Therapeutic orientation preferences in trainee clinical psychologists: personality or training?

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Overview

This thesis consists of three parts:

1) Part one is a literature review concerning factors influencing clinicians' preferences for therapeutic orientation. It consists of four main sections, pertaining to the literature on 1) the personality of the therapist, 2) their philosophical standpoint, 3) professional experiences and 4) life experiences. The review concludes with a discussion of methodological issues and implications of the research for training and practice.

2) Part two is an empirical investigation into preferences for therapeutic orientation amongst trainee clinical psychologists. The study used a questionnaire method to investigate the relative weight of importance of person and training factors in predicting preference for three common therapeutic orientations (cognitive-behavioural, psychodynamic and systemic therapies). The extent of influence of person and training factors differed by orientation.

3) Part three is a critical appraisal of the research. It firstly explores the origins of the research questions, before further addressing methodological issues surrounding sampling, design and measurement, including suggestions for future research. The appraisal concludes with a commentary on the importance of reflexivity with regard to preferences for therapeutic orientation, and is illustrated with comments from participants.

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PART 1 –

LITERATURE REVIEW:

What influences clinicians' preferences for therapeutic orientation?

Abstract

This review concerns the factors influencing a clinician's preference for therapeutic orientation, i.e. the theoretical frameworks used by practitioners of psychological therapy to guide formulation of a client's difficulties, and intervention. Despite the predominance within training institutions of a "school" approach to the teaching of psychological therapies, and the current zeitgeist within clinical psychology of selecting the treatment for a particular clinical problem which is scientifically validated, little is known about how individuals arrive at a preferred way of working. Literature on the following factors related to preference for orientation is reviewed: 1) the personality of the therapist, 2) their philosophical standpoint, 3) professional experiences and 4) life experiences. The review concludes with a summary of methodological issues, suggestions for future research, and a discussion of the implications of this area of research in terms of training, model integration and acceptance of evidence-based treatments.

Introduction

Within the various disciplines of psychological therapy (e.g. clinical psychology, psychotherapy and family therapy), therapeutic orientation is commonly understood to refer to the theoretical framework within which the practitioner formulates a client's difficulties, and selects an appropriate intervention (Lyddon & Bradford, 1995; Vasco, Garcia-Marques & Dryden, 1993). In addition to the type of professional training an individual has undertaken, clinicians often describe their practice in terms of a particular therapeutic orientation, such as cognitive-behavioural, systemic or psychodynamic (Poznanski & McLennan, 2004). Recent debate has focussed on both the efficacy and effectiveness of certain therapeutic approaches for particular clinical problems (e.g. Roth & Fonagy, 2006). However, there are also an increasing number of studies concluding there to be no demonstrably advantageous outcome for any particular orientation over another (e.g. Ahn & Wampold, 2001; Beutler et al., 2004; Lambert & Ogles, 2004). Despite this latter set of findings, and a subsequent increased interest in so-called "common factors" (e.g. Castonguay, 2000; Messer & Wampold, 2002), the "school" approach to therapeutic orientation continues to predominate in training institutions (Lambert, 1989; Poznanski & McLennan, 2003; Stevens, Dinoff & Donnenworth, 1998).

During training, clinical psychologists in the UK are commonly exposed to a variety of theoretical approaches, although the exact process by which this occurs and relative weight given to various models may vary according to which training course an individual is affiliated and the type of clinical placements undertaken. Stoltenberg and Delworth (1987) have proposed a three-stage model of the development of therapeutic orientation, in which novice therapists are inflexible and focus solely on

one approach, in order to limit their confusion and anxiety. According to this model trainees then graduate to a second level at which they move away from allegiance to a rigidly held single approach and become able to consider other models, but are unsure of when to pursue a particular orientation. In the final stage of development the trainee therapist tends to adhere to one main model, however is also flexible and enjoys dialogue about other approaches. However, despite the large numbers of clinical psychologists professing to work eclectically or integratively (Patterson, 1989), many clinical psychologists find themselves drawn more strongly towards certain orientations than others, and anecdotally can often become rigid and dogmatic in their adherence to the principles of one model and exclusion of alternatives. Several authors present evidence that supports this idea, suggesting that eclecticism may actually be on the decline (Milan, Montgomery & Rogers, 1994; Patterson, 1989).

Kolevzon, Sowers-Hoag and Hoffman (1989), in their discussion of the variety of therapeutic orientations within the family therapies, comment on the challenge facing clinicians in selecting an orientation from a number of often incompatible alternatives. Within the sphere of the psychological therapies as a whole, there are too many different therapeutic orientations to list here. What is perhaps surprising, given both the prevalence of discussion concerning the various models, and that therapeutic orientation determines the treatment a client receives, is how little is actually known about how clinicians arrive at their preferred orientations (Arthur, 2000; Poznanski & McLennan, 2003). The purpose of this review is to identify factors that influence clinicians' preferences for therapeutic orientation. As Murdock, Banta, Stromseth, Viene and Brown (1998) point out, understanding the

process by which clinicians come to adopt a particular therapeutic orientation is important because it may elucidate the assumptions and values which underpin work with clients, enabling increased awareness of their consequences clinically. Murdock et al. (1988) also stress the potential importance of understanding this process in terms of how we educate mental health professionals.

It is worth at this stage distinguishing between those factors external to the therapist, and those pertaining to the individual and their experiences, the latter of which is the primary focus of this review. Within the profession of clinical psychology in the UK, there are several prevalent narratives, external to the clinician as a person, with regard to how we select a therapeutic orientation. The first, which could be described as the client-fit model, is that clinical psychologists select the approach most suited to the client and their difficulties. The second, and perhaps the most prevalent view is the evidence-based model, i.e. that we select an appropriate intervention for the client's problem in terms of what has been scientifically validated for that specific problem (e.g. Roth & Fonagy, 2006). Underpinning both of these narratives is the assumption that clinical psychologists, owing to their particular training, are able to embrace a plurality of approaches and draw from a number of theoretical perspectives when considering a particular client and their difficulties. This review will, however, be concerned with a third possibility, that clinicians may be predisposed to a particular way of working by various factors relating to them as individuals, such as their personality and philosophy. There is of course an interplay between external factors such as the narratives outlined above, and the person of the therapist, such that a certain type of therapist may be more or

less attracted to the evidence-based narrative (Lucock, Hall & Noble, 2006). This point will be revisited in the discussion section of this review.

A review of the literature concerning influences on chosen therapeutic orientation was conducted using the PsycINFO databases and follow-up references from those initially obtained. This was restricted to peer-reviewed journals. Search terms included "theoretical orientation", "therapeutic orientation", "personality", "epistemol*", "philosophy", "life experiences", "training", "values" and combinations of the above. The paucity of literature mentioned elsewhere (e.g. Arthur, 2000; Norcross & Prochaska, 1983; Poznanski & McLennan, 2003) was confirmed, although it was possible to discover more on the topic than some other authors have found (e.g. Scandell, Wlazelek & Scandell, 1997), with the present review finding fifty-three papers on the subject. As noted by other authors (e.g. Arthur, 2001; Norcross & Prochaska, 1983), the majority of papers on this topic have been speculative rather than empirical, however non-empirical papers will also be included here where they have generated ideas which could serve as the basis for future empirical research. Throughout the literature, the terms "therapeutic orientation" and "theoretical orientation" are used interchangeably. For the sake of continuity, "therapeutic orientation" will be used here, as it seems the more descriptive term, given the focus on the therapeutic application of psychological theories.

Although some authors have proposed that the affiliation of a clinician to a particular orientation is more accident than design (Cummings & Lucchese, 1978), and others still that "the reasons for one's choice of theoretical orientations are as ineffable as

the explanation for the selection of one's spouse" (Steiner, 1978; p. 371), the literature reveals that a number of consistent factors influence development of a therapeutic orientation. They fall into four categories: 1) the therapist's personality, 2) philosophical beliefs, 3) professional experiences, and 4) personal experiences. Studies pertaining to each of these factors will be reviewed in the following sections, followed by a discussion of methodological issues and implications of this research.

Personality and therapeutic orientation

The personality of the therapist and its relation to preferences for therapeutic orientation is the factor that has received most attention in the literature, with thirty articles being found on the topic. The vast majority of studies and non-empirical articles have supported the suggestion that a relationship between an individual's personality and their choice of orientation exists (e.g. Arthur, 2000; Murdock et al., 1988; Poznanski & McLennan, 2003, 2004; Scandell et al., 1987; Scragg, Bor & Watts, 1999; Tremblay, Herron & Schultz, 1986). Arthur (2001) conducted the only thorough review to date of this area and cited forty-five papers, including those to be reviewed in the following section of the current review under the heading of "philosophical beliefs". He also included studies that focussed on the attitudes to treatment choice in samples only partially related to the current review, such as medical practitioners (Walton, 1966), psychiatrists (Kreitman, 1962), nurses (Caine & Smail, 1969), and a variety of non-clinical behavioural scientists (Johnson, Germer, Efran & Overton, 1988). A potential difficulty with including such populations is the wide variety of professional trainings and clinical placements (internships in the US) available within the mental health helping professions, which could possibly confound interpretation of the literature as a whole, given that one's

chosen orientation must be to some degree a function of type of training and exposure to various orientations, something that has been described as the "visibility factor" (Herron, 1978). This variety is held to be significant enough to be bewildering even within just the family therapies (Kolevzon et al., 1989) so the aim must be to minimise this confound of relative exposure to different models, in order to allow greater possibility of interpreting the findings in the literature as a whole. For the present purpose, therefore, this review will be limited to papers which use as their samples or topics of discussion, individuals who have both been trained in, and are currently engaged in one form of psychological therapy or another. It is assumed that those individuals primarily trained in the talking therapies will have some knowledge of most of the major schools of therapy, if not having been exposed to at least several during the course of their training and subsequent practice.

Early studies

The first significant review (Sundland, 1977) concluded that only scant attention had then been paid to this area. It reported on three studies (Allen, 1966; Patterson, Levene & Breger, 1971; Weiss, 1973) that were suggestive of a relationship between personality traits and therapeutic activity, although the studies were limited by either their lack of explicit measure of therapeutic orientation (Allen, 1966), inadequate number of participants (Patterson et al., 1971) or by lack of a recognised measure of personality (Weiss, 1973). These studies were flawed for the reasons described to the extent that interpreting their findings over and above their being suggestive of a role for personality in the selection of a therapeutic orientation is not warranted. There then followed a special edition of the journal *Psychotherapy: Theory, Research and Practice* (1978; Vol. 15 (4), pp. 307-415) devoted entirely to this topic.

Composed of nineteen articles, all but three (Cummings & Lucchese, 1978; Franks, 1978; Lazarus, 1978) broadly accepted the possibility that personality is an important determining factor in choice of orientation (e.g. Ellis, 1978; Chwast, 1978; Schwartz, 1978; Walton, 1978). However, it should be noted, as have others (e.g. Arthur, 2001; Tremblay et al., 1986), that the majority of these articles were speculative in nature, being drawn mainly from personal experience, and only four conducted an empirical investigation into this question (Chwast, 1978; Herron, 1978; Steiner, 1978; Walton, 1978).

Chwast (1978) interviewed five male psychologists who varied in orientation (albeit only within the psychoanalytic umbrella), using a questionnaire pertaining to whether a therapist's personality affected the way they worked. He found that each of the participants viewed their personalities as integral in their preference for orientation, with participants reporting that they had been driven toward a psychoanalytic orientation through introspective, obsessive and voyeuristic traits (Chwast, 1978). However, without a formal measure of personality, and without a larger sample of a wider range of therapists, such results can only be seen as suggestive as an area for future investigation. Also utilising a qualitative methodology, Steiner (1978) surveyed fifty psychotherapists using a postal questionnaire that included amongst other factors the extent to which participants viewed their personality characteristics as formative in their choice of orientation. In contrast to the findings of Chwast (1978), personality was not amongst the more important factors highlighted, although some useful comments were noted, such as a predilection amongst analytic respondents for reflection and interpretation as opposed to being directive and active (Steiner, 1978). Once again, without a formal measure of personality such findings

can only be taken as tentative, however they are not to be disregarded as unworthy of mention as in Arthur's (2001) review, since such qualitative observations often form the foundation for future qualitative investigations.

Of the two studies from this special journal issue employing quantitative methodology, Herron (1978) used the *Personal Orientation Inventory* (POI; Shostrom, 1972) to assess different traits associated with order of preference for three orientations (humanistic, behavioural and psychoanalytic) in twenty-one doctoral level psychology students in psychotherapy practice. Only limited evidence of a link between traits measured by the POI was found, with those preferring a psychoanalytic approach to behavioural therapy scoring in the "self-actualised" range on all twelve constructs measured by the POI. However, as Herron (1978) points out, his results were limited by sample size, and one could further add the criticisms that the measure of therapeutic orientation was somewhat restrictive in that it only allowed for three orientations, and also that the POI is not a measure of personality but rather a measure of self-actualisation. The final empirical study from the special journal issue relating to personality and preference for orientation (Walton, 1978), also utilised an old-fashioned measure of personality, in this case a ninety-eight item semantic-differential instrument constructed for the purpose of the study around concepts such as "my style of relating to clients", "my intuition" and "my rationality". As Scandell et al. (1997) point out, this instrument was unvalidated. However, the sample investigated was of a higher quality than in the previous studies discussed, constituting 145 clinical psychologists and psychotherapists of five theoretical persuasions (behavioural, rational-emotive, psychodynamic, humanistic and eclectic), and the study found significant differences between practitioners of

varying orientations. The analysis revealed that psychodynamic therapists viewed themselves as more complex and serious than rational-emotive therapists, who themselves scored significantly higher on the rationality factor than did the psychodynamic therapists (Walton, 1978). Although these findings are limited by the scope of the measure of personality used, it remains of interest that practitioners of essentially diametrically opposing theoretical persuasions, psychodynamic and rational-emotive, should differ on the constructs measured which, if nothing else, at least appear to have some face validity.

It is also worth considering several other, non-empirical views of this question, for example, that of Lazarus (1978). He proposed that to hypothesise a link between the personality of the therapist and their chosen orientation was to continue the proliferation of unhelpful stereotypes. As he puts it, "the sad-faced and bearded psychoanalyst, with stooped shoulders, pensive gaze and Talmudic depth is the presumed antithesis of the action-oriented behaviour modifier whose mindless technocratic methods reflect his or her manipulative tricks" (Lazarus, 1978; p. 359). He goes onto dispel such apparent generalisations through citing his personal knowledge of active and action-oriented psychoanalysts, and passive, reflective behaviourists, concluding that there are an equal number of personality differences both within and between orientations. Also arguing against the existence of a strong link between personality and orientation were Cummings and Lucchese (1978). They do not dismiss the notion of a relationship entirely, suggesting instead that personality is not as important in exerting influence on one's orientation in comparison to the more practical demands of life. They illustrate this point by citing the example of a doctoral trainee with an interest in psychotherapy who ended up

becoming a behavioural therapist as he was by chance offered a well-paid internship somewhere espousing that orientation (Cummings & Lucchese, 1978). This further suggests a role for training in selection of an orientation, which will be addressed in a later section of this review.

Recent studies

More recently, there have been a number of studies bearing on this question of a higher methodological quality than those so far reported. Although the studies utilised a variety of methodologies, making a direct comparison of findings difficult, in general their results confirm the earlier suggestions of a role for an individual's personality characteristics in influencing their preference for psychotherapeutic model (e.g. Arthur, 1998, 2000; Keinan, Almagor & Ben-Porath, 1989; Kolevzon et al., 1989; Murdock et al., 1998; Poznanski & McLennan, 2003, 2004; Scandell et al., 1997; Scragg et al., 1999; Tremblay et al., 1986).

In an investigation of 180 psychotherapists of self-designated behavioural, psychodynamic and humanistic orientations, Tremblay et al. (1986) found significant differences between orientations on the Inner Directed, Self-Actualising Value, Existentiality, Feeling Reactivity, Spontaneity, Acceptance of Aggression and Capacity for Intimate Contact scales of the POI (Shostrom, 1972). More specifically, it was found that participants of a humanist persuasion scored significantly higher on the Inner Directed, Self-Actualising Value and Spontaneity scales than did psychodynamic and behavioural practitioners, who did not differ significantly from one another on these constructs (Tremblay et al., 1986). The study also found that behavioural therapists scored significantly lower than did the other two orientation

groups on the Existentiality, Feeling Reactivity, Acceptance of Aggression and Capacity for Intimate Contact Scales (Tremblay et al., 1986). Although this study suggests the existence of distinct personality traits for therapists of differing theoretical affiliations, the authors also note considerable overlap between orientations, and propose the existence of a "therapist personality" over and above the differences between orientations, characterised by a focus on the present, strong self-acceptance and self-regard, and a constructive view of the nature of humanity (Tremblay et al., 1986). This finding would support the earlier hypothesis of Lazarus (1978). However, as the authors themselves point out, their results were limited by the scope of the POI (Shostrom, 1972), the limitations of which are discussed above.

