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ORIGINAL PAPER

The Therapists' Training and Their Attitudes Towards Therapy as Predictors of Therapeutic Interventions

Aureliano Crameri[1] · **Volker Tschuschke**[2] · **Margit Koemeda**[3] · **Peter Schulthess**[3] · **Agnes von Wyl**[1]

Abstract

Previous results have demonstrated that psychotherapists working in a practice setting have a relatively low treatment adherence, regardless of the therapy school to which they were affiliated. The objective of this study was to investigate whether the therapist's attitudes in therapeutic matters are a better predictor of interventions employed than the therapeutic method in which the therapist was trained. The relationships between various types of psychotherapeutic intervention and both predictors were tested by means of Markov Chain Monte Carlo simulations. A total of 162 therapy sessions conducted by 18 therapists affiliated to 6 different therapeutic methods were analyzed. The interventions were classified according to the criteria of essentiality and commonality. The analysis showed that 40% of the examined intervention types were significantly associated with at least one of the nine attitude scales considered, whereas only 14% exhibited a significant association with the completed type of therapy training. The latter predictor was only associated with interventions of the kind *essential/not common*, whereas the attitude scales were related with both essential and common interventions. The rather weak association between the type of completed training and preferred therapeutic intervention types means that many essential intervention techniques acquired during training assume a subordinate role in a practice setting. Choice of therapeutic action is conditioned to a greater extent by nuances in individual attitudes, which may change throughout a professional career. The reciprocal influence of a psychotherapist's attitude and his or her professional development is discussed.

Keywords Therapy training · Therapeutic techniques · Theoretical orientation · Bayesian analysis · Psychotherapy integration

Introduction

During the first half of the last century a growing number of psychotherapy methods were developed. Along with this proliferation there was a pronounced increase in eclectic practice with a consequent decline in allegiance to the classical techniques. Cook et al. (2010) observed in their web-survey that only 2% of the participating North American psychotherapists were exclusively committed to one orientation, whereas the rest of the respondents supported more than one theoretical orientation or declared themselves to be eclectic. Similar trends have been observed in Europe (e.g. Orlinsky et al. 1999; Suszek et al. 2016). This phenomenon is also referred to as integration (Hollanders 2000).

One of the therapists' arguments for adopting an eclectic procedure is the possibility of pragmatically selecting the most beneficial interventions for a particular client (Beutler and Clarkin 2014).

✉ Aureliano Crameri
aureliano.crameri@zhaw.ch

Volker Tschuschke
volker.tschuschke@icloud.com

Margit Koemeda
koemeda@bluewin.ch

Peter Schulthess
peter.schulthess@psychotherapie.ch

Agnes von Wyl
agnes.vonwyl@zhaw.ch

[1] School of Applied Psychology, Zurich University of Applied Sciences, Pfingstweidstrasse 96, 8005 Zurich, Switzerland

[2] Division of Medical Psychology, University Hospital of Cologne, Cologne, Germany

[3] Swiss Charta for Psychotherapy, Stäfa, Switzerland

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In contrast to this trend, psychotherapy institutes are still actively maintaining their identity and stressing the uniqueness of their techniques. Under this auspice, the Swiss Charter of Psychotherapy, an umbrella organization for psychotherapeutic training institutes in Switzerland, promoted a non-randomized field study in which differences in the process and in the outcome of various therapeutic approaches were investigated (Tschuschke et al. 2015). One important part of this project was the categorization and analysis of therapeutic interventions using audio-recordings of randomly drawn sessions (Tschuschke et al. 2015; Koemeda-Lutz et al. 2016a, b). The first result of these analyses was a low adherence to approach-specific interventions by the therapists, regardless of the therapeutic approach they were affiliated to. Between 50 and 73% of the observed interventions could be classified as common to various therapeutic methods. This result is compatible with the thesis that a substantial proportion of therapists work eclectically. The second result, which can be seen as a consequence of the first, was the equivalence in outcome of the different therapeutic approaches. This phenomenon is known in the literature as the "dodo bird verdict" ("Everybody has won, and all must have prizes", see e.g. Duncan 2002). Although, at the level of the disparate approaches delivered in a practice setting, the differences were not significant, at the level of the individual therapists, differences in both the use of interventions and the achieved averaged outcome were observable (Koemeda-Lutz et al. 2016a; Berglar et al. 2016).

