compare the different orientations regarding questions about focus in therapy. In addition, 12 t- tests compared first the therapists' self ratings with their ratings of their own orientation in general (3 paired-samples t-tests,) and then their self ratings with ratings from therapists of other orientations (9 independent-samples t-tests). In order to reduce the risk of Type 1 errors, 0.01 was used as alpha level.

In study IV, except for the factor analysis, 20 independent t-tests and ANOVAs were used. In all calculations of effect size, when significant differences between the orientations were found, Cohen's delta was used. Because we had large groups, many significant differences could be expected; therefore, our main interest was in large effect sizes. In order to reduce the risk of Type 1 errors, 0.01 was used as alpha level.

Studies I & II

Aims

The aim of the first study was to compare similarities and differences between PDT, CT, CBT, and IE psychotherapists with regard to:

(1) background factors between therapists of different orientations;
(2) how therapists of different orientations define the main focus in therapy, with five alternatives: (a) the patient's attitudes to the therapeutic relationship; (b) the patient's thoughts; (c) the patient's feelings; (d) the patient's behaviour; and (e) the relationship between the patient's behaviour, thoughts, and feelings;
(3) therapists' views about psychotherapy as art or science;
(4) therapists' views on psychotherapy as based on empirical versus hermeneutic science;
(5) factors therapists consider important to being a good psychotherapist (10 items); and
(6) psychotherapists' opinions of how psychotherapy should be pursued (17 VEP-Q items).

The first aim of study II was to reduce the 17 VEP-Q items to factors for comparison to elicit profiles of the relative importance of different aspects of psychotherapy for therapists of each orientation. Another aim was to investigate whether aspects other than theoretical orientation could explain some of the variance in the different factors.

Results

In study I we found more similarities between the orientations than were expected, but we also found important differences. In terms of background variables, PDT and I/E therapists tended to be older than CT and CBT therapists; CT therapists were more often psychiatrists, nurses, or care workers; CBT therapists were more often males and psychologists; and CBT therapists tended to regard their specific therapeutic orientation as more important than therapists of other orientations did. We found differences in attitudes towards scientific views, too. For example, PDT therapists often had a hermeneutic view and very seldom a positivistic-empirical view, while CT therapists more commonly preferred a positivistic-empirical approach to a hermeneutic view. More than half of the PDT, CT, and I/E therapists expressed the opinion that positivism and hermeneutics were complementary, but only slightly less than a quarter of the CBT therapists expressed this opinion. Similarities between orientations were more obvious than differences regarding focus in therapy: almost all therapists reported that their main focus was the

relationship between the patient's behavior, thoughts, and feelings, and the next most common focus was on the therapeutic relationship.

We found no significant differences between orientations in their rankings of the importance of three of the ten items for a good therapist: (1) theoretical knowledge; (2) being fairly well-functioning and happy in everyday life; and (3) being able to communicate clearly and simply. The CBT orientation showed the largest differences compared to the other orientations. Of the ten listed factors for being a good psychotherapist, they rated the importance of six differently from all the other orientations, four with large effect sizes: (1) the therapists' theoretical orientation was ranked higher and (2) the therapist's personal therapy, (3) the therapist's own personal qualities, and (4) the therapist's ability to trust his or her intuition were all ranked lower. On the same items, the CT therapists were more similar to the PDT therapists than to the CBT therapists, and we found differences with large effect sizes between CT and CBT therapists on the above-mentioned four items as well.

For the 17 items of how psychotherapy ought to be pursued, we found extensive differences with regard to techniques. The greatest differences concerned transference and assignments between sessions. CT and CBT therapists ranked goals in therapy, activation in depression, and exposure in phobias considerably more important than did PDT and I/E therapists, while the opposite was true for patients learning to understand the connection between their present situation and childhood circumstances. However, on five items we found no significant differences: (1) that the therapist shows an interest in the patient's present situation; (2) that the patient and therapist have a working alliance; (3) that the patient learns to accept his/her own emotions; (4) that the patient develops a more positive self-image as a result of the therapy; and (5) that the patient experiences understanding and acceptance on the part of the therapist.