Arthur's (1998, 2000) methodologically rigorous study also provided support for the notion of a common pattern of personality traits between orientations, in addition to confirming the existence of a pattern of differences. He used the *Millon Index of Personality Styles* (MIPS; Millon, 1994) with a sample of 247 cognitive-behavioural clinical psychologists and psychoanalytic psychotherapists, finding most similarity between orientations in the interpersonal behaviour domain of the MIPS (Arthur, 1998, 2000). The study also noted numerous differences between the two orientations, finding that psychodynamic therapists scored significantly higher on subscales of Preserving, Intuiting, Feeling and Innovating, whereas cognitive-behavioural therapists scored significantly higher on Enhancing, Individuating, Sensing, Thinking, Retiring, Conforming and Adjustment (Arthur, 2000). Scragg et al. (1999) also utilised the MIPS to assess personality, and found that of 68 applicants to a counselling psychology course, those with a preference for non-directive orientations scored significantly higher on the Intuiting scale than those

with an interest in directive therapies, who in turn scored significantly greater on scales of Systematising, Asserting and Conforming. The group differences on Intuiting and Conforming are in line with those of Arthur (1998, 2000), however due to the differences in sampling population and measure of orientation between the two studies, one cannot draw too many inferences from a lack of agreement on other personality traits.

The results of two other studies of the relationship between personality and therapeutic orientation are worthy of direct comparison in that they both assessed personality using the *NEO Personality Inventory* (NEO-PI-R; Costa & McCrae, 1992) or the shortened *NEO Five Factor Inventory* (NEO-FFI; Costa & McCrae, 1992). Scandell et al. (1997) surveyed 41 psychotherapists of various training backgrounds with the NEO-PI-R (Costa & McCrae, 1992) using a multi-dimensional measure of therapeutic orientation based on that of Hill and O'Grady (1985) in which participants were asked to rate the extent to which they believed in and adhered to the principles of seven different therapeutic orientations. Their analysis revealed a significant correlation between a cognitive orientation and Agreeableness, and between both humanistic and gestalt orientations and Openness to Experience (Scandell et al., 1997). These findings do not concur with those of Poznanski and McLennan (2003, 2004), however. Using the NEO-FFI (Costa & McCrae, 1992) with 103 Australian psychologists from four different theoretical backgrounds (psychodynamic, cognitive-behavioural, family-systemic and experiential), they found that psychodynamic practitioners scored significantly higher on the Neuroticism scale than cognitive-behavioural therapists, who in turn scored significantly less on Openness to Experience than practitioners of all other

orientations (Poznanski and McLennan, 2003, 2004). Again, direct comparison of findings is somewhat confounded by differing approaches to sampling. Poznanski and McLennan's (2003, 2004) sample was far larger, and consisted of only psychologists, whereas Scandell et al.'s (1997) participants were a mixture of counsellors, social workers and psychologists. A further difference between the samples is country of origin, Australia in Poznanski and McLennan's (2003, 2004) case and the US in the Scandell et al. (1997) study, so it is quite likely that the two samples may have had differing exposure to various models.

It is worth noting, however, that Poznanski and McLennan's (2003, 2004) finding that cognitive-behavioural practitioners score lower on Openness to Experience than do practitioners of psychodynamic, systemic and experiential therapies is in agreement with the findings of both Arthur's (1998, 2000) and Scragg et al.'s (1999) studies. Both found differences between participants of a psychodynamic persuasion (non-directive group in Scragg et al., 1999) and those of a cognitive-behavioural orientation (directive group in Scragg et al., 1999) on the Intuiting scale of the MIPS (Millon, 1994), which has been found to correspond most closely to the Openness to Experience domain of the NEO (Scragg et al., 1999). In a similar vein, correspondence can be found between Arthur's (1998, 2000) finding that psychodynamic therapists scored significantly higher on Preserving than cognitive-behavioural therapists, and Poznanski and McLennan's (2003, 2004) finding that psychodynamic practitioners scored higher on Neuroticism, as the Preserving scale of the MIPS (Millon, 1994) has been found to relate to the Neuroticism scale of the NEO (Scragg et al., 1999). Further correspondence can be found between Scandell et al.'s (1997) study and that of Scragg et al., (1999), with the former finding a

relationship between a humanistic orientation and Openness to Experience on the NEO (Costa & McCrae, 1992) and the latter between a group interested in non-directive therapies and the corresponding Intuiting scale on the MIPS (Millon, 1994). There is therefore considerable evidence of a relationship between an individual's personality traits and their chosen orientation.

Three other studies have investigated the relationship between personality and preference for therapeutic orientation in practitioners of psychological therapy, although in each case using a different measure of personality and markedly different samples (Keinan et al., 1989; Kolevzon et al., 1989; Murdock et al., 1998). Direct comparison of the findings of the studies in terms of the relationships between particular personality traits and particular orientations is therefore difficult, however each of the three studies concluded that some relationship existed. Murdock et al.'s (1998) study of 102 counsellors of a variety of orientations (psychodynamic, CBT, systems/ IPT, person-centred, existential/ gestalt) using the *Impact Message Inventory* (IMI; Kiesler & Schmidt, 1991) found that the personality dimension of interpersonal control was significantly associated with therapeutic orientation. Interpersonal control relates to the extent to which individuals are dominant or submissive in their relations to others, and the study found that psychoanalytic participants characterised themselves as the most interpersonally dominant of the orientations (Murdock et al., 1998). The authors suggest that although this may seem at odds with the psychoanalyst's neutral stance, that this result may reflect the more traditional doctor-patient dynamic employed in this type of therapy. Murdock et al. (1998)'s findings also suggested that personality may be more predictive of therapeutic orientation in the later stages of a clinician's development as they are

more comfortable in the therapeutic interaction, suggesting that research in this area should contain a measure of the level of experience of the therapist.

Keinan et al., (1989) asked 62 therapists from a variety of professional backgrounds and of three orientations (psychoanalytic, eclectic and behavioural) to rate themselves, a typical therapist of the same orientation, and typical therapists of two other orientations on three scales measured by the *Therapist Characteristics Rating Scale* (TCRS): Action-Orientated characteristics, Insight-Oriented Characteristics and Authoritarian-Oriented Characteristics. In terms of self-rated characteristics, they found that behaviourists rated themselves significantly higher than participants from the other two orientations on the Action-Oriented Characteristics Scale, encompassing such traits as Taking Initiative, Active, Practical and Assertive (Keinan et al., 1989). Participants from the three orientations did not rate themselves as significantly different on the Insight-Oriented and Authoritarian-Oriented Characteristics scales, suggesting again that in addition to differences between practitioners of certain orientations there may also be similarities (Keinan et al., 1989). Finally, Kolevzon et al. (1989) used the *Sixteen Personality Factor questionnaire* (16PF; Cattel, Eber & Tatsuika, 1962) to assess personality attributes and their relation to choice of model in 156 family therapists affiliated to one of three family therapy models (communications, structural/ strategic, Bowenian). They found that clinicians of different orientations exhibited differing and in some cases opposite personality profiles. For example, personality traits found to predict adherence towards a communications model of family therapy such as Experimenting, Outgoing and Tenderminded, were found to be predictive of difficulties of adopting a Bowenian model of working (Kolevzon et al., 1989).

Summary

A number of methodological considerations limit the interpretation of the literature as a whole. Firstly, a variety of personality measures were employed, with some studies not using a formal measure at all (e.g. Chwast, 1978; Keinan et al., 1989; Steiner, 1978; Walton, 1978), and others using a measure not related to today's generally accepted trait theories of personality (Herron, 1978; Tremblay et al., 1986). Secondly, sample sizes also varied considerably, with some studies having insufficient participants to assess differences in personality amongst groups of therapists from different orientations (e.g. Herron, 1978; Murdock et al., 1998; Keinan et al., 1989; Scandell et al., 1997). The constitution of samples also presents a problem in interpreting the findings as a whole, with some studies including therapists from a variety of training backgrounds (e.g. Keinan et al., 1989; Scandell et al., 1997), the difficulty with this being that this introduces the confounding factor of relative exposure to the various models, as some trainings are more pluralistic than others in their approach. In a similar vein, comparing studies on qualified populations (e.g. Arthur, 1998, 2000) with those on non-qualified populations (e.g. Herron, 1978; Scragg et al., 1999) may present problems for the same reason. This may also be true in comparing samples trained in the US (e.g. Scandell et al., 1997), Australia (Poznanski & McLennan, 2003, 2004), the UK (e.g. Arthur, 1998, 2000) and Israel (Keinan et al., 1989), where relative popularity of orientations may vary.

A third area of methodological concern is the measurement of therapeutic orientation. In some studies, participants ascribed their own orientation (e.g. Keinan et al., 1989; Scandell et al., 1997), however as has been pointed out elsewhere (e.g. Arthur, 2001), this may not be such an accurate marker of what an individual

actually does in practice. Several studies have alleviated this problem by also including a measure of the extent to which an individual adheres to their chosen model (e.g. Arthur, 1998, 2000; Poznanski & McLennan, 2003, 2004). A further approach used by Hill and O'Grady (1985) in a study of a different nature to that discussed here, was to ask participants to rate on a seven-point scale the extent to which they adhered to the principles of certain schools of therapy. As Hill and O'Grady (1985) point out, asking participants to choose between one or other of a fixed number of choices misses the opportunity to capture something about eclecticism, and their multi-dimensional measure would seem to have an advantage over most of the methods used to assess orientation in that it is possible to see how behavioural a psychoanalyst is, and vice versa. Too many of the studies in this area have been limited by including only a small number of only unidimensional measures of therapeutic orientation (e.g. Arthur, 1998, 2000; Keinan et al., 1989, Scragg et al., 1999; Tremblay et al., 1986), when it is likely that orientation is not so much a matter of belonging to distinct categories as being located upon a continuum between the more directive and less directive therapies.

A further criticism of this research is that being correlational in nature, one cannot draw inferences as to the causal relationship between personality and preference for orientation (Conway, 1992). Whilst this is true, there is considerable evidence that personality traits are stable in adults over long periods of time (e.g. Costa & McCrae, 1994), and as Arthur (2001) points out, behaviour, attitudes and beliefs about therapy can change over time, but they are likely to do so only in relation to an individual's underlying personality. Conway (1992) also notes that the findings of this literature may be confounded by the existence of a small number of participants with extreme

trait patterns, who mask the existence of a larger number of more similar individuals, and produce group differences between orientation when in fact the majority of therapists are quite similar. There is certainly evidence for some similarities amongst therapists of differing orientations (e.g. Arthur, 1998, 2000; Tremblay et al., 1986), which we might expect on the basis of a similar choice of career, however on this point we must trust that researchers have taken every necessary step to identify statistical outliers and check the normality of their variables prior to analysis. There is also something to be said for checking the ecological validity of the findings, i.e. are the differences between orientations reported in the literature consistent with our knowledge of practitioners of certain orientations?

Several authors (e.g. Arthur, 2001; Poznanski & McLennan, 2003, 2004) have attempted to delineate the profiles of psychoanalytic and cognitive-behavioural therapists based on the results of their studies and the available literature, however these will not be reviewed here as they contain factors reviewed later in this review such as philosophical beliefs (Arthur, 2001) and life experiences (Poznanski & McLennan, 2003, 2004). In terms of solely empirically measured personality traits, and the studies reviewed here, there appear to be a number of robust findings amongst studies using comparable instruments such as the NEO (Costa & McCrae, 1992) and MIPS (Millon, 1994). Firstly, both practitioners of a psychodynamic and humanistic/ experiential persuasion have been found to be more Open to Experience or Intuiting than practitioners of a cognitive-behavioural, behavioural and systemic orientation (Arthur, 1998, 2000; Poznanski & McLennan, 2003, 2004; Scandell et al., 1997; Scragg et al., 1999). Individuals scoring high on the Openness to Experience domain of the NEO (Costa & McCrae, 1992) or the Intuiting scale of the MIPS

(Millon, 1994) are likely to have a preference for the intangible, unstructured and symbolic as opposed to more concrete and externally observable phenomena (Scragg et al., 1999). This would certainly seem to fit with the more exploratory basis of psychodynamic and experiential therapies and more structured and directive natures of cognitive-behavioural and systemic therapies.

In addition, several studies (Arthur, 1998, 2000; Poznanski & McLennan, 2003, 2004) noted differences amongst psychodynamic and cognitive-behavioural therapists on the Neuroticism scale of the NEO (Poznanski & McLennan, 2003, 2004) and the corresponding Preserving scale of the MIPS (Arthur, 1998, 2000), with those of a psychodynamic persuasion scoring significantly higher. Individuals scoring high on these scales are likely to focus on and intensify the problems in life, and possess the view that the past has been personally troubling (Millon, 1994). In contrast the Enhancing scale of the MIPS (Millon, 1994), on which Arthur (1998, 2000) found cognitive-behavioural therapists scored significantly higher than psychodynamic therapists, is a measure of optimism, and the ability to look on the bright side of life (Millon, 1994). Again, these profiles are familiar, with the psychoanalytic focus on the past and its manifestation in the present, and cognitive-behavioural therapy's reliance on positive thinking to overcome difficulties. Both Scragg et al.'s (1999) and Arthur's (1998, 2000) studies also found that cognitive-behavioural therapists (those with a preference for directive therapies in Scragg et al.'s study) were significantly more Conforming on the MIPS than those with alternative orientations. Individuals scoring high on this scale tend to relate to authority in a respectful and cooperative manner, and exhibit an interpersonal style of formality and restraint, being unlikely to be self-expressive or spontaneous (Millon,

1994; Scragg et al., 1999). Both studies found several more differences between groups of various orientations, however they did not correspond with those of any other study, so will not be expanded upon here. It is of note that most studies have focussed on the differences between psychodynamic and cognitive-behavioural therapists, with little attention paid to systemically-oriented individuals.

Despite the methodological limitations of this research, a number of studies have therefore demonstrated differences in personality attributes between practitioners of different therapeutic orientations (e.g. Arthur, 2000; Murdock et al., 1988; Poznanski & McLennan, 2003, 2004; Scandell et al., 1987; Scragg et al., 1999; Tremblay et al., 1986). It should also be noted that a number of authors have found evidence of a common personality of a therapist, in addition to differences between therapists of differing theoretical persuasions (e.g. Arthur, 2000; Tremblay et al., 1986). Although the use of a variety of personality measures and populations is somewhat constraining in terms of interpretation of the more specific ways in which personality traits link to orientation, in another respect the fact that such a relationship has been empirically demonstrated with a variety of instruments and across a variety of populations suggests that this is a fairly robust phenomenon.

Philosophical beliefs and therapeutic orientation

Following personality, the role of what can broadly be described as the therapist's philosophical beliefs has received the most attention in the literature, with at least fourteen published articles on the subject. This factor has variously been referred to in the literature as ontological beliefs (Lyddon & Bradford, 1995), epistemological beliefs (Arthur, 2000), worldview (Lyddon, 1989), values (Patterson, 1989), vision

of reality (Messer & Winokur, 1984) and the German term '*weltanschauung*' (outlook on the world) (Fear & Woolfe, 1999). Some researchers have also explored the role of religious and political ideologies in their preference for therapeutic orientation (e.g. Bilgrave & Deluty, 2002). Making a simplification which many philosophers would (justifiably) not agree with, for the purposes of this review, literature in this area will be considered under the umbrella term of "philosophical beliefs", i.e. the set of beliefs and values an individual holds in order to make sense of their world. This encompasses ideas such as the individual's view of the nature of reality (ontology), the nature of knowledge and how it is acquired (epistemology), and worldview (frame of reference for interpreting the world) (Lyddon, 1989; Lyddon & Bradford, 1995).

Patterson (1989) observes that for most of the 20th century, the prevailing view within the psychological therapies was that the therapist purposefully set out not to impose their values on the client, a stance originating in psychoanalysis, summed up by the psychoanalyst Wilfred Bion's (1970; p. 315) oft-quoted dictum of "[letting] go of memory, desire and understanding". However, Patterson (1989) also poses the question as to whether this is really possible in practice, and proposes the likelihood that clinicians select a therapeutic orientation that is underpinned by a set of philosophies and values congruent with their own as an individual. Several authors have pointed out that psychotherapeutic theories differ not only along theoretical lines but also in their underlying metatheoretical assumptions (Johnson et al., 1988; Lyddon, 1989; Vasco et al., 1993). As individuals differ in the ways in which they see the world, the prediction might therefore follow that individuals of certain philosophical worldviews may be more attracted to certain therapeutic orientations

than others on the basis of congruence or dissonance between their own philosophy and the underlying assumptions of the therapeutic approach. Fear and Woolfe (1999) propose that this is actually a necessary condition for therapists to function effectively. One potential consequence is that practitioners working from different philosophical standpoints are likely to privilege different information, have differing opinions on what constitutes a "fact", how one goes about obtaining knowledge, and what constitutes change in the therapeutic situation (Lyddon, 1989). This is illustrated in Conway's (1992) discussion of the differences between Scientism and Humanism, which he describes as the highest-order dimension in metaphysical values. He proposes that individuals holding a Scientific view of psychology tend to focus on objectively measurable phenomena, seek understanding through the reduction of phenomena to their more elementary parts, and rely on hypothetico-deductive and quantitative methods in pursuit of understanding (Conway, 1992). Conversely, it is suggested that those individuals who embrace a Humanistic approach to the understanding of human psychology tend to focus on subjective experiences such as feelings, emphasise the complexity of phenomena and their relationships among interacting parts of the wider system, and have an interest not in causal explanations but the meaning of human behaviour in its social context as revealed through phenomenological, hermeneutic and linguistic analyses (Conway, 1992). Evidence for the existence of two such cultures within psychology in general was provided by Kimble (1984).