Other authors had dedicated their attention to the nuances of the theoretical orientation of individual psychotherapists and how these are related to their therapeutic practice (Poznanski and McLennan 1995; Sandell et al. 2004). The theoretical orientation, also referred to as *attitudes in therapeutic matters* (Sandell et al. 2004) or *implicit theory of psychotherapy* (Najavits 1997), encompasses convictions about e.g. human nature, curative factors, therapeutic goals and the role of the therapist in the therapeutic process. Most concepts of theoretical orientation are derived from principal therapeutic mainstreams, such as the psychodynamic, the cognitive-behavioral or the humanistic-experiential. For example, the role of insight as a curative factor is associated with a psychodynamic approach, whereas stress on the importance of adjustment belongs to the cognitive-behavioral paradigm (Sandell et al. 2004).

Differences in therapeutic style have repeatedly been demonstrated to reflect psychotherapists' differing ideological position (e.g. Vasco and Dryden 1997; Larsson et al. 2009). In the light of this, the aim of the present work is to test whether a therapist's personal theoretical orientation is a better predictor of interventions employed than the therapeutic method in which the therapist was trained. The work consists of a reanalysis of a selection of the intervention ratings used in our previous articles (Tschuschke et al. 2015; Koemeda-Lutz et al. 2016a) with the focus on two aspects. The first is the *relation between specificity and eclecticism*: What proportion of the interventions which therapists learned in their training are regularly used? What proportion of the interventions are used by therapists with different types of therapy training and can, therefore, be considered as common? Furthermore, what proportion of the interventions are used exclusively or more frequently by a certain group of therapists and can hence be considered as specific? The second aspect is the *association between the personal theoretical orientation and the use of determined interventions*: Is the frequency of the interventions used by a therapist associated with particular dimensions of his/her individual theoretical orientation? Are his/her attitudes in therapeutic matters a better predictor of the interventions applied than his/her therapy training?

Method

Participants

The project PAP-S (Practice Study Outpatient Psychotherapy—Switzerland; von Wyl et al. 2016) was originally realized with the participation of ten training institutes, each of them as the exponent of a distinct therapeutic method. Therapists who completed their training at one of these institutes recruited the patients for the study and carried out the psychotherapies in their practices.

For the present analysis, in order to equally weight institutes and therapists, a balanced sample was required, which we defined as three therapists per institute, three patients for each therapist and three audio recorded sessions for each patient.

Only six institutes representing the following methods generated at least this number of observations, and were therefore, included in the analysis: (1) bioenergetic analysis (Lowen 1971), (2) Gestalt therapy (Perls et al. 1951), (3) integrative body psychotherapy (Rosenberg and Rand 1989), (4) art and expression-oriented psychotherapy (Knill et al. 1995), (5) process-oriented psychotherapy (Mindell 1982) and (6) transactional analysis (Berne 1964). Consequently, the selected, balanced subsample consisted of 162 observations (i.e. 6 institutes × 3 therapists × 3 patients × 3 sessions).

The 18 therapists (11 women and 7 men) were on average 53 years old (SD = 8) with an average of 12 years of therapy experience (SD = 8). All fulfilled the following two criteria, which were crucial for the objective of the analysis: (1) completed training in one of the six specific methods, and (2) the self-declared allegiance to the same method. The subsample represented 38% of the complete sample of therapists from the six institutes (47 therapists) and shared similar characteristics with the latter (see Tschuschke et al. 2015).