In study II the 17 items about how psychotherapy ought to be pursued were transformed to three scales: a PDT scale with five items, a CBT scale with six items, and a common factor scale (CF) with seven items. These scales explained 58% of the total variance. The PDT and the CBT scales were negatively correlated (-0.41), while they were both positively correlated with the CF scale (CBT–CF = 0.37; PDT–CF = 0.27). On the PDT scale the largest differences were between PDT therapists and therapists of any of the other orientations. Inversely, on the CBT scale large differences were found when the CBT and CT therapists together were compared with PDT and the IE therapists. In contrast to both PDT and CBT scales, the CF scale showed no significant differences between any of the orientations. Furthermore, the CF scale had the highest mean rating in all groups (except in the CBT, where it was quite high too). Regarding other variables that may have influenced the scales, psychologists rated the PDT scale lower than other occupations, while women rated the CF scale higher than men.

Discussion

Study I showed that therapists of different theoretical orientations had very similar views on the importance of the therapeutic relationship, and only somewhat less similar views on focus in psychotherapy, time frames, and which effects psychotherapy ought to obtain, while there were differences concerning techniques and scientific world view. Study II confirmed the differences concerning technique, however, these differences between orientations were not as great as had been found in earlier research (Blagys & Hilsenroth, 2000, 2002). To our knowledge, a CF scale has not been used in other instruments to evaluate similarities and differences between theoretical psychotherapy orientations, and it seems to be a methodological advantage, because it lowers the risk for differences between therapists of different orientations to be exaggerated.

The differences found regarding techniques in psychotherapy could be obstacles to a more integrative development, especially between PDT versus CT or CBT therapists. As regards CT versus CBT therapists, CBT therapists had more confidence in using theoretical knowledge and less confidence in the more personal aspects of the psychotherapist than the CT therapists had. The consequences of these differences seem difficult to analyze. Their probable reliance on similar, if not identical, theories could facilitate communication between CBT and CT therapists, but their differences concerning the relative importance of more personal characteristics of the therapist could perhaps be an obstacle. The role of psychotherapy for therapists in training, for example, or the degree to which supervisors should focus on theoretical understanding versus more personal aspects of the supervisee, are perhaps areas where CBT and CT therapists could have difficulty finding agreement. It seems far from inevitable, however that the differences found between CT and CBT therapists in studies I and II are enough to motivate different trainings for these therapists in Sweden.

Study III

Aim

The aim of this study was to investigate whether psychotherapists can correctly estimate how therapists of different orientations rate the importance of two aspects of practicing psychotherapy: focus in psychotherapy and how psychotherapy ought to be pursued. Based on previous research and social psychological theories, three hypotheses were tested: (1) that practitioners from different theoretical orientations will misjudge each other with stereotypes; (2) that the stereotypes will increase with increased theoretical distance between the orientations; and (3) that the IE therapists will be less stereotypical towards therapists from other orientations as a result of not having an equally strong in-group identity.

Results

When the psychotherapists' self-ratings of their focus in therapy were compared with their ratings for their own orientation in general, no significant differences were found. However, when the self-ratings regarding how psychotherapy ought to be pursued were compared with their ratings of their own orientation in general, significant differences were found on the PDT, CBT, and CF scales. A common pattern for PDT, CT, and CBT therapists alike was to rate the distinguishing qualities of their own orientation as more characteristic of the typical therapist in their own orientation than for themselves.

When therapists' self-ratings were compared with their ratings of psychotherapists from the other orientations, extensive differences were found regarding both therapeutic focus and how psychotherapy ought to be pursued. In the therapists' self-ratings the foci were complex, with either a "connection" or a "connection and relation" focus, while the foci in other orientations were generally considered to be more restricted than complex. For example, while no CT therapist claimed to focus only on thoughts, a fifth of the PDT and CBT therapists considered CT therapists to focus only on thoughts.

Three types of differences were regularly found in therapists' ratings of other orientations regarding how psychotherapy ought to be pursued: (1) therapists of all orientations underestimated the degree to which aspects considered important for themselves were important for therapists of other orientations; (2) therapists of all orientations overestimated how important distinctive features of other orientations were for practitioners of those orientations; and (3) therapists of all orientations underestimated the importance of the CF scale for therapists of other orientations.