The empirical literature confirms that practitioners of differing therapeutic orientations do indeed identify with differing sets of philosophical beliefs (e.g. Arthur, 2000; Lyddon & Bradford, 1995; Poznanski & McLennan, 2003, 2004;

Schacht & Black, 1985; Vasco et al., 1993). Norcross and Prochaska (1983) surveyed 479 American psychologists as to their reasons for selecting their chosen orientation, with respondents rating their values and personal philosophy as the second most important factor. Lucock et al. (2006) constructed the *Questionnaire of Influencing Factors on Clinical Practice in Psychotherapies* (QuIF-CliPP) to assess the influences in the practice of 164 qualified and trainee clinical psychologists in the UK. They found that personal philosophy was rated as being a strong influence by both groups (Lucock et al., 2006). However, neither of these studies utilised a formal measure of philosophical variables. Other studies used standardised instruments to assess exactly which philosophical standpoint relates to particular orientations. For example, Schacht and Black (1985) used the *Psycho-Epistemological Profile* (PEP; Royce & Mos, 1980) to assess the epistemological preferences of 53 behaviour therapists and 66 psychoanalysts. They found that psychoanalysts scored significantly higher on an epistemic style known as Metaphorism than did behaviour therapists, who in turn scored higher than psychoanalysts on further epistemic styles of Empiricism and Rationalism, suggesting that practitioners of differing orientations are indeed characterised by distinctive epistemological styles.

The PEP (Royce & Mos, 1980) assesses an individual's preference for one of three epistemic styles: Empiricism, Rationalism and Metaphorism (Schacht & Black, 1985). Each of these relate to different approaches to knowing and each have their own core criterion for truth, hence individuals affiliated to different epistemic styles will have differing ways in which they evaluate and test the validity of their beliefs (Lyddon & Bradford, 1995). Individuals allied to Empiricism have beliefs based on

perceptual processes, and test those beliefs in terms of their correspondence to their observations (Vasco et al., 1993). This empirical style relies on inductive reasoning (Schacht & Black, 1985). Rationalism, in contrast, refers to an epistemic style in which beliefs are based on conceptual processes, and tested in terms of their logical consistency (Vasco et al., 1993). This way of knowing relies on deductive reasoning (Schacht & Black, 1985). The final epistemic style measured by the PEP (Royce & Mos, 1980), Metaphorism, involves beliefs that are based on symbolic processes, and the testing of those beliefs through their generalisability to other experiences (Vasco et al., 1993). Metaphorism relies on analogical reasoning (Schacht & Black, 1985).

Both Lyddon and Bradford (1995) and Arthur (2000) used a further measure of epistemological style, the *Organicism-Mechanism Paradigm Inventory* (OMPI; Germer, Efran & Overton, 1982), in addition to the PEP (Royce & Mos, 1980). The OMPI assesses an individual's relative preference for one of two of Pepper's (1942) worldviews: Organicism or Mechanism (Lyddon & Bradford, 1995). Organicism, derived from the root metaphor of the organism, refers to a belief system in which phenomena are understood as dynamic and developing as a whole (Lyddon, 1989). The organismic thinker believes that phenomena are inherently purposeful, and are always developing towards a more integrated and transformed whole, and that obstacles in this path present opportunities for growth as opposed to impedance (Lyddon, 1989; Lyddon & Adamson, 1982). Development within this worldview is seen as discontinuous and non-linear (Lyddon & Adamson, 1982). In contrast, the Mechanistic worldview, derived from the root metaphor of the machine, sees the world as composed of discrete and interacting elements, best understood through a

reductive analysis of these constituent elements and their antecedent-consequent relations (Lyddon & Adamson, 1992; Lyddon & Bradford, 1995).

Lyddon and Bradford (1995) used both the OMPI (Germer et al., 1982) and PEP (Royce & Mos, 1980) to assess differences in philosophical commitments between 59 psychotherapy trainees who were asked to read three therapy "scripts" (rationalist, constructivist and behavioural) and complete a short evaluation form for each, including questions such as "*How optimistic are you that this therapy approach would be beneficial for most clients?*" They found that participant preference for a behavioural or rationalist therapy approach (corresponding closely to a cognitive-behavioural approach) was significantly correlated with Rationalism and Empiricism as measured by the PEP, and negatively correlated with Organicism, as measured by the OMPI (Lyddon & Bradford, 1995). Conversely, preference for a constructivist therapy approach was significantly correlated with Organicism (Lyddon & Bradford, 1995). These findings concur with those of Schacht and Black (1985) who also found a significant relationship between a preference for behavioural therapy and the Empiricism and Rationalism scales of the PEP (Royce & Mos, 1980). Arthur's (2000) study also utilised the OMPI (Germer et al, 1982) and PEP (Royce & Mos, 1980) to assess differences in epistemological style in 247 self-designated psychoanalytic psychotherapists and cognitive-behavioural therapists. He found that psychoanalysts scored significantly higher on Organicism and Metaphorism than did CBT therapists (Arthur, 2000). It is perhaps surprising that Arthur's (2000) groups did not differ in terms of the PEP's (Royce & Mos, 1980) Rationalism and Empiricism scales, given the results of earlier studies (e.g. Lyddon & Bradford, 1995; Schacht & Black, 1985), however this may be explicable in terms of

differences in sample size and constitution, with Arthur's (2000) study having many more participants, and Lyddon and Bradford's (1995) study being on a non-qualified population. However, the significant findings of Arthur's (2000) study were congruent with those of the earlier studies (Lyddon & Bradford, 1995; Schacht & Black, 1985), further suggesting that a relationship exists between the philosophical standpoint of the practitioner and their preference for therapeutic orientation.

Several other methodologies have been employed in investigating this question. Vasco et al. (1993) used the same two measures (OMPI & PEP) to assess the metatheoretical assumptions of 140 Portuguese psychotherapists of five different orientations (psychodynamic, systemic, humanistic, behavioural and cognitive), constructing an index of dissonance between an individual's philosophical values and those of their chosen orientation. They did not report on differences between orientations in terms of philosophical standpoint, but found that dissonance between participants' personal philosophy and that of their espoused orientation was related to dissatisfaction with chosen orientation, particularly for cognitive-behavioural therapists (Vasco et al., 1993). This finding would seem to provide support for Fear and Woolfe's (1999) proposition that individuals need to practice within an orientation congruent with their own personal philosophy in order to be effective, and has implications for training therapists, a point addressed later in this review.

A further method for assessing the relation between personal philosophy and preference for therapeutic orientation is exemplified by Poznanski and McLennan's (2003, 2004) study. They used a combination of items from Coan's (1979) *Theoretical Orientation Survey* (TOS) and Sundland and Barker's (1962) *Therapist*

Orientation Questionnaire (TOQ) (Poznanski & McLennan, 2003, 2004). The items on both of these scales relate to views on actual therapeutic practice, as opposed to the OMPI and PEP which are more general worldview measures, and assess two second-order dimensions to therapeutic practice found to be the most significant in an earlier review (Poznanski & McLennan, 1995): Objective-Subjective and Analytical-Experiential (Poznanski & McLennan, 2003, 2004). The Objective-Subjective dimension, based on the work of Coan (1979), refers to a preference for acquiring data through observable, objective measurements and one more based on subjective, introspective and experientially acquired knowledge (Poznanski & McLennan, 1995). The Analytic-Experiential dichotomy is based on the work of Sundland and Barker (1962), with the Analytic pole referring to a way of conceptualising, based on the training of the therapist, using a planned approach and minimising therapeutic spontaneity (Poznanski & McLennan, 1995). The Experiential pole on the other hand, emphasises the personality of the therapist and the use of an unplanned, spontaneous approach (Poznanski & McLennan, 1995). It could be argued that these dimensions are in some ways very similar to the theoretical frameworks already discussed such as Organicism-Mechanism, but the measures themselves differ in that they ask questions specific to the practice of psychological therapy as opposed to more overarching philosophical questions such as those contained in the OMPI (Germer et al., 1982) or PEP (Royce & Mos, 1980).

In their study of 103 Australian psychologists of four orientations (psychodynamic, cognitive-behavioural, family/ systemic and experiential), Poznanski and McLennan (2003, 2004) found significant differences between practitioners of differing orientation on the two dimensions. Specifically, they found that cognitive-

behavioural, psychodynamic and family/ systemic practitioners reported a significantly greater affinity for an Analytical basis of belief than did experiential therapy practitioners (Poznanski & McLennan, 2003, 2004). They also found that cognitive-behavioural therapists scored significantly higher on the Objective scale than did therapists of all other orientations, who were more Subjective (Poznanski & McLennan, 2003, 2004). Murdock et al.'s (1998) study of 102 counsellors also used Coan's (1979) TOS, finding that philosophical assumptions predicted therapeutic orientation in their participants. More specifically, they found that systemic/ interpersonal and cognitive-behavioural therapists scored significantly towards the behavioural pole of the Behavioural-Experiential factor than did psychodynamic, person-centred and existential/ gestalt therapists (Murdock et al., 1998). This factor refers to the extent to which the therapist values conscious over unconscious experience as the most important psychological information (Poznanski & McLennan, 1995). They also found that on the Elementarism-Holism dimension, practitioners of existential and gestalt therapies were significantly more Holistic than those of a psychodynamic or systemic/ interpersonal orientation (Murdock et al., 1998). This dimension is related to whether the therapist is interested in theoretically based global patterns of relationships as opposed to conducting research investigating elementary relationships of specific variables (Poznanski & McLennan, 1995). A further finding from Murdock et al.'s (1998) study was that participants of a systemic/ interpersonal or cognitive-behavioural persuasion scored significantly higher on the dimension of Physicalism than did experiential/ gestalt or psychodynamic therapists (Murdock et al., 1998). Physicalism assesses the extent to which an individual conceptualises behaviour in terms of observable physical conditions and events (Poznanski & McLennan, 1995).

Summary

In attempting to interpret the findings of these studies as a whole, to better understand the philosophical assumptions related to particular therapeutic orientations, one must consider the methodological limitations of the research, some of which are in common with those of the literature on personality reviewed above. For example, samples are drawn from a variety of training backgrounds, such as counsellors (Murdock et al., 1998), clinical psychologists (Norcross & Prochaska, 1983), and mixed backgrounds (Arthur, 1998, 2000; Vasco et al., 1993). Similarly, studies have been conducted in a variety of countries, including the UK (e.g. Arthur, 1998, 2000), the US (e.g. Murdock et al., 1998) and Portugal (Vasco et al., 1993). As discussed earlier, this heterogeneity of studied populations allows in the potentially confounding factor of training and therapeutic status quo in a given profession or country, such that one speculates that not all participants even within one study let alone across studies will have been exposed to a wide variety of different orientations before coming to their preference. Several studies also suffer from a low number of participants in each orientation group (e.g. Murdock et al., 1998; Poznanski & McLennan, 2003, 2004), and others are limited by their narrow measurement of therapeutic orientation (e.g. Arthur, 1998, 2000; Lyddon & Bradford, 1995; Schacht & Black, 1985).

As with the research on personality, little attempt seems to have been made in the majority of these studies to actually measure therapeutic orientation, as opposed to simply asking participants which orientation best describes their practice (e.g. Murdock et al., 1998; Schacht & Black, 1985), which as Sundland (1977) points out, is rather limited in that most people may describe a secondary theoretical allegiance

to their primary orientation, and moreover, some individuals are more psychodynamic, or more cognitive-behavioural than others. With regard to the assessment of philosophical commitments, some studies have merely included it as an undefined factor amongst a list of other influences (e.g. Lucock et al., 2006; Norcross & Prochaska, 1983), and others (e.g. Murdock et al., 1998; Poznanski & McLennan, 2003, 2004) have used measures such as the TOS (Coan, 1979) and TOQ (Sundland & Barker, 1962), the problem with the latter being that although related to an individual's philosophical stance, they are really more measures of therapeutic orientation, and were originally intended for this purpose (Sundland, 1977). The items on these measures relate to actual practices one might use in the therapeutic encounter, and so it is not surprising that there would be differences amongst orientations such as psychoanalytic and cognitive-behavioural therapies, which rely on quite different techniques.

However, the fact that a link between philosophy and therapeutic orientation has been found in a wide variety of samples using several different methodologies is indicative of its potential importance, and the robustness of the relationship between orientation and philosophical standpoint. Taking the findings of the studies using formal measures of philosophical commitments as a whole, and notwithstanding these limitations, it is possible to sketch an outline of some differences in standpoint between practitioners of differing orientations. Schacht and Black (1985) and Lyddon and Bradford (1995) both found a cognitive-behavioural orientation (rationalist approach in Lyddon and Bradford, 1995) to be associated with Empiricism and Rationalism as measured by the PEP (Royce & Mos, 1980). Broadly speaking, this profile refers to a way of knowing that encompasses both

perceptual and conceptual processing, relating to the world through analytical reasoning skills (deductive and inductive), and testing beliefs through their correspondence with relevant observations (Lyddon & Bradford, 1995). This picture would seem to fit with the finding of Poznanski and McLennan (2003, 2004) that cognitive-behaviourally oriented therapists are more Analytical than Experiential, and more Objective than Subjective. In other words, they prefer to acquire knowledge through planned, observable, objectively conducted measurements and do not usually act spontaneously (Poznanski & McLennan, 1995). This profile is further augmented by Murdock et al.'s (1998) finding of a significant association between the Behavioural and Physicalism dimensions of the TOS (Coan 1979) and a cognitive-behavioural orientation, i.e. that such therapists value conscious information as the most important and conceptualise behaviour in terms of observable physical conditions and events (Poznanski & McLennan, 1995).

Conversely, psychodynamic therapists have been shown by several studies to embrace the epistemic style of Metaphorism as measured by the PEP (Arthur, 1998, 2000; Schacht & Black, 1985). Metaphorism involves beliefs that are based on symbolic processes, and the testing of those beliefs through their generalisability to other experiences (Vasco et al., 1993), relying on analogical reasoning (Schacht & Black, 1985). Poznanski and McLennan (2003, 2004) found that psychodynamic therapists were significantly more Subjective than cognitive-behavioural therapists, i.e. they privilege subjective, introspective and experientially-acquired data over observable and objective (Poznanski & McLennan, 1995). Murdock et al.'s (1998) finding that they were significantly more Experiential than CBT or systemic therapists concurs with this, however on a different but not unrelated dimension, the

Analytical-Experiential dichotomy of Sundland and Barker's (1962) TOQ, Poznanski and McLennan (2003, 2004) found that psychodynamic therapists were similarly Analytical to CBT and systemic therapists. Perhaps this lack of total agreement between these studies highlights once more the difficulties in interpreting data from samples of different sizes and constitution, and studies using different measures, however related. This also explains the lack of consensus on differences across orientations in the two studies assessing philosophical commitments using the OMPI (Arthur, 1998, 2000; Lyddon & Bradford, 1995), with the former finding that psychoanalytic therapists were more Organismic than cognitive-behavioural therapists, and the latter not including a psychoanalytic orientation in their study, but finding that those allied to a constructivist approach were more Organismic than those of a rationalist (cognitive) or behavioural approach.

With regard to orientations other than cognitive-behavioural and psychoanalytic, often the sole focus of this literature, Poznanski and McLennan (2003, 2004) and Murdock et al., (1998) perhaps not surprisingly both find therapists of a humanistic/ experiential persuasion to be Experiential, Subjective and Holistic in their philosophical outlook. In other words, they privilege knowledge gained through subjective, introspective experience, and are interested in a more global than elemental picture of the world (Poznanski & McLennan, 1995). Finally, practitioners of a family/ systemic orientation emerge with something of a mixed profile, similar in some ways to psychodynamic therapists, and in others to cognitive-behavioural therapists. For example, Poznanski and McLennan (2003, 2004) found them to be like psychodynamic therapists in their being Analytical and Subjective, and Murdock et al. (1998) also found similarities between the two

orientations in terms of their Elementarism. According to these studies, practitioners of a systemic orientation use a planned approach with restricted spontaneity, but also value knowledge gained through subjective experience, and research strategies focussing on relationships between elemental parts of the whole (Poznanski & McLennan, 1995). In other respects, however, systemic therapists have been found to be more similar in style to cognitive-behavioural therapists, with Murdock et al. (1998) finding both orientations to be associated with the Behavioural and Physicalism dimensions of the TOS (Coan, 1979). These dimensions refer to the extent to which the therapist values personal conscious experience as the primary source of information, and whether they conceptualise behaviour in terms of observable physical events (Poznanski & McLennan, 1995).