The 54 patients (35 women and 19 men) had a mean age of 38 years (SD = 11) and received on average 43 sessions of therapy (range 9–156 sessions). The most frequent primary diagnoses on Axis I of the DSM-IV were affective disorders, with 38%, followed by anxiety and adjustment disorders, each with 20%. 50% of the sample fulfilled the criteria of a personality disorder on the Axis II (2% of Cluster A, 25% of Cluster B, and 22% of Cluster C). 19% had already received in the past a psychiatric or psychotherapeutic treatment. This subsample of the 54 patients represented 26% of the whole sample (211 patients) of the six institutes and shared similar characteristics with the latter (see Crameri et al. 2015).

Measures

Type of Interventions

Within the ambit of the project, a standardized rating manual was developed in order to identify the type of interventions implemented during the therapeutic sessions (Tschuschke et al. 2014, 2015). The aim of this instrument was to assess the degree of treatment fidelity. Each of the ten institutes that originally participated in the project were asked to nominate and describe the ten most essential interventions of the specific therapeutic method they taught and supported. *Essential* interventions were defined as "therapist behaviors that should be found in the specified treatment, if that treatment is being administered appropriately" (Waltz et al. 1993, p. 624). The resulting compound list was extended with the inclusion of interventions from other prominent therapeutic approaches which are not represented in the study, such as the client-centered, the cognitive-behavioral and the systemic therapy. After the elimination of multiple occurrences of interventions, the final version of the manual encompassed 100 distinct interventions, which were described by an operational definition and illustrated with some examples.

Therapist Attitudes

The therapists' values and beliefs in therapeutic matters were assessed with the Therapeutic Attitude Scales (TASC-2; Sandell et al. 2004). The questionnaire encompasses nine scales, grouped in the following three domains: curative factors, therapeutic style and basic assumptions (see Table 1). The nine scales were created by principal components analysis and varimax-rotation within each domain using the ratings of 325 therapists from different therapeutic orientations and cross-validated with the ratings of 294 psychodynamic therapists. The profile of the TASC-2 scales demonstrated to be congruent with the self-reported theoretical orientation and professional training and could differentiate between psychodynamic, cognitive-behavioral and eclectic therapists.

The validation of the German version was carried out by Klug et al. (2008).

Following the more liberal suggestions of DeVellis (2003) who consider a Cronbach's alpha value of at least .65 a minimally acceptable internal consistency, three scales, i.e. Self-doubt, Artistry and Pessimism, have to be considered as insufficiently consistent (see Table 1). Nevertheless, we used the complete questionnaire without excluding any scales.

Procedure

The cooperating psychotherapists affiliated to the different institutes asked their new patients to participate in the study on a voluntary basis. There were no restrictions on patient inclusion. Patients who signed the informed consent participated to several assessments carried out by independent and trained psychologists. The assessment included, among other things, structured diagnostic interviews based on DSM-IV (Wittchen et al. 1997) criteria and the completion of self-report questionnaires.

The therapists committed to audio-record every therapy session. At the end of the treatment, three sessions were

Table 1 Description of the TASC-2 scales

Domain	Scale	Definition	No. items	Chronbach's α
Curative factors	Adjustment	Promoting the patients' ability to cope with everyday life and with inner pressures	13	.83
	Insight	Enabling the patient to become conscious of hidden or repressed contents	12	.87
	Kindness	Engaging in a warm and accepting relation	5	.82
Therapeutic style	Neutrality	Maintaining a personal distance	10	.77
	Supportiveness	Active help by e.g. structuring, prompting, questioning and encouraging	9	.75
	Self-doubt	Experiencing of limitations, doubts, obstacles and difficulties	6	.50
Basic assumptions	Irrationality	Assuming that the human behavior is irrational, subjective, unconscious, and uncontrollable	4	.67
	Artistry	Considering psychotherapy, a creative, intuitive work governed by relativistic views	5	.57
	Pessimism	Assuming limitations in the efficacy of psychotherapy	5	.50

randomly drawn and analyzed with the rating manual by the research team.