Discussion

While psychotherapists could evaluate their own theoretical orientation "in general" fairly well, they had stereotyped views of foci in the other orientations, and they exaggerated the differences between the orientations on the three scales. One explanation for this could be a lack of knowledge about other orientations. However, the orientations not only misjudged each other, they did so in a negative way. The importance of therapeutic aspects that were highly valued by the therapists in their own orientation (i.e., [1] ingredients that are distinctive for their own orientation, [2] the common factor, and [3] a connection focus) were underestimated for the other orientations. Simultaneously, the importance of aspects that were not highly valued was overestimated for other orientations.

This pattern of exaggerating in a negative way the differences between one's own and other groups seems to be the result of a phenomenon well known from social psychology: in-group/out-group thinking—the classic "us versus them" mentality. Consequently, it is probably more accurate to describe this as prejudice than as lack of knowledge or as stereotyping. Thus, while there seem to be real differences between the orientations, members of the orientations exaggerate these differences. Such exaggerations can be an obstacle for psychotherapists of different orientations to communicate and cooperate with each other. Applying methods from social psychological research to reduce prejudices could help if the different orientations wanted to communicate and cooperate more with each other. The fact that the orientations are organized into different schools, however, with their own training, associations, journals, etc., will contribute to continued in-group/out-group thinking.

Study IV

Aim

The general aim of this study was to explore issues arising from the division of psychotherapy into various schools from the patient's perspective. Six subordinate research questions were defined:

(1) Can a patient version of the VEP-Q (then VEP-Q-C) be designed and shown to have similar psychometric properties to the therapist version, especially with regard to being collapsed into the same three factors (PDT, CBT, and CF)?

(2) Do patients who start psychotherapy with a therapist oriented to one of the four orientations (PDT, CT, CBT, or I/E) respond differently to the VEP-Q-C-items, independent of the patient's preference for that orientation?

(3) Is a patient's preference for a specific orientation related to his or her responses on the VEP-Q-C?

(4) (a) Do the patients' responses to the VEP-Q-C change over time, from when they begin therapy (T1), to when they have either finished or participated for a reasonably long time (T2)? If so, (b) are changes in patients' responses to the VEP-Q-C from T1 to T2 related to the specific orientation the patient experienced?

(5) Are other patient variables (gender, age, previous psychotherapy, degree of choice about entering or continuing therapy, public health care vs. private practice, use of medication for psychiatric symptoms, preferences for a specific orientation) related to their responses to the VEP-Q-C?

(6) What patterns of similarities and differences could be found in a comparison of patients' and therapists' preferences respectively about how psychotherapy ought to be pursued?

Results

The 15 items about how psychotherapy ought to be pursued were transformed to three factors: a PDT factor with three items, a CBT factor with five items, and a common factor (CF) with five items. Two items were excluded from the factor solution for statistical reasons. The factors explained 56% of the total variance. Correlations between the subscales were also investigated. While the PDT and CBT factors were positively correlated (0.24), they were each more strongly correlated with the CF factor (CBT–CF = 0.49; PDT–CF = 0.36).

There were many similarities between the scales found among the clients and the scales found among the therapists, but also some differences. In order to make it possible to use scales with identical items in comparisons between therapists and clients, three reduces scales were defined. They were named the shared scales. The PDT-shared scale included two items (speaking about childhood, and understanding the connection between childhood and the present situation). The CBT-shared scale included three items (assignments between the sessions, clearly stated goals, and improvements in symptoms). Finally, the CF-shared scale included four items, (the working alliance, the client feels understood and accepted by the therapist, the therapist has a warm and supportive attitude towards the client, the therapist shows interested in the client's present situation).

Patient preferences were more similar than they were different, regardless of the therapist's theoretical orientation. The greatest differences between the orientations could be expected to be found among the 64% of the patients who wanted a therapist with a specific orientation. For these patients significant differences with large effect sizes were found on the PDT scale between clients with preferences for

a PDT therapist and clients who wanted a therapist with a CT or CBT orientation. However, on the CBT and the CF scales no significant differences were found at the 0.01 level.

The preferences were stable over time and did not change substantially as a result of psychotherapy. Moreover, the CF scale was generally rated higher than either of the method-specific scales. On the CF scale, gender was a significant variable, with the women rating this aspect higher than the men.