It is possible that this mixed picture of the various philosophical standpoints of practitioners reflects the research discussed earlier showing personality similarities, as well as differences between orientations (e.g. Arthur, 1998, 2000; Tremblay et al., 1986). This might be expected if a relationship existed between personality and philosophical outlook. Johnson et al. (1988) provide evidence that such a link exists, using the OMPI (Germer et al., 1982) to assess philosophical commitments and a variety of personality measures. In a survey of 622 participants of twelve different backgrounds, they found a pervasive pattern of relationships between philosophy and personality, with Organismic individuals consistently found to be more intellectual, aesthetically-minded, innovative, intuitive and socially-skilled than Mechanistic individuals, who were in turn generally found to be more concrete, down-to-earth, sense-oriented, ordinary and socially hesitant (Johnson et al., 1988).

Professional experiences and therapeutic orientation

Perhaps surprisingly given the predominance of the "school" approach to therapy taught in many training institutions (Lambert, 1989; Poznanski & McLennan, 2003; Stevens et al., 1998), and the great cost of training therapists, scant empirical attention has been given to the role of training, supervision and type (as opposed to length) of clinical experience in helping shape preference for therapeutic orientation. As has been commented upon already in this review, to some extent an individual's orientation will be a function of their exposure to various models and professional opportunities (Cummings & Lucchese, 1978; Herron, 1978). An analysis of the therapeutic orientations taught on 96 clinical psychology training programs in the US, although limited by only collecting ratings from the directors of training, showed that the majority embraced a pluralistic approach, however also showed evidence of the existence of programs allied to predominantly one approach (Nevid, Lavi & Primavera, 1987). This heterogeneity of approach to teaching therapeutic orientations confirms the validity of earlier criticisms of studies of therapeutic orientation on samples drawn from various training backgrounds, and highlights the importance of investigating the role of training in the development of orientation. Also, given the findings of studies on personality and philosophical beliefs, it would seem of importance to understand the link between training and all that encompasses, and the development of a therapeutic orientation in the individual, as it has been suggested on the basis of these findings that some may more readily be taught certain approaches than others (e.g. Kolevzon et al., 1989; Poznanski & McLennan, 2003, 2004; Vasco et al., 1993).

Much has been written about training issues and methods in various orientations (e.g. Bootzin & Ruggill, 1988; Greenberg & Goldman, 1988; Strupp, Butler & Rosser, 1988), however little empirical research has investigated the direct effect of components of training such as the orientations taught on training courses and orientations of supervisors on developing clinicians' own therapeutic orientation. Sundland's (1977) review of the effects of the supervisor's therapeutic orientation and training programs on the development of trainees' orientations was limited, with the exception of the study by Weismann, Goldschmid and Stein (1971), to citing papers not based on therapeutic orientation per se (Wile, Bron & Pollack, 1970), unpublished manuscripts (Sundland & Garfield, 1974), a dissertation (Vickers, 1974) and a study on a non-professional population (Paul & McInnis, 1974). The results of these studies were decidedly mixed as to whether supervisors' orientations had any impact on that taken up by the supervisee, and will not be reviewed further here for the reasons outlined above. The one study fully relevant to the present review that Sundland (1977) reported, that of Weismann et al. (1971), found that of the 116 psychologists assessed, only 19 remained in the orientation in which they had been trained. This may, however, say as much about the lack of variety of orientations the participants were exposed to during their training as the lack of influence of training per se.

Steiner (1978) surveyed fifty psychotherapists of four different orientations using a postal questionnaire, finding that participants ranked their graduate training, supervisor's orientation during training, and present senior colleagues' orientations as highly influential in determining their own orientations. Similar survey measurements, i.e. requiring participants to rate various factors influencing their

chosen orientation were used by Norcross and Prochaska (1983) and Lucock et al. (2006). Norcross and Prochaska (1983) surveyed 479 clinical psychologists in the US, who rated graduate and postgraduate training as their third and fourth most influential factors in their selection of orientation. Internship, the US equivalent of the UK's clinical placement was rated as fifth most important factor (Norcross & Prochaska, 1983). Similarly, using the QuIF-CliPP, devised by the authors, Lucock et al. (2006) assessed various factors influencing the orientation preference of 194 qualified and trainee clinical psychologists in the UK. They found that for the qualified group, current supervision was rated highest, with post-qualification and professional trainings very close behind (Lucock et al., 2006). The influence of post-qualification training may be interpretable, however, as indicative of the lack of a psychodynamic component in the courses where the participants trained, and the subsequent need for those inclined to seek out the relevant post-qualification training. For the trainee group, current supervision and professional training were also amongst the highest rated influences (Lucock et al., 2006).

Also using a non-experimental design to assess this particular variable, Poznanski and McLennan (2003, 2004) interviewed 103 Australian psychologists of four different orientations, finding some differences between participants of differing orientations. They reported that nearly all the cognitive-behavioural therapists in their sample identified their university training as an important influence in their preference for orientation, in contrast to just over half of the experiential therapists, and only about a quarter of psychodynamic and systemic therapists (Poznanski & McLennan, 2003, 2004). Although their group sizes were relatively small, and no statistics were reported for these findings, it is nevertheless of interest that there

appear to be some differences between individuals of different orientations in the extent to which training is rated as an influence in orientation selection. It may be, however, that this reflects differing approaches to teaching in different institutions. Rosin and Knudson (1986) found evidence that therapists of a psychodynamic orientation placed more emphasis on a relational way of teaching, whereas behavioural therapists tended to privilege the intellectual and more impersonal aspects of training. It may be that the group differences apparent in Poznanski and McLennan's (2003, 2004) sample reflect the possibility that Australian institutions privilege the latter approach to teaching (Poznanski & McLennan, 2004). Poznanski and McLennan's (2003, 2004) sample also revealed differences in the extent to which post-training supervision influenced their orientation, with almost all psychodynamic practitioners describing this as a major determinant, in contrast to about half of the experiential, systemic and cognitive-behavioural therapists. Murdock et al.'s (1998) study of 102 counsellors of various orientations also assessed, amongst other factors, the role of the supervisor's therapeutic orientation, finding that a theoretical match with supervisors predicted the orientation of the supervisee. A major limitation in all of these studies, however, is their failure to assess the relationship between supervision and orientation over time. It may be the case that individuals of a particular theoretical persuasion seek out training or supervision within that orientation, and thus one cannot draw causal inferences from any of these studies.

Two studies have, however, utilised a longitudinal design to investigate the relationship between supervision and training on therapist orientation (Freiheit & Overholser, 1997; Guest & Beutler, 1988). Freiheit and Overholser (1997) examined

whether pre-existing biases concerning cognitive-behavioural therapy affected the acquisition of cognitive-behavioural skills and knowledge during a nine-month training course. They studied the attitudes towards various therapies among 40 graduate students in clinical psychology before the course using the *Behaviour Therapy Survey* (BTS; Freiheit & Overholser, 1997), categorising students as either cognitive-behavioural, not cognitive-behavioural, or undecided. The students' attitudes, and clinical use of cognitive-behavioural techniques were then re-assessed following the course, with the finding that all trainees had benefited from the training, regardless of their initial orientation (Freiheit & Overholser, 1997). More specifically, the three groups all showed significant decreases in negative evaluations of cognitive-behavioural therapy, increases in positive evaluations, increases in knowledge, increases in cognitive ideology and increases in the use of cognitive-behavioural techniques (Freiheit & Overholser, 1997). Those participants who were initially interested in psychodynamic and person-centred approaches did not, however, lose their interest in these approaches, rather they appeared to develop a further interest in cognitive-behavioural therapy (Freiheit & Overholser, 1997). This finding has implications for the successful integration of various therapies within teaching programs, as it suggests that certain approaches are not unteachable to individuals from different pre-existing theoretical backgrounds, as has been implied by some of the authors of research into the role of personality and epistemological beliefs (Kolevzon et al., 1989; Poznanski & McLennan, 2003, 2004; Vasco et al., 1993). This conclusion is limited, however, by the number of participants, and also by the use of a self-report measure to assess frequency of use of cognitive techniques (Freiheit & Overholser, 1997). It might also be argued, on the basis of the previously reviewed research on personality and philosophical beliefs, that this particular

sample was by chance predisposed to a cognitive-behavioural orientation owing to their personality traits and epistemic style. Without a measure of these factors, it is impossible to conclude any more than to say that for this sample, those from a non-cognitive-behavioural background did appear to make use of training in that therapy.

Guest and Beutler (1988) conducted a longitudinal study including the orientation of the supervisor, locus of control, personality and values of the trainee, in order to assess the relationship between these variables and the trainees' development of a therapeutic orientation. At baseline, trainees were assessed on locus of control, personality (measured by the *Eysenck Personality Questionnaire*, Eysenck & Eysenck, 1969), values (Rokeach, 1973) and therapeutic orientation (TOQ; Sundland & Barker, 1962), and at the end of the training year, measures of therapeutic orientation and values were repeated. Crucially, three to five years later, trainees completed a further measure of therapeutic orientation, with the addition of ranked ratings of their former supervisor's influence, and parallel data for all the supervisors rated as first or second most influential by trainees (Guest & Beutler, 1988). Using multiple regression analyses, they found that over the course of training and during the follow-up period, none of the non-supervisory variables such as personality or locus of control independently contributed to changes in trainee therapeutic orientation or values (Guest & Beutler, 1988). This is not to say that personality factors do not play a role in orientation preference, but the premise of the study was to assess change in orientation, and as such, at both the end of the training year and at follow-up, trainees' scores were residualised for their pre-training scores. They did, however, find that the supervisor's scores on several scales of the TOQ were related to those of the trainees, at both the end of the training year and after the follow-up

period, suggesting that not only do supervisors exert an influence over the development of orientation in trainees, but that the influence is a lasting one. Their results also provided some evidence for what Herron (1978) described as the 'visibility factor', with participants all rating their director of clinical training as their most influential supervisor. One further finding was that the trainees in their sample showed evidence of a temporally evolving pattern of need, with novice trainees valuing technical guidance and support, and more experienced trainees placing increasing value on more complex and personal issues related to the work (Guest & Beutler, 1988). The study is laudably the only one of its kind found by the current review to include a multivariate analysis, however the use of only 16 participants in such a design severely limits the conclusions that can be drawn.

Personal experiences and therapeutic orientation

A final area of research on therapeutic orientation has been concerned with what can broadly be termed personal experiences, encompassing early family experiences, attachment styles, and personal therapy. In an interesting phenomenological account of her own development as a therapist, Brown (2005) reports that her own difficult family experiences, characterised by loss and her own parentification in the face of her mother's mental illness, was formative in her interests in human behaviour and in developing her capacities as a therapist. She also describes how her non-conformist upbringing and experience of being an outsider at school led her towards a tendency for contrarianism and an attraction for the radical, and goes on to link this with her later professional development as a radical feminist therapist. In a similar way, Poznanski and McLennan's (2003, 2004) study of 103 psychologists revealed through interview that the majority of participants of a family-systemic orientation,

closest to Brown's (2005) own social constructionist-based orientation, also reported early parentification. Individuals of a psychodynamic persuasion described their early family experiences as emotionally extreme, characterised by turmoil and disengagement, whereas cognitive-behavioural therapists generally described their childhoods in more positive terms, frequently commenting on a more pragmatic and practical family in which problems were solved (Poznanski & McLennan, 2003, 2004).

In terms of quantitative studies, only Norcross and Prochaska (1983) and Rosin and Knudson (1986) have assessed the influence of life experiences on orientation. Norcross and Prochaska (1983) found in their survey of 479 clinical psychologists that life experiences were rated as the fifth most influential factor by participants in their development of an orientation. In assessing differences in life experience between 20 psychologists of a psychodynamic orientation and 20 of a behavioural orientation, Rosin and Knudson (1986) found support for the differences noted by Poznanski and McLennan (2003, 2004). They found that those with a psychodynamic allegiance reported significantly more mental illness and conflict in their family. As noted by Rosin and Knudson (1986), however, these findings are unable to answer the question as to whether therapists' early experiences predisposed them to a particular orientation, or whether now seen through a particular conceptual framework their family narratives are distorted by that framework. In addition to the necessity of longitudinal studies to answer this question suggested by Rosin and Knudson (1986), further light is shed on this area by Leiper and Casares' (2000) study which investigated the attachment style of therapists and their therapeutic orientation, assuming that attachment style is a robust indicator of early experience.

In their study of 196 British clinical psychologists, Leiper and Casares (2000) found significant differences between practitioners of differing orientations on level of early loss experience measured by the *Adult Attachment Organisation (attachment style)* (Hazan & Shaver, 1987), more specifically for both the number of loss events and unempathic parental response reported. Again, there are problems with causality here due to retrospective reports of early family experiences, but this study nonetheless provides firmer empirical evidence of a relationship between early life experiences and later preference for therapeutic orientation. It could be argued, however, that this does not add significantly to the finding of a link between personality and orientation, if we allow that personality structure is at least in part determined by early experiences.

The final area that has interested researchers is that of the role of personal therapy in the development of orientation. Many of the studies already reviewed have suggested that such a relationship exists (e.g. Brown, 2005; Lucock et al., 2006; McNair & Lorr, 1964; Norcross & Prochaska, 1983; Poznanski & McLennan, 2003, 2004; Rosin & Knudson, 1986; Steiner, 1978; Sundland, 1977), with all those assessing differences between practitioners of varying orientation finding that viewing personal therapy as an influence was significantly associated with a psychodynamic orientation (e.g. Poznanski & McLennan, 2003, 2004; Rosin & Knudson, 1986). This is perhaps unsurprising given the fact that a personal therapy is mandatory in most psychoanalytic trainings, and also that the practice of this therapy involves using the countertransference, necessitating some understanding of one's own unconscious processes. It would be interesting, however, to investigate when in the developmental trajectory of those citing personal therapy as an influence

they first undertook the therapy: was it in response to difficulties in their own life, or was it as a professional necessity?

Discussion

Implications

In the opening remarks of this review it was suggested that perhaps the most prevalent narrative within clinical psychology in the UK is that a theoretical approach to practice should be selected on the basis of the available evidence for treating a particular clinical problem. However, this review demonstrates that there are also other important factors influencing a clinician in their preference for orientation. Lambert, Bergin and Garfield (2004) suggest that the current trend for developing new and more effective techniques of psychotherapy has somewhat obscured the subjectivity of our choice of techniques. Contrary to suggestions that individuals arrive at a preferred orientation through some mysterious process or by chance (e.g. Cummings & Lucchese, 1978; Steiner, 1978), the literature demonstrates that the adoption of an orientation is in fact understandable (Norcross & Prochaska, 1983). The literature reveals that preference for therapeutic orientation is related to the therapist's personality (e.g. Arthur, 1998, 2000; Poznanski & McLennan, 2003, 2004; Scandell et al., 1997; Scragg et al., 1999), philosophical beliefs (e.g. Arthur, 1998, 2000; Lyddon & Bradford, 1995; Schacht & Black, 1985), experiences during training (e.g. Freiheit & Overholser, 1997; Guest & Beutler, 1988; Lucock et al., 2006) and life experiences (e.g. Brown, 2005; Leiper & Casares, 2000; Rosin & Knudson, 1986).

As Poznanski and McLennan (2003) suggest, the development of an individual's preferred way of working is likely to result from the complex interaction of all these factors, as opposed to a simple process of modelling during training which is often assumed to be the case. This has undoubted implications for training therapists, particularly given the continued predominance in many teaching institutions of the 'school' approach to teaching psychological therapies (e.g. Lambert, 1989; Poznanski & McLennan, 2003; Stevens et al., 1998). For instance, it may be that individuals arriving on training courses with a certain constellation of personality and epistemological attributes are more receptive to teaching in particular models, and certain modes of teaching than others (e.g. Kolevzon et al., 1989; Poznanski & McLennan, 2003; Rosin & Knudson, 1986; Scragg et al., 1999). As Scragg et al. (1999) point out, a lack of fit between the models espoused by a training course and that which an individual is perhaps predisposed to take up could result in a waste of money, and low morale amongst students and trainers. Kolevzon et al. (1986) suggest that trainees with different personalities should begin their training at different points, and Scragg et al. (1999) have proposed the possibility of using personality assessment during selection for training as a way of ensuring congruence between the individual and what the training course offers. It may well be, though, that individuals possessing certain views gravitate towards those trainings consonant with their views (within the UK it is well known that certain training courses are allied to particular models (Scragg et al., 1999)), and it has been argued that teaching departments should clearly espouse their theoretical allegiance to help students decide (Poznanski & McLennan, 2003). It would also seem incumbent, however, on training institutions to help trainees become more aware of the links between their personalities and philosophical worldviews and the various theoretical models, and

explore the implications therein (Lyddon & Bradford, 1995), something conspicuously lacking in clinical psychology training in the UK.