Overall six postgraduate psychology students have been trained to segment the audio-recorded sessions into relevant rating units and to classify the intervention according to the manual. The raters were blind to the affiliation of the therapists as well as to membership of the interventions to the different therapeutic methods. Their interrater reliability reached an average kappa coefficient of .65 (Tschuschke et al. 2015; Koemeda-Lutz et al. 2016a).

Data Analysis

Classification of the Interventions

In our analysis, we classified the interventions according to the following two criteria: essentiality and commonality. *Essential* interventions are therapist behaviors that should be found in the specified treatment, if that treatment is being administered appropriately (Waltz et al. 1993). Which interventions have to be considered as essential for a specific therapeutic approach was determined during the development phase of the rating manual by inquiring experts, such as training therapists or psychotherapy supervisors. Independently of their essentiality, we defined interventions as *common* if they were observed in every therapeutic approach. Commonality was empirically determined, namely by analyzing the audio-recordings from sessions from each of the six considered therapeutic approaches. The criteria overlap leading therefore to four classificatory combinations (i.e. essential and not common, essential as well as common, not essential but common, neither essential nor common).

Regression Models

The relationship between the frequency of the single interventions and the two predictors, type of training and attitudes, respectively, was explored within a Bayesian framework by means of a Markov chain Monte Carlo (MCMC) approach. This methodology is particularly suited for the present analysis since it allows a multilevel modelling of repeated measures not normally distributed and offers a robust inference with small samples (see e.g. Gelman and Hill 2006; Lunn et al. 2013). We modeled the frequencies of the interventions as Poisson distributed, non-equidispersed count data. The model analyses were run in JAGS 4.2 (Plummer 2017).

We based our judgement on the analysis of the following four nested types of models applied to each of the interventions taken into account: null model without predictors (0), simple model with type of training as predictor (1a), simple model with one or nine attitude scales as predictors (1b) and full model with all predictors (2). We calculated two statistics for assessing the significance of the predictors: the 95% highest density intervals (HDI) and the deviance information criterion (DIC). These two criteria were considered conjointly in order to avoid inflating the Type I error. A specific regression coefficient was considered as significant if the 95% HDI of the posterior distribution did not include zero. This approach is analogous to the decision to reject a null hypothesis on the basis of a confidence interval within a frequentist framework. We were not only interested in determining significant coefficients but also in assessing whether the independent variables lead to an improvement in the prediction of the interventions. For this purpose, we used the DIC as a measure of comparison of two nested models in order to identify the one with the best prediction and at the same time the most parsimonious. According to Lunn et al. (2013) a DIC difference of five or more can be considered as substantial. The predictive contributions of the type of training and of attitude scales were assessed by comparing model (0) both with model (1a) and also model (1b). In situations in which both the type of training and the attitude scales exhibited a substantial predictive contribution, the comparison of model (1b) with (2) was used to the test for the possible redundancy of the training type as predictor.

Clinical patient characteristics were not considered as decisive confounders and not included as predictors in the models for the following reasons. Firstly, previous analyses demonstrated that level of symptom severity is not related to treatment adherence (Tschuschke et al. 2015). Secondly, in the present subsample, the proportions of affective disorders, anxiety disorders, adjustment disorders or personality disorders did not differ significantly between the six institutes ($\chi^2[5] \leq 3.6$, $p \geq .608$). Also, the proportion of patients been previously treated by mental health professionals, as a possible indicator of the presence of treatment resistant conditions, was not significantly different between the institutes ($\chi^2[5] = 3.4$, $p = .639$).