When both clients and therapists were compared on the reduced scales about preferences regarding how psychotherapy ought to pursued, distinct patterns were found. Generally the therapists rated all the three scales higher than the clients did. The CBT-shared scale was rated very high by the CT and CBT therapists, with large effect sizes compared to all groups of clients, also those clients who were beginning in therapy with CT and CBT therapists. While the CBT-shared scale was rated somewhat higher by CT and CBT clients compared to PDT therapists, these differences was not significant. The PDT-shared scale was rated much higher by PDT therapists than by clients in all orientations, also by those clients who started therapy with a PDT therapist. The PDT-shared scale was rated higher by CT therapists than by PDT clients, and equally high by CBT therapists and PDT clients. On the CF-shared scale no significant differences were found, either between the groups of therapists, or the groups of clients. However, between the clients and therapists differences with large effect sizes were found; also the CF-shared scale was rated much higher by therapists than by their clients.

Discussion

The most obvious conclusions from this research seem to be two; first, clients' preferences are much more similar than they are different, irrespective of which theoretical orientation their therapist has. Between clients who were about to start psychotherapy with therapists of different orientations, only few significant differences were found on the method scales. The clients' preferences were also stable over time, and they did not change to any substantial degree after having been in psychotherapy for at least 10 sessions. Another conclusion is that the largest differences were not found between the theoretical orientations; instead the largest differences were between clients and their therapists. Therapists have stronger preferences than clients have; the clients' preferences were centered around the scales' midpoint, somewhat below the middle on the more method specific scales, and above the middle on the common scale. Thus, while clients sometimes prefer one of the methodological aspects to have a more prominent role, the three aspects ought to be mixed and are all valuable according to the clients. Among the therapists the differences on the method scales were of a much larger extent. The therapists also had a higher evaluation of the common factors than the

clients, irrespective of the therapist's theoretical orientation. Perhaps the clients' more moderate views reflect a more unsure position about what really is important in psychotherapy, while the therapists' views reflect some kind of combination of clinical experience and theoretical convictions.

General discussion

The starting-point for this thesis was a curiosity about how the psychotherapeutic field will develop over the next few decades, combined with a degree of skepticism about whether the current organization of psychotherapeutic training and professional communication within different therapeutic schools is scientifically optimal in the long run. As was shown in the introduction, the founders of the most important schools of psychotherapy were all aware of similarities as well as differences between their own schools and the orientation of others. Although the founders recognized the occurrence of common factors among different therapies, they generally focused more on what distinguished their own orientation from the other schools'. Their followers have often brought the orientations closer to each other through shared recognition of valuable elements in clinical practice such as empathy and other aspects of the therapeutic relationship. Some theoretical views of the more prominent representatives of different schools have also become more similar, for example in describing defenses as forms of avoidance. At the same time, followers of particular schools have usually preserved the idea of unique valuable elements in their own theoretical orientation. As a consequence of increased similarities between the schools, an organized integrative movement has arisen, prompted by the results of psychotherapy research. Despite this movement and increased similarities, however, the idea of separate schools still remains important within psychotherapy and is very seldom disputed. But questions of origin and maintenance are different kinds of questions according to scientific logic. The reasons for the appearance of the therapeutic schools during the 20th century cannot therefore legitimate their persistence in the 21st century.

Over the last several decades, the value of different theoretical orientations has been highlighted because of an increased demand for evidence for psychotherapy. Somewhat paradoxically, as the orientations grew more similar and developed more similar views about evidence, competition for legitimacy grew between the schools as each try to show at least as much scientific evidence for their own orientation as had been found for any of the others. This raises questions such as whether it is even appropriate to compare orientations at such an abstract level as the psychodynamic, the cognitive-behavioral, or the experiential, since effective therapists and effective kinds of therapy can be found in all these schools.

Given the situation described above, the aim of this thesis is to contribute some additional information about the similarities and differences in attitudes between therapists of different orientations and their patients, and with this knowledge as a basis, to examine the opportunities and obstacles for increased communication and cooperation between the orientations. As expected, we found many similarities, but also many differences, between the therapists' views in all investigated areas, and among the patients we found some differences, too. However, finding differences is not the same as identifying obstacles, since obstacles are by definition difficulties, while differences may lead to creative resolutions. The important question then is which of our results represent real obstacles and which point to opportunities for communication and cooperation between the orientations?