In a wider sense, there are several other implications of this literature. The research on philosophical commitments would suggest that certain individuals, of a certain worldview, would be more attracted to a scientific basis for psychology than others, and as such, would be more likely to accept that their choice of treatment approach should be based on the available evidence base. The argument over evidence-based treatments has been noted to have caused something of a split in the profession, and the implication of the relationship between orientation and personal philosophy is that this split is unlikely to be resolved (Poznanski & McLennan, 2003). Several authors have also pointed out that this may also present something of a problem for attempts to integrate different therapies and developing multi-disciplinary team working (e.g. Arthur, 2001; Schacht & Black, 1985). Finally, a growing area of interest within clinical psychology has been the use of the client's personality traits to plan treatment (e.g. Harkness & Lilienfeld, 1997), and one could speculate in the light of the research reviewed here that this endeavour could be improved through some consideration of the therapist's personality.

Methodological issues

Assessing the literature as a whole and the ability of the research to adequately ascertain what influences therapeutic orientation, a number of methodological concerns present themselves. A great quantity of what has been written on this topic is speculation and does not include any empirical investigation (e.g. Brown, 2005; Conway, 1992; Cummings & Lucchese, 1978; Lazarus, 1978; Lyddon, 1989;

Schwartz, 1978). Those studies that have employed empirical methods have been limited in three ways: 1) in their measurements, 2) sampling and 3) design.

Firstly, many of the studies were limited in their ability to assess meaningfully the influence of various factors on orientation by their lack of rigorous measurement of the variables in question (e.g. Lucock et al., 2006; Norcross & Prochaska, 1983; parts of Poznanski & McLennan, 2003, 2004; Rosin & Knudson, 1986; Steiner, 1978). Of those using formal measures, the use of a variety of measures of personality and philosophical beliefs have, as already discussed, limited interpretation of the literature as a whole. Some of these measures bear no resemblance to today's accepted trait theories of personality, for example, the POI (Shostrom, 1972), used by Herron (1978) and Tremblay et al., (1986), and some appear to not be based on any recognised theory of personality, for example the measure used by Keinan et al., (1989). Future research should attempt to assess personality using measures with sound psychometric properties such as the NEO (Costa & McCrae, 1994), based on the *Big Five*, the most generally accepted theory of personality which is derived from a factor analysis as opposed to being theory-generated (Scragg et al., 1999). Measurement of therapeutic orientation has also been inadequate in many studies, with many relying on self-designation of orientation (e.g. Keinan et al., 1989; Murdock et al., 1998; Tremblay et al., 1986; Vasco et al., 1993), and most limiting their sample to only a few, distinctly defined schools of therapy (e.g. Arthur, 1998, 2000; Lyddon & Bradford, 1995; Schacht & Black, 1985; Scragg et al., 1999). Although some studies have improved their measure of orientation by including a check on adherence to a particular model (e.g. Arthur, 1998, 2000; Poznanski & McLennan, 2003, 2004), as has been pointed out elsewhere (e.g. Scandell et al.,

1997), limiting participants to only one therapeutic orientation may be problematic in that many individuals would cite the influence of several models on their practice. More rigorous methods noted in the literature include the multidimensional ratings of Hill and O'Grady (1985) also used in Scandell et al.'s (1997) study, and the *Counsellor Theoretical Position Scale* (CTPS; Poznanski & McLennan, 1999), based on Coan's (1979) TOS and Sundland and Barker's (1962) TOQ. Hill and O'Grady's (1985) method requires individuals to rate on a Likert scale the extent to which they adhere to the principles of various different models, and the CTPS (Poznanski & McLennan, 1999) presents 40 statements concerning the therapeutic encounter, with participants rating the extent of their agreement or disagreement with each, giving a score on two dimensions of psychotherapeutic practice, Rational-Intuitive, and Objective-Subjective. It is suggested that a combination of these two methods would provide a more rigorous assessment of therapeutic orientation.

Secondly, a variety of approaches to sampling have hindered many of the studies, with some having very small numbers of participants for the analyses conducted (e.g. Guest & Beutler, 1988; Herron, 1978; Keinan et al., 1989; Lyddon & Bradford, 1995; Murdock et al., 1998; Scandell et al., 1997). A further problem with the sampling approach of many studies has been to invite participants from a variety of training backgrounds as a way of ensuring groups of differing orientation (e.g. Arthur, 1998, 2000; Schacht & Black, 1985), however this introduces the confounding factor of relative exposure to a plurality of approaches, with some trainings being more eclectic than others (Nevid et al., 1987). One cannot therefore be sure in such studies whether effects are due to the variables in question, such as personality and epistemic style, or whether they are more due to the monotheoretical

trainings participants have undertaken. It is suggested that samples in future studies should be drawn from only one training background, and preferably from a profession such as clinical psychology, which in comparison to other mental health professions, embraces a plurality of theoretical approaches in its teaching and practice.

Lastly, with regard to design, and given the multi-factorial nature of the influences on therapeutic orientation, too many studies have relied on univariate analyses, i.e. they have only focussed on the relationship between one variable, in isolation, and therapeutic orientation (e.g. Keinan et al., 1989; Lyddon & Bradford, 1995; Schacht & Black, 1985; Scandell et al., 1997; Scragg et al., 1999; Tremblay et al., 1986). Some studies have assessed the influence of a number of factors, however, have still assessed their relationship to orientation in a univariate manner (e.g. Arthur, 1998, 2000; Murdock et al., 1998; Poznanski & McLennan, 2003, 2004). The major limitation to all of this research is that despite its obvious value in revealing the various factors involved in the development of a therapeutic orientation, is that it tells us nothing about the weight of importance of the various influences. Although the factors involved are likely to interact to some degree, it would seem important to assess the relative weight of importance of each influence on choice of orientation within individuals. For instance, can the experience of an inspirational supervisor practicing a particular model overcome the influence of personality or epistemological beliefs? Or are trainees doomed to an unhappy time on clinical placement with a supervisor practicing an orientation dissonant to their own? The one genuine multivariate study bearing on this topic (Guest & Beutler, 1988) had too small a sample size to be able to answer this question. It is suggested that there is a

need for future research using a multivariate design with sufficient statistical power to evaluate the relative independence of all of the above factors in influencing an individual clinician's preference for orientation. A final point on design is that the vast majority of this research has been cross-sectional in nature, making causal inferences as to antecedent and consequent conditions impossible. It is therefore also suggested that future research be conducted longitudinally.

Summary

This review has revealed a number of important factors involved in the development of a preferred therapeutic orientation, for both clinicians and trainers of therapists to be aware of. However, the literature as a whole lacked cohesiveness, suggesting that this is an under-researched and somewhat neglected area, which is perhaps surprising given the importance accorded to therapeutic orientation within the psychological therapies. Further knowledge about this area, particularly through the type of multivariate and longitudinal studies outlined above, would be of value in training therapists.

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PART 2 -

EMPIRICAL PAPER:

Therapeutic orientation preferences in trainee clinical psychologists: personality or training?

Abstract

This study investigated the relative influence of person and training factors on preference for three common therapeutic orientations (cognitive-behavioural therapy (CBT), psychodynamic therapy, systemic therapy) in 142 trainee clinical psychologists in the UK. Previous findings that preferences for therapeutic orientation are related to personality, philosophical worldview, the theoretical emphasis of training courses and the orientation of supervisors were upheld. Overall, training factors predicted preference for therapeutic orientation over and above the influence of person factors, with the extent of influence differing by orientation. Preference for psychodynamic therapy was influenced more by training factors and preference for CBT more by person factors, with the influence of both sets of factors being approximately equal for systemic preference. Supervision was more influential than the theoretical emphasis of training courses in predicting preferences for psychodynamic and systemic therapies, with the converse pattern found for CBT. Additionally, first year trainees were more likely to identify with multiple therapeutic orientations and be more objective in their beliefs about therapy than third years, a greater proportion of whom identified with only one orientation, and held more subjective beliefs about therapy. Implications for training clinical psychologists and for the wider profession are drawn.

Introduction

Clinicians typically define their practice in terms of an allegiance to a particular therapeutic orientation, i.e. the conceptual model used to understand their clients' problems and to guide intervention (Lyddon & Bradford, 1995; Vasco, Garcia-Marques & Dryden, 1993). Clinical psychologists in the UK are commonly trained in a variety of orientations, although the emphasis may vary according to the ethos of the training institution or the orientation of their supervisors on clinical placement. As several authors have pointed out, the "school" approach to therapeutic orientation, as opposed to a more generic training in "common factors", predominates in training institutions (Lambert, 1989; Poznanski & McLennan, 2003; Stevens, Dinoff & Donnenworth, 1998). Despite this focus during training, relatively little is known about how individuals come to adopt a preferred orientation (Arthur, 2000; Poznanski & McLennan, 2003).

There are several prevalent models for the selection of therapeutic orientation within clinical psychology. The first and perhaps most prevalent is the evidence-based practice model, i.e. that treatment approach is selected on the basis of what has been empirically shown to be of most benefit for a particular problem (e.g. Roth & Fonagy, 2006). The second, which might be described as the client-fit model, is that clinical psychologists select the approach most suited to the client and their difficulties. Underpinning both of these models is the assumption that owing to their particular training, clinical psychologists are able to draw on a number of theoretical perspectives. During training, Stoltenberg and Delworth (1987) suggest that trainees' adoption of therapeutic orientations goes through three distinct stages. According to their model, novice therapists graduate from a level at which they are

inflexible and focus solely on one approach, through one of considering other approaches but being unsure of when to pursue a particular orientation, and finally to one of having a preferred orientation whilst being flexible and enjoying dialogue about other approaches. However, despite the large numbers of clinical psychologists who work eclectically or integratively (Patterson, 1989), it is also the case that many find themselves drawn more strongly towards certain orientations, and no doubt most clinical psychologists can think of colleagues who appear rigid and dogmatic in their adherence to a particular model and exclusion of others. Several authors present evidence that supports this idea, suggesting that eclecticism may actually be on the decline (Milan, Montgomery & Rogers, 1994; Patterson, 1989). Taken together with the fact that clinical psychologists do not en masse reject treatment approaches without an evidence base, this begs the question of what makes some orientations, for some individuals, more attractive than others?

A number of studies have demonstrated a relationship between the personality of the therapist and their preference for therapeutic orientation. Practitioners of a psychodynamic or experiential orientation have been found to be significantly more Open to Experience on the *NEO Personality Inventory* (NEO-PI; Costa & McCrae, 1992) or Intuiting on the *Millon Index of Personality Styles* (MIPS; Millon, 1994) than practitioners of a cognitive-behavioural, behavioural or systemic orientation (Arthur, 1998, 2000; Poznanski & McLennan, 2003, 2004; Scandell, Wlazelek & Scandell, 1997; Scragg et al., 1999). In other words, individuals who prefer psychodynamic and experiential therapies have a preference for the unstructured and symbolic as opposed to more concrete and externally observable phenomena (Scragg et al., 1999). Several studies also found that psychodynamic therapists scored higher

than cognitive-behavioural therapists on the Neuroticism scale of the NEO-PI (Poznanski & McLennan, 2003, 2004) and the corresponding Preserving scale of the MIPS (Arthur, 1998, 2000). Individuals scoring high on these scales are likely to focus on and intensify the problems they encounter in life, and possess the view that the past has been personally troubling (Millon, 1994). In contrast, cognitive-behavioural therapists have been found to be more Enhancing (on the MIPS) than psychodynamic therapists, i.e. they possess the ability to look on the bright side of life (Arthur, 1998, 2000).

Practitioners of differing therapeutic orientation can also be distinguished by their philosophical beliefs or worldview, with philosophical beliefs here referring to the individual's epistemological commitments or their views of the nature of knowledge and its acquisition. Using the *Psycho-Epistemological Profile* (PEP; Royce & Mos, 1980), both Lyddon and Bradford (1995) and Schacht and Black (1985) found that a cognitive-behavioural orientation is associated with the epistemic styles of Empiricism and Rationalism. This profile refers to a way of knowing that encompasses both perceptual and conceptual processing, relating to the world through analytical reasoning skills (deductive and inductive), and testing beliefs through their correspondence with relevant observations (Lyddon & Bradford, 1995). In contrast, psychodynamic therapists have been shown to embrace the epistemic style of Metaphorism as measured by the PEP (Arthur, 1998, 2000; Schacht & Black, 1985). Metaphorism involves beliefs that are based on symbolic processes, and the testing of those beliefs through their generalisability to other experiences (Vasco et al., 1993), relying on analogical reasoning (Schacht & Black, 1985). A similar pattern between orientations is noted by studies using the *Organicism-Mechanism*

Paradigm Inventory (OMPI; Germer, Efran & Overton, 1982) to assess philosophical worldview (e.g. Arthur, 2000; Lyddon & Bradford, 1995). These studies found that psychoanalytic and systemic therapists were more Organismic than cognitive-behavioural therapists, who tended to be more Mechanistic. Organicism, a subjectivist worldview, refers to a belief system in which phenomena are understood as dynamic and developing as a whole (Lyddon, 1989). In contrast, the Mechanistic worldview is objectivist, and sees the world as composed of discrete and interacting elements best understood through a reductive analysis of these constituent elements and their antecedent-consequent relations (Lyddon & Adamson, 1992; Lyddon & Bradford, 1995).

Training experiences are also related to preference for orientation, and in particular the supervisor's orientation has been found to be influential (e.g. Freiheit & Overholser, 1997; Guest & Beutler, 1988; Murdock et al., 1998, Poznanski & McLennan, 2003, 2004; Rosin & Knudson, 1986). Guest and Beutler's (1988) longitudinal study showed that not only was this true during training, but that the supervisor's orientation still exerted an influence several years after qualifying. However, Poznanski and McLennan (2003, 2004) found that the extent to which training experiences influence development of orientation differs according to orientation. Almost all the cognitive-behavioural psychologists in their sample reported that their university training was an important influence on their development of orientation, in contrast to only a quarter of psychodynamic and systemic therapists. It may also be the case that individuals with different therapeutic orientations privilege different types of teaching, as Rosin and Knudson (1986) found evidence that therapists of a psychodynamic persuasion placed more

emphasis on a relational way of teaching, in contrast to the more intellectual aspects of training valued by behavioural therapists. Only one study has investigated whether individuals holding pre-existing therapeutic orientations can meaningfully be taught alternative approaches (Freiheit & Overholser, 1997). They found that regardless of initial orientation, a CBT training course increased knowledge and use of CBT skills, with individuals of a pre-existing orientation other than CBT developing an additional interest in CBT rather than losing interest in their earlier preferences.

Individuals arriving on training courses with a certain personality and philosophical worldview may possibly be more receptive to teaching in particular therapeutic orientations and modes of teaching than others (e.g. Kolevzon, Sowers-Hoag & Hoffman, 1989; Poznanski & McLennan, 2003, Rosin & Knudson, 1986; Scragg et al., 1999). Scragg et al. (1999) suggest that a dissonance between models espoused by a training course and that which an individual is perhaps predisposed to take up could result in low morale amongst students and trainers. Furthermore, if personality traits are relatively stable in adults over long periods of time (e.g. Costa & McCrae, 1994), it could be argued that training prospective psychologists in orientations they find incompatible with their personality and philosophical worldview is a waste of public money. Freiheit and Overholser's (1997) findings suggest that this may not be the case, however almost all of the research in this area has been limited by use of a univariate design. It would therefore seem important before drawing any firmer conclusions for the implications in training psychologists, to assess the relative influence of personality and philosophy on the one hand, and training experiences on the other, in a multivariate design. In particular, to ask the

question, can training add significantly to the more long-standing influences of personality and worldview on preference for therapeutic orientation? The current study investigated this question in determining preferences within a sample of UK trainee clinical psychologists for three common therapeutic orientations (cognitive-behavioural, psychodynamic and systemic). It tested the following hypotheses:

1) Personality is related to preference for therapeutic orientation, with Openness to Experience and Neuroticism associated with preference for psychodynamic therapy and negatively associated with preference for CBT (following Arthur, 1998, 2000; Poznanski & McLennan, 2003, 2004).

2) Philosophical worldview is related to preference for therapeutic orientation, with an Organismic worldview related to preference for psychodynamic and systemic therapies, and Mechanism related to preference for CBT (following Arthur, 1998, 2000; Lyddon & Bradford, 1995).

3) The therapeutic orientation of training courses and clinical supervisors are related to preference for orientation (following Guest & Beutler, 1988; Murdock et al., 1998). This is particularly true for those with a preference for CBT (following Poznanski & McLennan, 2003, 2004).

4) Training experiences contribute to preferences for therapeutic orientation in addition to the influence of personality and philosophical worldview factors, congruent with Freiheit and Overholser's (1997) findings. Training has a larger

influence on individuals with a preference for CBT (following Poznanski & McLennan, 2003, 2004).

5) Finally, the study examined the pattern of preferences for therapeutic orientation according to year of training, in order to test Stoltenberg and Delworth's (1987) model. No specific prediction was made.