Results

Frequency of the Interventions

Before reporting the inferential statistical results, we shall present and comment on a preliminary descriptive analysis based on all 100 interventions for the different therapists' groups, as defined by the corresponding type of completed therapy training. Table 2 shows the number of intervention types that were observed as well as the number of those that were declared as essential by the training institutes. Most of the essential interventions were observed in the practice setting and one or more of these were present in at least two-thirds of the analyzed sessions. However, if we consider the ratio of the frequency of the essential interventions to the

Table 2 Number and proportions of interventions in each therapists' group

Learned therapeutic method	Number of observed intervention types	Essential interventions			Proportions of observed interventions	
		Total number of types	Number of observed types	Prop. of sessions with at least one essent. interv. (%)	Essential (%)	Common (%)
Art/express. oriented	72	9	8	67	8	79
Bioenergetic	49	10	8	83	9	91
Gestalt	51	12	10	81	7	94
Integrative body	54	11	9	100	28	79
Process oriented	59	7	6	70	5	91
Transactional	61	10	9	93	11	90

frequency of those interventions not mentioned as essential, then the importance of the former is less clear. In four of the six analyzed therapists' groups, < 10% of the interventions utilized during a session were classified as essential. The highest frequency was observed among the integrative body psychotherapists with a mean proportion of 28% essential interventions in their sessions. All in all, more than two-thirds of the implemented interventions can be considered as non-specific. The number of intervention types that were observed in all therapists' groups, and can therefore be classified as common, was 32. Among these common interventions all four major mainstreams were represented, i.e. the psychodynamic, the humanistic, the behavioral and the systemic approach. Techniques focusing on behavior are most prominent (six intervention types) followed by those addressing preconscious and unconscious elements (five types) and those with supportive character (four types). Other classical interventions commonly used were clarification, confrontation, interpretation, biographical exploration, feedback provision, analysis of therapeutic goals, work on the therapeutic alliance, and self-disclosure. Two further types of intervention were used in every therapists' group: an artistic/expression-oriented intervention, such as the sensitization of perception and imagination; and a typical body psychotherapeutic intervention, such as focusing on body impulses. The analyses in general indicate that the utilization of both families of interventions just mentioned is not confined to the corresponding therapists' groups. Seven typical body-oriented interventions were listed in the rating manual: one of them was never used, the other six were used by body psychotherapists, but were also found in other therapists' groups. A similar situation was found among the six artistic/expression-oriented interventions considered: five of these were also used in at least one further therapists' group.

The descriptive analysis so far shows that the similarities in technique between therapists' groups clearly overweigh the differences. This picture doesn't change if we explicitly seek interventions that can be classified as unique for therapists with a specific qualification: the number of essential interventions that were exclusively used by the corresponding therapists' group varied between zero and two. Put another way: on average only one in ten essential interventions can be also considered as exclusive for a certain therapeutic method.

Regression Models

A convergence of the MCMC chains and a satisfactory level of accuracy in the estimated posterior distributions could only be reached with interventions that were observed in at least 6 of the 162 examined sessions. This minimal prevalence was fulfilled by 58 of the 100 interventions included in the rating manual. Of the remaining 42 interventions, 12 had never been used and the other 30 had been used in between one and five sessions.

The significant results of the MCMC analyses are summarized below. These concern the regression models of the 58 intervention types that were observed in at least six sessions.

Type of training emerged as a significant predictor for only eight intervention types, which corresponds to 14% of the analyzed types. All of them belonged to the kind "essential and not common" (Table 3) and were limited to body-focused and artistic/expression-oriented interventions. The models demonstrated—as expected—that therapists with training in these approaches were significantly more likely to use these interventions than therapists with other trainings. However, in the case of four of these eight interventions, comparison of the models (2) and (1b) indicated a negligible reduction of the deviance, i.e. if the attitude scales were included first in the model, then the addition of the training type as a predictor did not substantially improve the predictive value of the model. This result suggests that for various interventions the differences associated with training type could also be explained through differences in attitudes.