In our exploration of psychotherapy as an art/craftsmanship versus an applied science, and as hermeneutical versus empirical science, we found that many therapists claimed that psychotherapy is, at least to some extent, both an art/craftsmanship and a science. CBT therapists rated the scientific aspect higher and the art/craftsmanship aspect lower than therapists in other orientations did. PDT and the I/E therapists more commonly claimed a hermeneutic view of science than a positivistic-empirical view, while among the CT and CBT therapists the pattern was the opposite. These results could indicate that many PDT and I/E therapists will not be positive to systematic evaluation of psychotherapy, since in the most philosophical variants of hermeneutic theory, psychoanalysis is not an analytic-empirical science with a "technical cognitive interest," but rather the cognitive interest in psychoanalysis is "self-reflection" (Habermas, 1972), and the "verification procedures of psychoanalysis are not experimental, they are hermeneutic." (Steele, 1979, p. 408). This view is incompatible with traditional psychotherapy outcome research, because it reduces the science to reflections about the dialogue between the analyst and the analysand. However, many PDT therapists claimed that hermeneutics could be combined with an empirical-positivistic view. It is possible then that when PDT therapists call themselves hermeneutic, in accordance with the view of Lang (1995), they only want to assert the importance of such elements as interpretation and conducting the psychotherapeutic process within a "hermeneutic circle." Future research with more specific items about attitudes to scientific questions, e. g. the attitude to quantitative versus case studies as evidence in outcome research, would be helpful to clarify whether these differences about scientific issues are a real obstacle or not. The current emphasis on evidence-based psychological practice suggests that differences between the orientations concerning science will probably be reduced in the future; thus, it is uncertain whether the differences found regarding science really are an obstacle, at least not in a longer time perspective.

When asked about what constitutes a good psychotherapist, theoretical knowledge was rated high by therapists of all orientations. This similarity could be an opening for cooperation if the therapists advocated roughly the same theories. However,

therapists also claimed that theoretical orientation was at least somewhat important (IE therapists) ranging to very important (CBT therapists). Probably then therapists will continue to advocate different theories depending on their own theoretical orientation. This conviction seems to create distance between therapists of different orientations to a degree that could aggravate communication and cooperation. Perhaps it is possible for subgroups within the orientations—groups interested in evidence-based treatments, a more common language for psychotherapy, or both—to cooperate in a limited area, for example, training in psychotherapy with integrative features such as MBT or ACT, or treatment for a specific diagnostic area, such as generalized anxiety disorder, where it is possible to find therapy with integrative features and empirical support (Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008; Newman, Castonguay, Borkovec, & Molnar, 2004). However, the theoretical differences between PDT and CT/CBT therapists in general could probably still create obstacles for effective communication and closer cooperation.

On the questions about focus in therapy the similarities dominated, however, PDT therapists focused significantly more on the therapeutic relationship than did CBT therapists. This result seems to create an obstacle between these orientations only if the importance of the therapeutic relationship for the PDT therapists is positioned against using more specific therapeutic techniques, or if the PDT therapists actually have some specific relationship-oriented techniques in mind when they stress the importance of the relationship. As the results about how psychotherapy ought to be pursued showed, it is on the items about technique that the greatest differences are found. Some similarities were found here, too, but the differences seem more important than the similarities, especially regarding transference and assignments between sessions, but also about treatment of phobias and depression. Since techniques play a central role in psychotherapy, the differences here could mean considerable problems for therapists of different orientations trying to cooperate to a larger degree, for example, organizing a common training in psychotherapy.

Finally, in the study about attitudes to other orientations, the common in-group/out-group phenomenon appeared. The consequence of this is that therapists tend to think therapists in other orientations have narrow and somewhat simplistic views of psychotherapy, while their own group has a more complicated and, by implication, better idea about psychotherapy. This phenomenon could create substantial obstacles for communication and cooperation between therapists of different orientations, since a probable consequence is that therapists will be doubtful about whether they can learn anything valuable from therapists in other orientations than their own.

After this description of possible obstacles, which of our findings can then be opportunities to facilitate communication and cooperation between the orientations? We found many similarities which could be considered common

ground. First, psychotherapists in different orientations seem to agree in many ways regarding focus in therapy. The orientations had much in common regarding time focus since therapists in all orientations found an interest in the patient's present situation to be very important, and the PDT therapists stated that an interest in the patients' future was also very important. The therapists also agreed about the two most important focuses in therapy: (1) the connection between thoughts, feelings, and behavior, and (2) the therapeutic relationship.