Method

Recruitment procedure

With the prior agreement of training course directors, all 331 trainee clinical psychologists on the four London-based courses were contacted with details of this cross-sectional study. This was achieved either by email or in the case of trainees from the same course as the author, in person. With regard to the trainees recruited through face-to-face meetings, the author met briefly with each of the three years of trainees on the course, giving an outline of the study as detailed on the information sheet for the study received by all trainees (see Appendix 1). Owing to time pressures, the author was not given permission to meet trainees from other courses directly, however he was allowed to approach potential participants by email. Trainees contacted in this way also received the same information sheet, and were given an opportunity to ask questions about the study either by email or telephone. One month after initial contact, trainees were contacted again by email as a reminder. Individuals wishing to take part were given a questionnaire pack to complete, either by the author in the case of those trainees on the same course, or by the course administrators or heads of year on other courses. The overall response rate was 43% (142 participants), however amongst the four courses the rates were 69%, 35%, 28%

and 23%, with the highest rate of participation amongst the author's cohort perhaps reflecting the two different recruitment methods used.

Participants

Of the 142 participants, 25 (18%) were male and 117 (82%) were female, with ages ranging from 22 to 43 (median 27). The sample was roughly divided equally in terms of the year of training, with 42 (30%) in their first year, 48 (34%) in their second, and 52 (37%) in their third. In terms of ethnicity, 131 (92%) were White, 7 (5%) Asian, and 3 (2%) Black. Although participants were drawn only from London courses, the demographics of this sample are almost identical to those reported nationwide by Clearing House for Postgraduate Courses in Clinical Psychology (CHPCCP, 2006). With regard to the statistical power necessary to conduct multivariate analyses, the number of participants was estimated using Tabachnick and Fidell's (2001) guideline which states that $N \geq 104 + m$ where m is the number of independent variables. The guideline assumes a medium effect size, with $\alpha = 0.05$ and $\beta = 0.20$.

Ethical approval

The research was approved by the UCL Committee on the Ethics of Non-NHS Human Research (project ID: 0513/001: see Appendix 2 for approval letter). It was deemed that participation involved minimal risk to individuals taking part, and all necessary steps were taken to ensure that responses were anonymous and remained confidential. This latter point was felt to be of particular importance in eliciting honest responses to the study given the author is himself a trainee and personally known to some of the participants.

Materials

Each questionnaire pack included a series of measures, a consent form (see Appendix 3), and a Freepost envelope to return the completed pack to the author. The packs were coded in order to enable calculation of response rates from each course, and to ensure anonymity. The front cover included a series of demographic questions such as the age, gender, ethnicity and year of training of each participant. The following measures were included:

1) *Therapeutic Orientation and Experiences Survey* (TOES: Appendix 4). This 28-item measure was constructed for this study to assess participants' preferences for therapeutic orientations and their teaching and supervisory experiences during training in terms of exposure to different orientations. It incorporated a variant of Hill and O'Grady's (1985) multidimensional measure of therapeutic orientation (also used by Scandell et al., 1997), focussing on the three currently dominant orientations in the UK: cognitive-behavioural, psychodynamic and systemic therapies, and also using open ended questions concerning any further orientations participants identified with. For each orientation there were three questions: 1) "*To what extent do you identify with the basic principles of x therapy?*", 2) "*To what extent does x therapy appeal to you personally?*" and 3) "*How much do you envisage using x therapy when qualified?*". Participants were asked to rate each question on a 5-point Likert scale ranging from "not at all" (1) to "very much" (5), and also whether they identified with any further orientations.

The TOES also assessed participants' exposure to the three orientations on their course and during clinical supervision by asking the questions "*How much does your*

course emphasise x therapy?" and "*How much has your placement supervision exposed you to x therapy?*" for each orientation. Again, participants were asked to rate each question on a 5-point Likert scale ranging from "not at all" (1) to "very much" (5), with further space provided for participants to describe any further orientations they had encountered in their teaching or supervision.

2) *Counsellor Theoretical Position Scale* (CTPS: Poznanski & McLennan, 1999: Appendix 5). A further measure of orientation, the CTPS (Poznanski & McLennan, 1999) was included as a check on the validity of the TOES on the basis that the "school" approach to measuring therapeutic orientation is limited (Sundland, 1977) and that a measure incorporating only a therapist's stated orientation may give an incomplete or inaccurate representation of their beliefs about therapy (Poznanski & McLennan, 1999). The CTPS consists of 40 items related to views about therapy such as "*Unconscious motives and intuitive processes should be considered as essential aspects of psychological theory*" and "*I generally prefer to practice a goal-directed approach to psychological therapy*". Participants were required to rate the extent to which they agreed or disagreed with each statement on an anchored 7-point Likert scale ranging from "*strongly disagree*" (1) to "*strongly agree*" (7). The CTPS provides a score on two dimensions of therapeutic practice: Rational-Intuitive (R-I) and Objective-Subjective (O-S). The R-I dimension describes a preferred style of knowing or acquiring information through either rational judgement based on logical and analytical reasoning or intuitive processes (Poznanski & McLennan, 1999). In contrast, the O-S dimension refers to a preference for acquiring data through observable, objective measurements or one more based on subjective, introspective and experientially acquired knowledge (Poznanski & McLennan, 1995).

Poznanski and McLennan (1999) found in a factor analysis that the two subscales measured separate constructs and also that the items were reliable, with internal consistency coefficients for the O-S and R-I subscales reported as 0.87 and 0.81 respectively. In addition they found evidence of criterion validity, with the scales able to distinguish between practitioners of different therapies. Cognitive-behavioural therapists were found to score towards the Objective and Rational ends of the two subscales, with psychodynamic and experiential therapists tending to score more towards the Subjective and Intuitive poles, and systemic practitioners somewhere in between. In the present study, several small changes were made to the wording of the items in order to make them more relevant for the sample in question, with "clinical psychologist" substituted for words such as "counsellor" and "psychotherapist" in the original measure. Cronbach's alpha for the R-I and O-S subscales in the present study were 0.84 and 0.88 respectively.

3) *Organicism-Mechanism Paradigm Inventory* (OMPI: Germer et al., 1982: Appendix 6). Congruent with previous studies (e.g. Arthur, 2000; Lyddon & Bradford, 1995), the philosophical worldview of participants was assessed by the *Organicism-Mechanism Paradigm Inventory* (OMPI: Germer et al., 1982). A 26-item forced-choice inventory, the OMPI assesses an individual's relative preference for two of Pepper's (1942) worldviews: Organicism or Mechanism (Lyddon & Bradford, 1995). Each item consists of a choice between two alternative statements, for example "*Organisms change by forces from outside themselves*" (Mechanistic) or "*Organisms can change themselves*" (Organismic). It has been shown previously that the OMPI discriminates between practitioners of differing therapeutic orientation

(e.g. Arthur, 2000; Lyddon & Bradford, 1995), providing evidence for its criterion validity. In terms of reliability, Germer et al. (1982) report a Cronbach's alpha of 0.76 and 3-week test-retest reliability of 0.77. In the present study Cronbach's alpha was 0.67.

4) *NEO Five Factor Inventory* (NEO-FFI; Costa & McCrae, 1992).

Participants' personality traits were assessed using the *NEO Five Factor Inventory* (NEO-FFI: Costa & McCrae, 1992). The NEO-FFI is a 60-item measure corresponding to the "five factor" personality dimensions of Neuroticism (N), Extraversion (E), Openness to Experience (O), Conscientiousness (C) and Agreeableness (A). Examples of items are: "*I am not a worrier*" (Neuroticism) and "*I don't like to waste my time daydreaming*" (Openness to Experience). Participants rated the extent to which they agreed or disagreed with each statement on an anchored five-point Likert scale ranging from "*strongly disagree*" to "*strongly agree*". The NEO has been used by other studies in this area (e.g. Poznanski & McLennan, 2003, 2004; Scandell et al., 1997) and has good psychometric properties, with Costa and McCrae (1992) reporting internal consistency coefficients ranging from 0.68 to 0.86. In the present study Cronbach's alpha for the five personality domains ranged from 0.65 to 0.88. Prior to analysis, raw scores on the NEO subscales were converted into standardised scores using Costa and McCrae's (1992) norms.

Results

Following a description of the steps taken to ensure the integrity of the data and an analysis of the measures of therapeutic orientation, each hypothesis is addressed in turn, with univariate analyses followed by multivariate analyses. In order to reduce the possibility of Type I error, a conservative critical significance level of 0.01 was adopted in all tests. Analyses were conducted using SPSS for Windows 11.5.

Data preparation

A missing data analysis found that no key variables had more than 5% of missing cases, and those values that were missing were distributed randomly. Several dependent variables used in the analysis (overall preference for CBT and overall preference for systemic therapy) exhibited a slight negative skew, which was not alleviated by the reflect and square root transformations recommended by Tabachnick and Fidell (2001). Since deviation from normality was slight, and given the robustness of parametric tests to small deviations from normality, untransformed data and parametric tests were used. Two independent variables (course emphasis in CBT and supervision in CBT) also showed negative skewness and again the deviation was not rectified by transformation, so this data was also used untransformed. With regard to outliers, only one variable (supervision in CBT) had cases with standardised scores in excess of 3.29 (the cut-off recommended by Tabachnick & Fidell, 2001). However, these two cases were only very slightly in excess of that value, and were not deemed to belong to another population.

Univariate analyses of therapeutic orientation

Firstly, the questions pertaining to preference for therapeutic orientation on the TOES were analysed. The three questions for each of the three main orientations were all correlated within, but not between, orientations, providing evidence for the construct validity of the TOES (r ranged from 0.56 to 0.78, all $p < 0.001$). Mean scores across each triad of questions were therefore calculated for each participant, as an index of approach preference. Cronbach's alpha was 0.83, 0.89 and 0.85 for overall CBT, psychodynamic and systemic preference respectively. Correlations between these new overall approach preference variables and the R-I and O-S subscales of the CTPS are shown in Table 1.

Table 1.

Correlations between measures of therapeutic orientation.

	PSYD	**SYST**	**R-I**	**O-S**
CBT	-0.30**	-0.16	0.45**	0.51**
PSYD	-	0.04	-0.68**	-0.24**
SYST	-	-	0.03	-0.28**
R-I	-	-	-	0.29*

Note: CBT, PSYD, SYST = overall preference for CBT, psychodynamic and systemic therapies, R-I = Rational-Intuitive subscale of the CTPS, O-S = Objective-Subjective subscale of the CTPS.

* = significant at $p < 0.01$, ** = significant at $p < 0.001$ (2-tailed).

Preference for CBT was negatively correlated with preference for psychodynamic therapy, with preference for systemic therapy not related to either of the two other orientations. Preference for CBT was also correlated with Rational and Objective

beliefs about therapy, whereas in contrast preference for psychodynamic therapy was correlated with Intuitive and Subjective beliefs. Preference for systemic therapy was also associated with Subjective beliefs about therapy. This pattern of results provides further evidence for the construct validity of the TOES. Lastly, the correlation of the two subscales of the CTPS suggests that the subscales are not fully orthogonal.

1) Personality and therapeutic orientation

Correlations between measures of therapeutic orientation and the five personality domains are shown in Table 2. Preference for CBT was correlated with Conscientiousness, and negatively correlated with Openness to Experience with the opposite pattern being found for preference for psychodynamic therapy. Preference for systemic therapy was not significantly related to any of the personality factors, although its relation with Extraversion approached significance ($p = 0.018$), as did the correlation between preference for CBT and Agreeableness ($p = 0.018$).

Table 2.

Correlations between personality domains and preferences for therapeutic orientation.

	N	E	O	A	C
CBT	-0.14	0.08	-0.31**	0.20	0.31**
PSYD	0.08	-0.09	0.23**	0.01	-0.25**
SYST	0.02	0.20	0.07	0.15	0.05

Note: N, E, O, A, C = Neuroticism, Extraversion, Openness, Agreeableness, Conscientiousness (NEO), CBT, PSYD, SYST = overall preference for CBT, psychodynamic and systemic therapies.

** = significant at $p < 0.001$ (2-tailed).

2) Philosophical worldview and therapeutic orientation

Preference for CBT was associated with a Mechanistic worldview ($r = 0.28$, $p < 0.001$) whereas in contrast, preference for psychodynamic therapy was associated with an Organismic worldview ($r = 0.26$, $p < 0.001$). The relationship between preference for systemic therapy and Organicism approached significance ($r = 0.18$, $p = 0.036$).

3) Training experiences and therapeutic orientation

Table 3 shows the correlations between participants' views of the emphasis on each therapeutic orientation within their course, their experiences of the three orientations in clinical supervision, and their preferences for orientation. Preference for CBT and psychodynamic therapy were correlated with a course emphasis in that approach, and preference for systemic therapy was correlated with a systemic course emphasis at borderline significance ($r = 0.21$, $p = 0.015$).

Table 3.

Correlations between training experiences and preferences for therapeutic orientation.

	CBT course	**PSYD course**	**SYST course**	**CBT s-v**	**PSYD s-v**	**SYST s-v**
CBT	0.29**	-0.03	-0.11	0.18	-0.10	-0.10
PSYD	0.10	0.28**	0.03	-0.23**	0.50**	0.03
SYST	-0.07	0.02	0.21	-0.18	-0.15	0.22

Note: CBT, PSYD, SYST s-v = supervision in CBT, psychodynamic and systemic therapies, CBT, PSYD, SYST course = course emphasis in CBT, psychodynamic and systemic therapies, CBT, PSYD, SYST = overall preference for CBT, psychodynamic and systemic therapies.

** = significant at $p < 0.001$ (2-tailed).

The pattern was more mixed with regard to supervision, with only supervision in psychodynamic therapy being correlated with preference for that approach. For preference in systemic therapy, the relationship with systemic supervision was borderline significant ($r = 0.22$, $p = 0.011$). However, the relationship between supervision in CBT and preference for CBT only approached significance ($r = 0.18$, $p = 0.036$). Additionally, preference for psychodynamic therapy was negatively correlated with having had supervision in CBT, with the same pattern being found for preference for systemic therapy, the latter only approaching significance ($r = 0.18$, $p = 0.03$).

4) Year of training and therapeutic orientation

A One-Way ANOVA found borderline significant differences across the three year groups in Objective beliefs about therapy as measured by the CTPS ($F(2,141) = 4.65$, $p = 0.011$). Bonferroni post hoc tests showed that first year trainees held significantly more Objective beliefs about therapy than third year trainees.

In order to test Stoltenberg and Delworth's (1987) model of development of therapeutic orientation, participants were divided according to the median score for preference for each of the three orientations, firstly into groups of 'pure CBT', 'pure psychodynamic', 'pure systemic' and the four possible combinations of mixed (eclectic) groups within those therapies. The total number of individuals in each subgroup was then aggregated so as to produce a total number of therapeutically 'pure' and eclectic individuals in each year group, with 'pure' defined as scoring at the median or above on only one of the three main approaches and eclectic defined as scoring at the median or above on two or three (see Table 4).

Table 4.

Numbers of participants with 'pure' and eclectic therapeutic approaches across years of training.

	PURE APPROACH	ECLECTIC APPROACH	Total
YEAR 1	10 (26%)	28 (74%)	38
YEAR 2	14 (30%)	32 (70%)	46
YEAR 3	26 (52%)	24 (48%)	50
Total	50 (37%)	84 (63%)	134

74% of the first year trainees in the sample were interested in more than one therapeutic orientation, whereas within the third year trainees distribution was roughly equal between those with 'pure' and eclectic approaches. However, the apparent decrease in eclecticism across the three years of training only approached significance (χ^2 (2) = 6.88, p = 0.032).

Multivariate analyses

Therapeutic orientation: person of the therapist or training?

Having shown in the preceding univariate analyses that personality, philosophical worldview and training variables were related to preference for therapeutic orientation, the final analysis was concerned with assessing the relative influence of these factors, specifically to investigate the hypothesis that training would predict preference for orientation in addition to personality and philosophical worldview factors. A regression model was therefore tested for each of the three orientations containing two blocks of variables as predictors: 1) person variables (personality and philosophical worldview), and 2) training variables (course theoretical emphasis and

orientation of supervision). Each regression model met the three assumptions of normality associated with multiple regression analyses, i.e. the unstandardised residuals were normally distributed, there was homogenous variance in arrays, and there were no multivariate outliers (as assessed using Cook's distance).

a) Preference for CBT. Person variables predict preference for CBT, with 22% of the variance explained by these factors alone (see Table 5). The coefficients for the individual predictors show Openness to Experience to have the largest influence. The addition of training variables to the model increases the proportion of variance explained to 27%, an increase of borderline significance. This suggests that training does influence preference for CBT in addition to the person of the therapist. The individual coefficients show that the theoretical emphasis of the course is the more influential of the two training variables. The reverse of this regression model was also tested owing to the fact that the shared variance in Model 1 in effect privileges person factors. The regression model with only training factors had an R^2 of 0.104 ($F(2,140) = 8.04$, $p < 0.001$), with the addition of person factors giving an increase in R^2 of 0.164 to a total of 0.268 (F change $(6,132) = 4.92$, $p < 0.001$). The results therefore show that although both training and person factors predict preference for CBT, personality and philosophical worldview are more influential.

Table 5.

Regression model showing predictors of preference for CBT.