Attitude scales emerged as significant predictors for 23 interventions, i.e. in 40% of the analyzed types (Tables 3,

Table 3 Summary of the MCMC analyses showing a significant association between, on the one hand, interventions of the kind "essential and not common" and, on the other hand, the training type or the attitude scales

Intervention of the kind essential and not common	Significant coefficient (95% HDI)									Predictive improvement (DIC difference)		
	Tr	Ad	In	Ki	Ne	Su	Ir	Ar	Pe	(0) − (1a)	(0) − (1b)	(1b) − (2)
Breath work (B)	•		+		+		−	−		**9.5**	**9.3**	**8.0**
Working with character and defense style (B)	•			−						**16.9**	**21.9**	1.1
Working with energetic boundaries (B)	•			−						**16.1**	4.3	**16.0**
Stimulating body awareness (B)	•	+		−				−		**32.3**	**36.0**	**16.7**
Body exercises (B)	•									**14.3**	-16.0	**16.7**
Stimulating and practicing creativity (A)	•	+	−	+		+			+	**28.5**	**63.4**	0.2
Employing art-aesthetic responsibility (A)	•	+	−	+		+			+	**22.0**	**17.4**	0.6
Soliciting experiences during the creative process (A)	•		−	+		+				**5.7**	**12.0**	− 0.2
Discovering new meaning through creative work (A)						+				1.8	**7.3**	− 1.7

Tr training type, *Ad* Adjustment, *In* Insight, *Ki* Kindness, *Ne* Neutrality, *Su* Supportiveness, *Ir* Irrationality, *Ar* Artistry, *Pe* Pessimism, *B* body focused, *A* artistic/expression-oriented. Symbols: •=positive coefficient for the corresponding therapists' group, +=positive coefficient, −=negative coefficient. (0), …, (2)=model number. DIC differences ≥ 5 are in boldface. Self-doubt is omitted from the table because it did exhibit no significant relationship with the listed interventions

Table 4 Summary of the MCMC analyses showing a significant association between, on the one hand, interventions of different kinds and, on the other hand, the training type or the attitude scales

	Intervention	Significant coefficient (95% HDI)								Predictive improvement (DIC diff.)
		Ad	In	Ki	Ne	Su	Sd	Ir	Ar	(0) − (1b)
Essential as well as common	Psychoeducation				−					27.5
	Interpretation			+		−			−	23.8
	Addressing therapeutic goals							+		6.1
	Role playing							+		25.7
	Discussion of past experiences						−			7.0
Not essential but common	Empathy	−								27.2
	Working with patient feedback	+								8.6
	Positive regard	+			−			+		8.6
	Clarification				−			−		90.5
	Self-disclosure					+				25.7
	Discovering meaning in life					−				10.6
Neither essential nor common	Homework assignment								−	7.8
	Paradoxical intention			+				+		8
	Addressing pharmacological treatment	+								5.1
	Reframing	−	−			−				6.8
	Directing session activity		−							26.3

Ad Adjustment, *In* Insight, *Ki* Kindness, *Ne* Neutrality, *Su* Supportiveness, *Sd* Self-doubt, *Ir* Irrationality, *Ar* Artistry. Symbols: +=positive coefficient, −=negative coefficient. (0), (1b)=model number. Training type and Pessimism are omitted from the table because they did exhibit no significant relationship with the listed interventions

4). As with the training type, the largest number of significant relationships were observed with "essential and not common" interventions. Artistic/expression-oriented interventions in particular exhibited a positive relationship with Kindness and Supportiveness and a negative relationship with Insight. Among body-focused interventions the opposite trend, characterized by a negative e relationship with Kindness, was observed. The attitude scales that were related to the largest number of intervention types were Supportiveness (8 types), Kindness (8), Adjustment (7), Insight (6) and Irrationality (6). The three scales with a low internal consistency ($\alpha < .65$), i.e. Self-doubt, Artistry and

Pessimism, had only a marginal predictive contribution. Self-doubt and Pessimism were correlated only with one and the latter with two interventions. The Artistry scale demonstrated a lack of criterion validity: Therapists with a training in art and expression-oriented therapy did not have a higher mean score (M = 2.5) than therapists with other types of training (M = 2.8). In the whole subsample the correlation between the score on the Artistry scale and the amount of used art and expression-oriented interventions was not significant ($r = .11$, $p = .66$).