Second, differences regarding the goals of psychotherapy were surprisingly small. The orientations agreed on it being very important that patients learn to accept their emotions, develop more positive self-images, and increase their self-knowledge. Symptom improvement as a result of therapy was more important for CBT and CT therapists than for PDT and I/E therapists, but the PDT therapists still thought that it was important that the symptoms improve. Third, their equal and high evaluation of the CF scale is an important similarity among the orientations. These results taken together—the similarities regarding focus, therapeutic goals, and the role of common factors—are an interesting reminder of how much psychotherapists can have in common, despite seemingly opposing theoretical orientations.

In summary, the main obstacles for increased communication and cooperation between therapists seem to be three: preferences for different theories, preferences for different techniques, and the group thought that comes with the division of psychotherapy into different theoretical orientations. However, the first two of these, preferences for different theories and for different techniques, are probably obstacles only between PDT and CT/CBT therapists. Admittedly, we did not have items about very specific theoretical preferences such as object relation theories, Kohut's self psychology, Beck's cognitive theory, classical and operant conditioning, and so on. Moreover, as mentioned in the introduction, while CT and CBT trainings have their historical roots in different theories and different organizations in Sweden, they nevertheless had a rather common view regarding techniques in psychotherapy. This is an indication that the important obstacle to cooperation between the CT and CBT therapists is not their different theories or techniques, but perhaps only the historical division of the schools.

The differences among the patients were much smaller than among the practitioners. There were differences in ratings of the PDT scale, which could be used as an argument for the value of a specific PDT orientation, but the PDT scale was important for patients in all orientations. It is far from self-evident, however, that a significant difference on a specific factor is an argument for the merits of any particular theoretical orientation. Instead it may be preferable, and likely, that patients find therapists with appropriate skills—whether it be talking about childhood and connecting the past to the present, making use of the common factors, or something else that suits the patient—regardless of the difference between theoretical orientations.

As was shown in the introduction, in research about similarities and differences in practice between PDT and CT/CBT therapists, the differences are usually smaller than theoretical differences would suggest. This is particularly true when the therapists are experienced. The empirical work in this thesis could be regarded as a part of a general tendency towards increased attention to similarities, and the results as evidence of a de facto increase in similarities between the orientations. It should also be noted that the therapists in our research were experienced: 90% had worked with psychotherapy for 10 years or more, and usually they had treated more than 100 patients. Our research emphasizes that psychotherapists share more essential attitudes and agree more about what is important in psychotherapy than they themselves usually recognize.

Since the research suggests that the differences between them are smaller than therapists commonly believe, it is possible that this thesis can contribute to an increased interest in communication between the orientations. Perhaps our research may also inspire increased cooperation among therapists interested in a more common language in psychotherapy and shared application of scientific findings. A result of a development in this direction might be that the different theoretical orientations would become less homogeneous, allowing new constellations and subgroups to arise in Sweden. Some individuals already operate in this "school-transcending" way. In the international arena, the most famous psychotherapists working in this direction are probably Leslie Greenberg and Jeremy Safran. Greenberg's main interest is in theories about emotion, and he is one of the most famous advocates of experiential therapy (Elliott, et al., 2004; Pos, Greenberg, & Elliott, 2008). However, this does not prevent him from making contributions in the CBT orientation, too (Greenberg, 2004, 2007). Safran is a member of the editorial board of a psychoanalytical journal (Safran & Jurist, 2009), but he also publishes articles about cognitive therapy with an integrative approach (Safran, Eubanks-Carter, & Muran, 2010). Despite some loosening of the strict borders between the orientations, however, everything points to different theoretical schools continuing to exist for a long time.

Explanations are seldom offered for the difficulties therapeutic orientations have in getting closer to each other. Norcross, one of the few who has written about this, made an early attempt in 1987 to define the obstacles to psychotherapy integration by mailing a survey to members of the Society for the Exploration of Psychotherapy Integration (Norcross & Thomas, 1988). Frequently nominated obstacles were "partisan zealotry and territorial interests of different psychotherapies and their adherents" and "absence of a comprehensive and conceptual psychotherapy framework acceptable to diverse audiences." Norcross has returned to the question of obstacles to psychotherapy integration and put together some explanations (Norcross, 2005), and he continues to stress that probably the most severe obstruction centers on "the partisan zealotry and

territorial interest of ‘pure’ systems psychotherapists” (p. 17). A similar but more elaborated explanation is given by Dattilio and Norcross (2006). They argue that resistance to psychotherapy integration may be a by-product of instinctual territoriality (Dattilio & Norcross, 2006). The authors argue that while human beings, by our very nature, are a territorial species, the notion of territoriality is not limited to a physical territory, but it may also refer to areas such as theory. Our group psychological explanation has some similarities with the territorial views, since the in-group/out-group mentality also has evolutionary roots (Kurzban & Neuberg, 2005). To our knowledge, the in-group/out-group explanation has not been used before in the context of competition between psychotherapy schools; we suggest that this explanation is preferable to a theory of territorial instinct because it is closer to the data and less speculative.