	R^2	F	β	t	p	ΔR^2	ΔF (p)
Model 1: personal variables	0.221	6.35	-	-	0.000**	-	-
Neuroticism	-	-	-0.011	-0.121	0.904	-	-
Extraversion	-	-	0.076	0.871	0.386	-	-
Openness	-	-	-0.244	-2.978	0.003*	-	-
Agreeableness	-	-	0.165	1.968	0.051	-	-
Conscientiousness	-	-	0.177	2.096	0.038	-	-
Worldview	-	-	-0.173	-2.070	0.040	-	-
Model 2: complete model	0.268	6.04	-	-	0.000**	0.047	4.212 (0.017)
Course emphasis	-	-	0.175	2.192	0.030	-	-
Supervision	-	-	0.120	1.576	0.118	-	-
Neuroticism	-	-	-0.026	-0.301	0.764	-	-
Extraversion	-	-	0.103	1.197	0.234	-	-
Openness	-	-	-0.207	-2.553	0.012	-	-
Agreeableness	-	-	0.113	1.350	0.179	-	-
Conscientiousness	-	-	0.164	1.971	0.051	-	-
Worldview	-	-	-0.157	-1.196	0.058	-	-

Note: Model 1 *df* = (6,140), Model 2 *df* = (8,140).

* = significant at $p < 0.01$, ** = significant at $p < 0.001$ (2-tailed).

b) Preference for psychodynamic therapy

With regard to preference for psychodynamic therapy, person variables also predict preference, however not to the same extent as for CBT, with only 14% of the variance explained (see Table 6). When training variables were added to the model, the explained variance increased significantly to 35%, with the individual coefficients showing that supervision in psychodynamic therapy was the most influential factor. Again, the reverse regression model was tested to confirm this pattern, finding that training factors alone had an R^2 of 0.273 ($F(2,141) = 26.15$, $p < 0.001$), increasing by 0.071 to a total of 0.345 on the addition of person factors (F change (6,133) = 2,42, p = 0.03). Therefore whilst training factors also predict

preference for psychodynamic therapy over and above the influence of person factors, they do so in the converse pattern than for CBT preference. In other words, training factors appear to be more influential than personality or philosophical worldview in predicting preference for psychodynamic therapy.

Table 6.

Regression model showing predictors of preference for psychodynamic therapy.

	R^2	F	β	t	p	ΔR^2	ΔF (p)
Model 1: personal variables	0.137	3.558	-	-	0.003*	-	-
Neuroticism	-	-	-0.004	-0.046	0.963	-	-
Extraversion	-	-	-0.151	-1.660	0.099	-	-
Openness	-	-	0.155	1.804	0.073	-	-
Agreeableness	-	-	0.053	0.607	0.545	-	-
Conscientiousness	-	-	-0.185	-2.078	0.040	-	-
Worldview	-	-	0.158	1.802	0.074	-	-
Model 2: complete model	0.345	8.750	-	-	0.000**	0.208	21.14** (0.000)
Course emphasis	-	-	0.143	1.894	0.060	-	-
Supervision	-	-	0.412	5.449	0.000**	-	-
Neuroticism	-	-	-0.027	-0.328	0.743	-	-
Extraversion	-	-	-0.132	-1.645	0.102	-	-
Openness	-	-	0.072	0.933	0.353	-	-
Agreeableness	-	-	0.043	0.543	0.588	-	-
Conscientiousness	-	-	-0.119	-1.516	0.132	-	-
Worldview	-	-	0.161	2.072	0.040	-	-

Note: Model 1 $df = (6, 141)$, Model 2 $df = (8, 141)$.

* = significant at $p < 0.01$, ** = significant at $p < 0.001$ (2-tailed).

c) Preference for systemic therapy

With the stringent critical significance level, person factors alone only approached significance in predicting preference for systemic therapy, accounting for 10% of the variance (see Table 7). The addition of training variables to the model significantly increased the proportion of explained variance in systemic preference to 17%, with

supervision in systemic therapy the more influential of the two training factors. The reverse of the regression model found that training factors alone had an R^2 of 0.082 ($F(2,136) = 6.02$, $p < 0.01$), which increased by 0.085 to 0.168 on the addition of person factors (F change (6,128) = 2.19, p = 0.048). Therefore in contrast to the other two orientations, person and training factors appear to be of roughly equal importance in predicting preference for systemic therapy. Furthermore, the overall proportion of variance in systemic preference explained by the whole model (17%) is considerably lower than that for CBT preference (27%) or psychodynamic preference (35%).

Table 7.

Regression model showing predictors of preference for systemic therapy.

	R^2	F	β	t	p	ΔR^2	ΔF (p)
Model 1: personal variables	0.103	2.498	-	-	0.025	-	-
Neuroticism	-	-	0.185	1.906	0.059	-	-
Extraversion	-	-	0.207	2.203	0.029	-	-
Openness	-	-	-0.022	-0.244	0.808	-	-
Agreeableness	-	-	0.109	1.206	0.230	-	-
Conscientiousness	-	-	0.164	1.772	0.079	-	-
Worldview	-	-	0.216	2.349	0.020	-	-
Model 2: complete model	0.168	3.224	-	-	0.002*	0.064	4.949* (0.009)
Course emphasis	-	-	0.160	1.949	0.054	-	-
Supervision	-	-	0.182	2.205	0.029	-	-
Neuroticism	-	-	0.168	1.771	0.079	-	-
Extraversion	-	-	0.185	2.021	0.045	-	-
Openness	-	-	-0.046	-0.522	0.603	-	-
Agreeableness	-	-	0.105	1.196	0.234	-	-
Conscientiousness	-	-	0.147	1.635	0.104	-	-
Worldview	-	-	0.203	2.267	0.025	-	-

Note: Model 1 *df* = (6,136), Model 2 *df* = (8,136).

* = significant at $p < 0.01$, ** = significant at $p < 0.001$ (2-tailed).

Discussion

In summary, the major finding of this study was the difference between orientations in the extent to which person and training factors predicted orientation preference, with person factors found to be more influential for CBT preference, training factors more influential for psychodynamic preference, and the influence of the two sets of factors approximately equal for systemic preference. Although not wholly consistent with previous findings, this study also confirmed that practitioners of differing therapeutic orientation exhibit different personality characteristics. Similarly, the hypotheses that philosophical worldview and the therapeutic orientation of training courses and clinical supervisors would be related to preference for therapeutic orientation were confirmed. In addition, evidence of differences in views about therapy and eclecticism were found across years of training.

With regard to personality, congruent with previous studies (e.g. Arthur, 1998, 2000; Poznanski & McLennan, 2003, 2004), preference for psychodynamic therapy was associated with Openness to Experience, with the opposite being true for preference for CBT. However, the expected relationship between Neuroticism and preference for orientation was not confirmed. There was in fact a greater, but non-significant relationship between preference for CBT and Neuroticism than any other orientation. In addition, preference for CBT was related to Conscientiousness, with the converse being true for a psychodynamic preference. Weaker relationships were also found between preference for CBT and Agreeableness, and systemic preference and Extraversion, with the former corresponding to the findings of Scandell et al., (1997). The present study also confirmed previous findings (e.g. Arthur, 1998, 2000; Lyddon & Bradford, 1995) with regard to philosophical worldview, with preference for CBT

being associated with Mechanism and preference for psychodynamic and systemic therapies with Organicism, although the relationship was not as strong for systemic preference. This pattern was confirmed by the finding that preference for CBT was related to Rational and Objective beliefs about therapy on the CTPS, with psychodynamic preference related to Intuitive and Subjective beliefs, and systemic preference with Subjective beliefs. Therefore the current study provides further evidence that preference for different therapeutic orientations is associated with particular personality traits and philosophical beliefs.

A relationship was also found between the theoretical emphasis of training courses and preference for therapeutic orientation for all three orientations, however this effect was stronger for preference in cognitive-behavioural and psychodynamic therapies than for systemic. Supervision in psychodynamic and systemic therapies was also related to preference for those approaches, with the same relationship only approaching significance for CBT. So although the present study is generally congruent with previous findings (e.g. Guest & Beutler, 1988; Murdock et al., 1998) in that teaching and supervision were related to preference for orientation, the prediction based on Poznanski and McLennan's (2003, 2004) finding that training would be more influential for individuals with a preference for CBT was not confirmed. One potential reason for this is that as Poznanski and McLennan (2003, 2004) themselves point out, university training in Australia tends to be skewed towards CBT, and it may be that the trainee clinical psychologists in the present study have been exposed to more of a variety of models in their training. An additional finding of the present study was an inverse relationship between having had supervision in CBT, and preference for psychodynamic and systemic therapies,

although this may reflect the fact that trainees often have a choice in their placement based on their interests.

With regard to the relative influence of person and training factors, it was found that training experiences did predict preference for therapeutic orientation over and above the influence of personality and philosophical worldview for each of the three orientations under consideration, although the extent to which this was true differed according to orientation. The reverse pattern than that expected was discovered in that person factors explained a greater proportion of the variance in preference for CBT than training factors, with the converse pattern found for preference in psychodynamic therapy. The relative influence of person and training factors were more equal for preference in systemic therapy. One possible reason for the greater influence of training factors on preference for psychodynamic therapy is the fact that psychodynamic therapy is generally underrepresented in undergraduate psychology teaching and is often misunderstood, being subject to the unhelpful stereotyping discussed by Lazarus (1978). Therefore, although individuals could have the personality and philosophical standpoint congruent with a psychodynamic orientation, it might be the case that it is not until they receive teaching or supervision in that approach that they find a fit with their underlying predisposition. In terms of individual training factors, a training course emphasising CBT was the most important aspect of training in influencing preference for CBT, whereas for psychodynamic and systemic orientations it was supervision in that approach which influenced orientation preference the most. This is congruent with Rosin and Knudson's (1986) finding that practitioners of differing orientation privilege different types of learning experience.

In terms of the pattern of preferences for therapeutic orientation across years of training, a trend approaching significance even with the conservative critical significance level employed was found in terms of theoretical eclecticism. A higher proportion of first years embraced more than one therapeutic orientation as opposed to an approximately equal distribution between theoretical purism and pluralism amongst third year trainees. Although only cross-sectional in nature, this finding suggests that trainees may come into training willing to try out different approaches but by the end of training many who were initially open-minded theoretically have settled upon their preferred orientation. This broadly concurs with Stoltenberg and Delworth's (1987) model in that a greater proportion of trainees in the third year of training appear to have developed a preferred orientation than those in their first year. However, this is only true for approximately half of the third year trainees, and one explanation for this apparent contradiction might be that the third stage of Stoltenberg and Delworth's (1987) model could refer to a later level of development following additional post-qualification clinical experience and training, during which a further narrowing of approach occurs. The present study's findings further contradict this model in that the majority of first year trainees appear theoretically open-minded, in contrast to the model's first stage in which novice therapists are said to focus solely on one approach. The model also predicts that trainees in a later stage of development will be more flexible in their approach and enjoy dialogue about other approaches, however this is not possible to ascertain with any degree of certainty from the measures employed in the present study.

One further difference between trainees in different years of training found by the current study is that first year trainees were found to hold significantly more

Objective beliefs about therapy (as measured by the CTPS) than trainees in their final year of training. In other words, first year trainees tend to have a preference for acquiring data through observable, objective measurements as opposed to more subjective, introspective and experientially acquired knowledge (Poznanski & McLennan, 1995). This finding is congruent with Guest and Beutler's (1988) suggestion that trainees exhibit a temporally evolving pattern of need, with novice trainees valuing technical guidance and support, and more experienced trainees placing increasing value on more complex and personal issues related to the work.

However, the present study is limited in several respects. Although steps were taken to ensure confidentiality, the fact that some participants were personally known to the author may have affected participants' responses, particularly for questions of a personal nature. This may explain the lack of correspondence between this study and previous findings of a relationship between Neuroticism and preference for orientation (e.g. Arthur, 1998, 2000; Poznanski & McLennan, 2003, 2004), given that the Neuroticism domain of the NEO includes questions such as "*When I'm under a great deal of stress, sometimes I feel like I'm going to pieces*". The study also relied on self-report measures of therapeutic orientation and it may have been the case that participants wished to portray themselves as more theoretically pluralistic than they actually are in clinical situations, where they may be more allied to a particular approach as a way of alleviating the anxiety every novice therapist faces. This may have limited the study's ability to test Stoltenberg and Delworth's (1987) model, in that this model is borne out of experience in supervising trainees so may be closer to what actually occurs in trainees' therapeutic practice. Although the use of the CTPS was in part an attempt to ascertain what individuals would actually do in

practice, as opposed to merely asking what "school" of therapy they preferred, future research in this area might benefit from a consideration of actual in-therapy practices, as there may well be a distinction between what people think they do, and what they actually do.

The same criticism could be applied to the measures of training factors employed by this study in that they were participants' views of their teaching and supervision in the various approaches, as opposed to a measure of the actual content of teaching programmes and clinical placements. A closer understanding of the relationship between training and preference for orientation might be gained from such an analysis. Additionally, being cross-sectional in nature, this study cannot answer the key question of whether individuals can be meaningfully trained in theoretical approaches dissonant to that which they are perhaps predisposed to take up by their personality and philosophical worldview. For instance, can the experience of an inspirational supervisor practicing a particular model influence a trainee's orientation in addition to their personality or philosophical worldview? Or are trainees doomed to an unhappy time on a training course or clinical placement where the dominant therapeutic orientation is dissonant to that related to their personality and worldview? Further research utilising a longitudinal design is necessary to answer these questions.

Notwithstanding these limitations, the findings of the current study further highlight the potential importance in training psychologists of considering the relationship between personality and philosophical standpoint, and preference for therapeutic orientation. As a way of ensuring congruence between the individual and what the

training course offers, Scragg et al. (1999) propose the rather extreme possibility of personality assessment during selection for training. However, it is probable that individuals gravitate towards those trainings consonant with their views, but as Poznanski and McLennan (2003) suggest, teaching departments should at least clearly espouse their theoretical allegiance to help prospective students decide. It appears to be important that training institutions offer a theoretically pluralistic training, and show flexibility in terms of recognising the different needs trainees might have in terms of types of teaching and clinical placements. During training, it would seem incumbent on training institutions to help trainees become more aware of the links between their personalities and philosophical worldviews and the various theoretical models, and explore the implications therein (Lyddon & Bradford, 1995), something conspicuously lacking in clinical psychology training in the UK. A further implication in terms of training resulting from the present study is the suggestion of a temporally evolving pattern of need, suggesting that training programmes might benefit from an early focus on didactic teaching, models and specific techniques, with a gradual move towards more personally reflective, experiential teaching.

In terms of the wider implications of this research, it has been suggested previously that the argument over evidence-based treatments has caused something of a split in the profession, and that one implication of the relationship between therapeutic orientation and personal philosophy is that this split is unlikely to be resolved (Poznanski & McLennan, 2003). It has also been pointed out that this may present something of a problem for attempts to integrate different therapies and developing multi-disciplinary team working (e.g. Arthur, 2001; Schacht & Black, 1985). In

addition, a growing area of interest within clinical psychology has been the use of the client's personality traits to plan treatment (e.g. Harkness & Lilienfeld, 1997), and one could speculate that this endeavour might be improved through some consideration of the therapist's personality, i.e. matching with the client's. The approximately equal distribution of eclectic and 'pure' approaches within third year trainees in the current study is of also note with regard to the point made in the opening remarks of this study concerning the decline of eclecticism (Milan et al., 1994; Patterson, 1989), suggesting that within a population of UK trainee clinical psychologists, this may not be the case.

In summary, it was argued in the introduction to this study that preference for therapeutic orientation is commonly regarded as an intellectual decision made on the basis of the available evidence, or what appears to be most suitable for the client and their difficulties. However, the present study confirmed the implication from previous findings that the development of an individual's preferred way of working is likely to result from the complex interaction of factors relating to the person of the therapist and training experiences. Given that our choice of orientation dictates the type of treatment a client receives, and in some sense the treatment involves an implicit or explicit conveyance of the values and beliefs attached to that model to the client, an acknowledgement and ownership of our allegiances and prejudices would seem to be of importance.

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PART 3:

CRITICAL APPRAISAL

Introduction

The purpose of this section is to explore the origins of the research questions, before further addressing methodological issues surrounding sampling, design and measurement, including suggestions for future research. It concludes with a commentary on the importance of reflexivity with regard to preferences for therapeutic orientation, and includes some comments from participants.

Reflecting on the process of conducting this project, it is first worth returning to its origins. During the process of applying to train as a clinical psychologist, I recall being excited at the prospect of a training that involved multiple therapeutic models, unlike other model-specific trainings such as psychotherapy and family therapy. Like most prospective trainees, my answer to the question on the application form asking, "*What should be the role of a clinical psychologist?*" included a statement to the effect that the clinical psychologist is able to select from a variety of therapeutic models on the basis of the empirical evidence and a particular client's difficulties. On commencing training, I was fortunate that my first clinical placement involved working within four different therapeutic modalities (CBT, psychodynamic, person-centred and cognitive-analytic therapies), with specialist supervision in each. However, it quickly became apparent that, rather than each clinical psychologist selecting from several approaches, each seemed to be strongly allied to one approach, and not only seemed to exclude other approaches but often to denigrate them. Treatment choice seemed to be based less on the evidence base and the particular difficulty a client was experiencing but more on the approach to therapy preferred by the clinician. Thus an incongruity was apparent between the explicit narratives within clinical psychology of the evidence based practitioner and

flexibility of the clinician and what I had experienced on placement. At the end of the placement one of my supervisors asked me how I had found the experience of working in multiple approaches, and which model I had preferred. I answered that I had found parts of all of the models useful and could see myself perhaps developing an eclectic approach to practice, only to be told that in my supervisor's opinion, being truly eclectic was impossible. I recall being quite shocked at this response.