Discussion

The present study was motivated by our previous results, which demonstrate a relatively low treatment adherence of therapists working in a practice setting, regardless of the therapy school they were affiliated to. This result implies that the kind of completed therapy training is a rather weak predictor of the interventions used in therapy sessions. Our previous analysis demonstrated, furthermore, a negative relationship between professional experience and level of adherence (Tschuschke et al. 2015). This suggests that therapists with the same training become heterogeneous in their therapeutic action in the course of their career: their practice is conditioned by nuances in the individual theoretical orientation, shaped by professional experience. Differences between therapists of the same school become as large as differences between therapists of distinct schools. Therefore, the main aim of the present study was to investigate the hypothesis that the *personal* conceptual orientation of an individual therapist is a better predictor of interventions than his/her *official* affiliation to a determined school. The current results support this hypothesis: 40% of the analyzed intervention types were significantly associated with at least one of the nine attitude scales of the TASC-2, whereas the completed training type exhibited a significant association with only 14% of the analyzed intervention types. The training type was informative in the case of body-focused and artistic/expression-oriented interventions, i.e. these kinds of interventions were used significantly more often by therapists who completed the corresponding training than by therapists with other qualifications. At first this fact may seem trivial. However, this is not necessarily the case, because, as our data demonstrated, not only Rogerian conditions—such as empathy—or cognitive-behavioral interventions—such as giving feedback about the client's inappropriate or maladaptive attitudes—but also interventions derived from body psychotherapy or art therapy are assimilated by therapists of several orientations. More specifically, six intervention types used by body psychotherapists and five of the artistic/expression-oriented interventions were found in other therapists' groups.

A similar conclusion was reached by Thoma and Cecero (2009), whose results, based on therapists' self-reported data, "indicate that therapists endorse substantial use of techniques outside of their orientation" (p. 412). Their data, like ours, demonstrated that every theoretical orientation, i.e. behavioral, humanistic, psychodynamic and systemic, has techniques that are popular among therapists from other orientations. Preliminary analyses of our data also shown a positive correlation between professional experience and amount of advanced training, which were partially accomplished in other approaches. According to the Swiss law the accomplishment of regular advanced training belongs to the professional duties of psychotherapists. Essentially, the longer the carrier of the therapist is, the higher the probability is for her/him to come in contact with other therapeutic orientations; it doesn't matter getting in touch through formal courses or informally for example, through reading books or exchanging views with colleagues.

Beside the integrative aspect, our data revealed a subordinate utilization of essential interventions acquired during training: In four of the six analyzed orientations, < 10% of the interventions utilized in a practice setting could be classified as essential. This fact brings into focus the difference between what is taught and what is practiced. In our opinion, this is similar to the difference between the therapist's behavior in a randomized clinical trial (RCT) and in a naturalistic setting, as reported by Goldfried et al. (1997) and Godfried et al. (1998). These authors compared sessions of psychodynamic-interpersonal therapies with those of cognitive-behavioral therapies—reproduced within a manual-driven RCT—and found many significant differences in the foci of the therapist's feedback. However, using the same analysis system applied to sessions carried out in a naturalistic setting, very few significant differences were found between exponents of the two therapeutic orientations. This supports the thesis that the utilization of highly specific techniques included in the treatment manual declines in a practice setting.

Psychotherapy training and psychotherapeutic attitudes toward psychotherapy are two related predictors. Sandell et al. (2004) reported some relationships between affiliation and attitudes measured by TASC-2: cognitive-behavioral therapists exhibited high scores on Adjustment and Supportiveness and extremely low scores on Neutrality and Insight. In contrast, psychoanalytically oriented therapists had quite low scores on Adjustment, Supportiveness and Kindness. Our analysis also supports the hypothesis of dependence between both predictors. The training type was a significant predictor of interventions categorized as "essential/not common". In this category of interventions, we also found the largest number of significant relationships with attitude scales. Furthermore, in several cases,

the predictive value of the training type became irrelevant if this variable was supplemented with the attitude ratings.