A radical solution to eliminate the negative effects of in-group/out-group thinking would be to dissolve the psychotherapy schools. Research about small groups with specific goals to achieve, such as psychotherapy groups or groups of business partners, has shown that such groups often have a stage of dissolution, which can be either spontaneous or planned, but which is usually final (Tuckman & Jensen, 1977). However, when a group—such as a psychotherapeutic school–has arisen without a clear goal to fulfill, and socio-emotional bonds have been formed, then it will be almost impossible to dissolve the group, because belonging has too many advantageous for the individual, especially if there are other competing groups. Furthermore, since belonging to the group is an aspect of an individuals’ identity (Tajfel, 1981), attempts to dissolve it will meet with resistance from members to the threat to their individual identities. Often it seems necessary for the successful planned dissolution of a group that other groups with similar goals be available for members to participate in (Forsyth, 2009). The schools in psychotherapy fit the description above of groups that are difficult to dissolve almost perfectly and as a result of this and other factors will probably continue to survive for a long time. Besides this, since there are real differences in theories and techniques, attempts to dissolve the psychotherapy schools too soon could have negative consequences.

In the short term, if it is seen as desirable, antagonism between therapists of different orientations could instead be moderated through the use of methods derived from social psychological theories about the reduction of prejudices between groups. First, an “insight-oriented” approach might help psychotherapists realize that although they are well-educated people with insight into psychological processes, they produce the same patterns of in-group/out-group phenomena as other people do. Another strategy could be to provide increased contact between practitioners of different theoretical orientations, leading to personalizing of others rather than categorizing them according a stereotype of a typical psychotherapist of a certain orientation. A further strategy could be fostering perceptions of the common identity as psychotherapists rather than as psychotherapists of different orientations, redefining the group as something larger. Both of these strategies

could be accomplished through trainings in newer kinds of psychotherapies, with integrative features using concepts with the potential of becoming part of a more common language for psychotherapy. For example, if PDT therapists start to take complementary training in ACT or ST, if CBT therapists start training in MBT or APT, or if therapists of different orientations learn IPT, this will make it possible for them to see therapists of other orientations as individuals rather than as "typical" members of specific theoretical schools. Another way to strengthen the common identity of psychotherapists is spread knowledge about common factors in psychotherapy and how in practice to apply the techniques originating from them. The final proposition expresses a more general ambition: to use knowledge founded in empirical research, rather than rely on school-specific techniques and theories.

Some limitations and objections to this research should be mentioned. First, the therapist sample was a fusion of two samples: one, a random representative sample of 676 therapists (15% of the psychotherapists who were licensed by the Swedish NBHW at the time the questionnaire was mailed in November 2004); the other sample comprised 255 CT and CBT therapists, listed from their professional bodies. It would have been better had this sample also been random, since it is possible that psychotherapists who are member of an organization differ in some ways from unorganized therapists. However, the CT and CBT groups of therapists would have been even smaller compared to the PDT therapists if not all available CT and CBT therapists had been included.

It could be argued that to explore the opportunities and obstacles for psychotherapists of different orientations to communicate and cooperate more effectively, another direction in the research would have been preferable. Instead of research about attitudes, a more relevant measure may have been the actual differences shown when psychotherapists of different orientations practice psychotherapy in the consulting room. With this design, the research would have captured real differences, and thus real opportunities and obstacles. While research on attitudes may be criticized on the grounds that, due to the phenomenon of social desirability, it can lead to an overestimation of items that are positively valued, as are the common factors. Research about what psychotherapists actually do in the consulting room is of course extremely important, however it would not have answered our research questions; only research about attitude could do this. Members of a group make judgments about preferable relationships with other groups guided not by the actual circumstances of the similarities and differences between the groups, but by their personal beliefs about these circumstances. Consequently, we wanted to learn how therapists' images of themselves compared to their images of other therapists, both in their own orientation "in general" and in other orientations.