The causal relation between the two predictors cannot be explained with the current data. It is like the chicken or the egg causality dilemma. Does the training shape the attitudes or do the attitudes lead to the choice of a particular training? Nevertheless, our results demonstrate that attitudes exhibit a broader range of relationships with the utilized interventions than the completed training type does. The attitude scales are related to both essential and common interventions.

As pointed out in the introduction, one reason for adopting an eclectic approach is that one can select the most beneficial interventions for a particular client from a broad arsenal of techniques. Indeed, the efficacy or the effectiveness of most of the interventions used by our sample of integrative therapists had been demonstrated in the past. There is also some documented empirical support for the less well investigated techniques, such as the body-oriented or artistic/expression-oriented techniques (Fenner et al. 2017; Röhricht 2014; van Lith 2016). However, in an eclectic approach, interventions are extracted from different internally consistent systems. For instance, pure-form paradigms, such as psychoanalysis or client-centered therapy, have their own coherent personality theory. And as stated by Hollanders (2000), different paradigms can be reconciled with each other at some point, but overall, they are *not commensurable*, i.e. one cannot view the world in two fundamentally different ways at the same time. And so, the question arises, whether interventions, which are effective in their original systems, still remain effective in an eclectic treatment. Unfortunately, we cannot test this condition, even by using a larger sample from our project. Testing the superiority of eclectic compared to pure-form treatments, means comparing high adherence therapies with low adherence therapies applied to patients with similar clinical and psychological profiles. And the problem lies in the too small number of treatments meeting a high adherence in the different institutes, which does not allow this kind of analyses.

Another limitation of our data is the incomplete range of therapeutic approaches considered, which was restrained to humanistic and psychodynamic approaches; cognitive-behavioral and systemic methods were not represented in the project. A propensity toward an integrative professional development among psychotherapists with a training in one of the last-named methods were reported by other researchers (Rihacek and Roubal 2017; Salter and Rodhes 2018); however, with somehow different patterns from those found among humanistic and psychodynamic therapists. Rihacek and Roubal (2017) reported, for instance, that systemic therapists tend to avoid techniques belonging to the psychodynamic and humanistic frameworks, whereas cognitive-behavioral therapists tend to rather borrow techniques from the systemic repertoire than from the psychodynamic and humanistic frameworks.

It is not only a good client-technique fit that is assumed to be crucial for the success of a therapy, but also a good therapist-technique fit. As stated by Toska et al. (2010), "when a therapist is practicing a model that shares the therapist's way of perceiving the world, the therapy process might reflect this compatibility and translate into more effective outcomes, owing to the authenticity and capacity of the therapist to fully embody and genuinely enact the processes and procedures associated with that form of therapy" (p. 67). Furthermore, job satisfaction is negatively affected by an incongruence between the personality traits of the therapist and the kind of therapeutic approach in which the therapist was trained (Poznanski and McLennan 2003; Topolinski and Hertel 2007). For these reasons, we are of the opinion that it is important to consider these issues in the training of clinical/counselling psychology students. Exposure to different therapeutic orientations allows the student to choose the approach that is most compatible with his or her personality and so facilitates the development of therapeutic skills.

Ultimately, it should be stated that an integrative approach "does not absolve the therapist from the responsibility of being able, at any point in the process of therapy, to give a coherent rationale for what is being done which is consistent over time" (Hollanders 2000, p. 39).

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. A research application was submitted to the ethics committees of each of the Swiss cantons in which the project was carried out; all of the applications were approved.

Informed Consent Written informed consent was obtained from all individual participants included in the study.

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