Our results can also be seen as rather trivial. For example, psychotherapists focus on the connection between thoughts, feelings and behavior. Well, what else would

we expect? If we had had explored only how therapists rated themselves and found that they had a connection focus, that they regarded the therapeutic alliance as extremely important, and so on, such results could be, on their own, somewhat trivial. However, we also explored how the therapists rated other orientations on the same issues. We discovered that psychotherapists had difficulty believing that therapists of other orientations could have a focus as complex as their own, or that therapists from other orientations would rank common factors as high as the therapists rated them themselves. These results seem distinctly not trivial.

To finish with some speculations about the future. Fifty years ago, that is in the 1960s, we had three dominating schools of psychotherapy: psychodynamic therapy, behavior therapy, and the humanistic therapies. Today the field of psychotherapy looks different. Due to the development of psychotherapy research, new theories of child development, the appearance of cognitive therapy, and creative thinking among members of the different orientations, many new forms of psychotherapy unite features from the older forms of psychotherapy schools. Presumably this development towards increased similarities will continue, although it is difficult to predict in what way this will happen.

One reason to expect differences to continue to shrink in the future is that psychotherapy is becoming more of an applied traditional science. Historically, psychotherapeutic schools have had different views about how psychotherapy ought to be pursued; while they all have made scientific claims, the realization of these claims has diverged considerably. Freud claimed that publishing statistics about successes and failures was "worthless" (Freud, 1916) and many of his followers have also recommended the case study as evidence, while Rogers was interested in both quantitative outcome and process research (Rogers, 1967; Rogers & Dymond, 1954), and the CBT tradition has advocated different forms of quantitative research, for example randomized clinical trials and single-subject design (Thyer & Myers, 2007), from the beginning.

These different attitudes towards science have contributed to similarities between the development of the competing psychotherapeutic schools during the twentieth century and what Tomas Kuhn called "the route to normal sciences" in the natural sciences, where different schools appeared in the early pre-paradigmatic stages of a science's development (Kuhn, 1962). The schools now seem to be developing a more common view on research issues than before, as shown by the researchers from different schools who support the view on research and evidence presented by the American Psychological Association (APA Presidential Task Force on Evidence-Based Practice, 2006). The view in this document of multiple types of research evidence and future directions for research could serve as a common research paradigm in psychotherapy, resulting in a phase similar to Kuhn's description of "normal science," based on a shared paradigm with the same rules and standards for scientific practice. Another possible consequence of APA's view

could be that since evidence-based psychological practice should be based on the three pillars of best available research, clinical expertise, and the patient's characteristics, culture and preferences, the disadvantages of organizing psychotherapeutic science and practice within separate schools may become more apparent in the future. When psychotherapists are organized by theoretical orientation, they are more motivated to look for evidence-based treatment within their own orientation, rather than in the psychotherapeutic field in general—which is hard to see as an optimal situation.

Finally, research indicates that the difference between eclectic therapists and non-eclectic therapists is that eclectic therapists are older and more experienced (Beitman, Goldfried, & Norcross, 1989). Perhaps the same is true for psychotherapy in general: with a longer history, integrative ambitions become more pronounced.

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Research papers

I. Larsson, B. P. M., Kaldo, V., & Broberg, A. G. (2009). Similarities and differences between practitioners of psychotherapy in Sweden: A comparison of attitudes between psychodynamic, cognitive, cognitive–behavioral, and integrative therapists. *Journal of Psychotherapy Integration, 19*(1), 34-66.

II. Larsson, B. P. M., Kaldo, V., & Broberg, A. G. (in press). Theoretical orientation and therapists' attitudes to important components of therapy: A study based on the 'Valuable Elements in Psychotherapy' Questionnaire. *Cognitive Behaviour Therapy*.

III. Larsson, B. P. M., & Broberg, A. G. (2010). What psychotherapists with different theoretical orientations think about each other: The role of prejudice. Manuscript submitted for publication.

IV. Larsson, B. P. M., Kaldo, V., & Broberg, A. G. (2010). Similarities and differences in preferences between Swedish clients in four different psychotherapies: An explorative and prospective study. Unpublished manuscript