My early impression that clinical psychologists in practice were often quite rigid in their adherence to one particular model and exclusion of alternatives was confirmed by subsequent placement experiences. Moreover, this did not seem to be confined to my experience, as what essentially amounts to petty squabbling can often be seen between practitioners of differing orientation (e.g. Cohen, 1977) and is even played out in the more public domain of the wider media (e.g. *The Observer*, 19th Feb 2006). Given the emotional investment evident in these arguments, some authors have even gone as far as to portray the apparently fanatical allegiance to particular therapeutic orientations to a kind of quasi-religious sectarianism (e.g. Adams, 1984). As I developed as a clinician, I found that I too was more strongly drawn to a particular orientation (psychodynamic therapy), and that other models somehow failed to resonate with me personally. I began to wonder what psychological processes underpinned these observations, and why the reality appeared so different to the prevalent professional narratives concerning the evidence base and selecting a treatment to fit the client and their difficulties. Increasingly I viewed this as an important area for self-reflection, especially given that my choice of intervention for a client would essentially form the framework for the client to understand themselves, others and their world, and with each model a different set of underlying

beliefs and values is imparted, knowingly or otherwise (Arthur, 2000). It was from these experiences that I gained the impetus and motivation for this research project.

The research process

On commencing a search of the literature and discussing my embryonic ideas with several college tutors, it was apparent that little empirical research had been carried out in this area. Interestingly, despite some interest generated in discussions with tutors and colleagues, there was an equal amount of scepticism, as though researching a topic such as this was not "proper" research, and that it would have no clinical validity. This further supported my idea that clinical psychologists were not fully reflective on the process of developing a therapeutic orientation to practice. The initial literature review found that the most commonly researched factors were those of personality and philosophical worldview, with a very small literature on the influence of training and life experiences. My suspicions that preferences for therapeutic orientations were linked to something about the person of the individual practitioner had been confirmed, and an additional question had now been generated. Were one's preferences entirely to do with personality characteristics and philosophical standpoint or could training experiences in particular orientations still exert an influence, given that personality is believed to be relatively stable over time in adults (Costa & McCrae, 1994)? The study aimed to answer this question, and also to replicate previous findings with regard to the relationship between personality, philosophical standpoint and training, and therapeutic orientation, as the existing literature was thin. Additionally, the initial phase of planning the project had uncovered Stoltenberg and Delworth's (1987) model of the development of therapeutic orientation, and I became interested in testing the model, as its major

tenet that individuals start out narrow in their approach to therapy and gradually become more flexible appeared to run contrary to my observations.

Sampling

The decision to investigate these questions within a sample of trainee clinical psychologists in the UK was based on the grounds that no study had to date investigated the relationship between personality, philosophical beliefs, training experiences and therapeutic orientation in this population. To assess these questions during training also seemed a better way to assess how individuals develop an orientation than in a sample of individuals who have been qualified for many years and may be far removed from their original influences. It would also be possible to assess Stoltenberg and Delworth's (1987) model as the sample would hopefully convey something of a pattern of change between first year trainees and those in their third year. Additionally, trainee clinical psychologists would be relatively easy to recruit, which would be important given the time constraints of this project.

In retrospect, it would have been preferable to have not had to rely on the two separate recruitment methods for trainees on my course and those on others, as this was most likely responsible for the higher response rate amongst trainees from the author's course. As the theoretical emphasis of courses is known to vary, and hence it might also be said the type of clinical placements trainees undertake reflects this, the difference in response rates amongst courses may have introduced a confounding factor related to the type of experiences trainees have been exposed to. This hypothesis was in part confirmed by a comparative analysis of twenty key variables used in the study (see Table 1). T-tests found significant differences between

trainees recruited from the same course as the author and those from other courses on three of the variables: overall preference for psychodynamic therapy, course emphasis in psychodynamic therapy, and Rational-Intuitive beliefs about therapy. Trainees from the same course as the author had a greater preference for, and course emphasis in psychodynamic therapy, and more Intuitive beliefs about therapy. However, this was not deemed a significant problem for the current study in that there were no between group analyses, though future research might benefit from a sample drawn from only one training institution, to control for relative exposure to different models. A further solution to overcome this problem would be an actual measurement of the content of teaching on courses and the orientation of supervisors, as opposed to a participant self-rating. Previous studies (e.g. Nevid, Lavi & Primavera, 1987) have used course director ratings for this purpose, however this method may be limited by a wish to portray theoretical open-mindedness.

Table 1.

Course differences in psychodynamic orientation

	AUTHOR'S COURSE (N=81)		**OTHER COURSES (N=61)**		**t (*df*)**
	M	**SD**	**M**	**SD**	
PSYD	3.37	0.92	2.79	0.89	3.78 (140)**
PSYD course	3.07	0.67	2.20	0.73	7.47 (140)**
R-I	62.5	11.57	71.72	12.02	-4.61 (140)**

Note: PSYD = overall preference for psychodynamic therapy, PSYD course = course emphasis in psychodynamic therapy, R-I = Rational-Intuitive subscale of the CTPS.

** = significant at $p < 0.001$ (2-tailed).

Design

Pragmatism dictated that the design of the study had to be cross-sectional. However, as discussed in the empirical paper, without time constraints a longitudinal study would have been preferable, as it would have enabled an investigation into the question of whether individuals arriving on training courses with a certain personality and philosophical standpoint could meaningfully be taught therapeutic approaches with dissonant underlying values. Ideally, the study would have assessed individuals' personality, philosophical beliefs, pre-training clinical and academic experiences, and their preferences for therapeutic orientation prior to the commencement of clinical training, repeating these measurements at the end of each year of training, with care taken to also assess the type of training experiences that may be related to any changes in orientation during training.

Measurement

In terms of the selection of variables to investigate, I decided to investigate the factors most researched previously: personality, philosophical beliefs, training experiences and personal therapy. Eventually the project became focussed on the question of personality versus training, and as such personal therapy was excluded from the analyses as it did not contribute anything original. In retrospect, I think I have learnt to try and make research questions more focussed early on in the process, as there was quite a lot of data I collected that was eventually excluded from the analyses.

With regard to measurement, well-established scales of personality (the NEO: Costa & McCrae, 1992) and philosophical worldview (the OMPI: Germer, Efran &

Overton, 1982) were available, however the measurement of training experiences and therapeutic orientation were more problematical. It was decided to construct a measure for the purposes of the study (the TOES) to assess these factors. Of particular note were the comments of previous researchers that the "school" approach to measuring therapeutic orientation is limited (Sundland, 1977) and that a measure incorporating only a therapist's stated orientation may give an incomplete or inaccurate representation of their beliefs about therapy (Poznanski & McLennan, 1999). It was therefore decided to pay particular attention to the careful measurement of therapeutic orientation, as this was the key dependent variable in the analysis, and include several measures, both quite direct (in the TOES) and indirect (in the CTPS). With the benefit of hindsight and the knowledge that the two different measures were strongly related, it may have been possible to rely solely on the measures of orientation provided by the TOES. The TOES did not measure simply "school" of orientation but the extent to which participants identified with three major schools of therapy, and as such gave a more robust indication of individuals' allegiances than the measures criticised by Sundland (1977) and Poznanski and McLennan (1999).

Furthermore, the results of the questions on the TOES concerned with orientations further to the main three under consideration provided support for the decision to select only CBT, psychodynamic and systemic therapies for investigation. Under half of participants identified with further orientations other than the main three under investigation, with about a third having experienced further orientations in their teaching, and half citing further orientations they had been exposed to on clinical placement. The vast majority of these further orientations were variants of

the main three schools. For example, narrative, solution-focussed and social constructionist therapies are usually associated with systemic practice, and schema-focussed, dialectical behavioural, behavioural, mindfulness, acceptance and commitment therapies with CBT. The further orientation most cited by participants was cognitive-analytic therapy, which itself is explicitly an integration of the more structured aspects of CBT with the focus on the therapeutic relationship and transference from psychoanalytic therapy. Given the quantity of space within the measures pack devoted to assessing therapeutic orientation both within the TOES and CTPS, it may have been the case that limiting the assessment of orientation to just the three main orientations within the TOES would have enabled the space to be more usefully occupied by a measure of a further factor found to relate to preference for orientation such as attachment style (Leiper & Casares, 2000) or life experiences (Poznanski & McLennan, 2003, 2004).

Conclusion

The central question of this investigation concerns what influences clinical practice, and more specifically that our preferences for therapeutic orientation and the factors underlying them are not reflected upon adequately, given the importance of treatment selection within clinical psychology. The fact that this is a relatively under-researched area confirms this suspicion, and further compelling evidence for this was provided by several unsolicited comments from participants:

"It asked me questions I hadn't specifically asked myself but was grappling with"

"Often I see myself as more eclectic and open-minded than I realised I am after completing the questionnaires, when I realised that I do fall down on one side of the fence more than the other"

"We should think about things like this more in our training"

More worrying in terms of the reflexivity of the clinical psychologist were comments such as:

"Some of these questions are far too philosophical for me to engage in"

"I'm not sure what this has got to do with why I work the way I do"

These remarks concerned the *Counsellor Theoretical Position Scale* (CTPS: Poznanski & McLennan, 1999: See Appendix 5), which includes statements such as "*Unconscious motives should be considered as essential aspects of psychological theory*" and "*Human beings need to know meanings rather than simply factual information*". Although I'm sure these two participants were in the minority, the comments show that whilst clinical psychologists can go some way towards understanding the motivations of others, they sometimes fail to do so with regard to themselves. Cohen's (1977) interview-based study of eminent psychologists of different schools found that "Few of the psychologists were very forthcoming when it came to discussing their own motivations, not so much because of reticence as because of the fact, it seemed to me, that it was an odd question for them" (p. 9). During recruitment for the present study, there seemed to be something

uncomfortable for some trainees in contemplating another trainee asking questions such as those posed by this research, and this was exemplified by an extremely suspicious reaction to the study by one year group on one course, reported to me by a member of this group. A discussion apparently ensued in which my motivations for investigating this area were called into question, and some went as far as to label the study as unethical. Although this made the process of conducting the research at times uncomfortable, I remained convinced of the importance of a fuller understanding of the factors influencing our preferences for therapeutic orientation. The findings of the literature review and empirical study show that questions regarding our preferences for therapeutic orientation should be asked not as an academic matter, but as part of appropriate reflective practice, in order that we can serve our clients in the most informed way possible. Moreover, some consideration of the issues raised by this project and previous research could be usefully incorporated into the training of clinical psychologists. Our preferences for therapeutic orientation are not just based on the available evidence or what may suit the client but on what suits us as individuals. As Cohen (1977) puts it, "A psychologist's personality must be reflected in some way in the manner he treats of Man" (p. 9).

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Appendix 1 – Information sheet given to participants

(N.B. the author's contact details have been removed)

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE

LONDON

GOWER STREET LONDON WC1E 6BT

Participant Information sheet

Factors associated with trainee clinical psychologists' preferences for therapeutic orientations

(Approved by University College London's Committee on the Ethics of Non-NHS Human Research)

You are invited to participate in a study of factors associated with trainee clinical psychologists' preferences for therapeutic orientation. Clinical psychologists are often trained in several different approaches, and there are a variety of influences on an individual's preference for the way they work psychotherapeutically. This study aims to investigate the relative importance of several different factors, and be informative both in terms of training clinical psychologists, and in highlighting to clinicians the factors which may be involved in their preference for way of working.

Participation involves a one-off, roughly 30-minute session in which you will be asked to complete several questionnaires relating to your preferences for therapeutic orientation and yourself more personally. Participation in the study is voluntary, and refusal to participate involves no penalty or loss of benefits to which you are otherwise entitled. If you do choose to participate, you are free to withdraw from the study at any time, with no penalty or loss of benefits to which you are otherwise entitled. There are no foreseeable risks or discomforts to participants. All data collected will be confidential.

The data in this study will be collected and stored in accordance with the Data Protection Act (1988). It will be retained until the study has been completed (approximately September 2006) and will be subsequently disposed of in a secure manner. The results will be submitted as part of my Doctorate in Clinical Psychology thesis, may be published in a journal, and may be used for subsequent research.

If you have any questions relating to the research, or concerns about participation, please contact Joe Buckman (details above).

If you do agree to participate, please turn over the page and complete the attached consent form. You may detach and keep this information sheet.

Version 4, 18.1.06

Appendix 2 – Ethical approval letter

The Graduate School
University College London
Gower Street London WC1E 6BT

Head of the Graduate School

Tel:
Fax:
Email:

26 July 2005

Sub-Department of Clinical Health Psychology

Dear Professor

Re: Notification of Ethical Approval

Project ID: 0513/001: Factors associated with trainee clinical psychologists' preference for theoretical orientation

The above research has been given ethical approval following review by the Chair of the UCL Committee for the Ethics of non-NHS Human Research for the duration of the project subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The form identified can be accessed by logging on to the ethics website homepage: http://www.grad.ucl.ac.uk/ethics/ and clicking on the button marked 'Key Responsibilities of the Researcher Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

   Reporting Non-Serious Adverse Events.
   For non-serious adverse events you will need to inform Ms , Ethics Committee Administrator , within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Reporting Serious Adverse Events
The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

3. On completion of the research you must submit a brief report (a maximum of two sides of A4) of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

With best wishes

Yours sincerely

Chair of the UCL Committee for the Ethics of Non-NHS Human Research

Cc: , Sub-Department of Clinical Health Psychology, UCL

Appendix 3 – Informed consent form

(N.B. the author's contact details have been removed)

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE

LONDON

GOWER STREET LONDON WC1E 6BT

Informed Consent Form

Factors associated with trainee clinical psychologists' preferences for therapeutic orientations

	YES	NO
Have you read the participant information sheet?		
Has the project been explained to you orally?		
Have you had the opportunity to ask questions and discuss the study?		
Have you received satisfactory answers to all your questions?		
Have you received enough information about the study?		
Do you understand that you are free to withdraw from the study without penalty at any stage?		
Do you understand that the results of this study may be published in a journal?		

Comment or concern during the study

If you have any comments or concerns you should discuss these with Joe Buckman (contact details above). If you wish to go further and complain about any aspect of the way you have been approached or treated during the course of the study, you should contact the Chair of the UCL Committee for the Ethics of Non-NHS Human Research (Sir J. Birch), or send a letter to: The Graduate School, North Cloisters, Wilkins Building, UCL, Gower Street, London WC1E 6BT who will take the complaint forward as necessary.

Signed:.....
Date:.....

Full name in capitals:.....

Signature of researcher:.....
Date:.....

Version 4, 18.1.06

Appendix 4 – Therapeutic Orientation and Experiences Survey (TOES)

Therapeutic Orientation and Experiences Survey

This questionnaire assesses your views on different therapeutic orientations to psychological therapy and your experiences both clinically and during training of a variety of approaches.

Please respond to the questions by circling one of the following numbers:

1 = not at all 2 = a little 3 = somewhat 4 = moderately 5 = very much

---

1) To what extent do you agree with the basic principles of cognitive-behavioural therapy?

not at all **1 2 3 4 5** *very much*

2) To what extent does cognitive-behavioural therapy appeal to you personally?

not at all **1 2 3 4 5** *very much*

3) How much do you envisage using cognitive-behavioural therapy when you qualify?

not at all **1 2 3 4 5** *very much*

---

4) To what extent do you agree with the basic principles of psychodynamic therapy?

not at all **1 2 3 4 5** *very much*

5) To what extent does psychodynamic therapy appeal to you personally?

not at all **1 2 3 4 5** *very much*

6) How much do you envisage using psychodynamic therapy when you qualify?

not at all **1 2 3 4 5** *very much*

---

7) To what extent do you agree with the basic principles of systemic therapy?

not at all **1 2 3 4 5** *very much*

8) To what extent does systemic therapy appeal to you personally?

not at all **1 2 3 4 5** *very much*

9) How much do you envisage using systemic therapy when you qualify?

not at all **1 2 3 4 5** *very much*

---

10) How much does your course emphasise cognitive-behavioural therapy?

not at all **1 2 3 4 5** *very much*

11) How much does your course emphasise psychodynamic therapy?

not at all **1 2 3 4 5** *very much*

12) How much does your course emphasise systemic therapy?

not at all **1 2 3 4 5** *very much*

---

13) How much has your placement supervision exposed you to cognitive-behavioural therapy?

not at all **1 2 3 4 5** *very much*

14) How much has your placement supervision exposed you to psychodynamic therapy?

not at all **1 2 3 4 5** *very much*

15) How much has your placement supervision exposed you to systemic therapy?

not at all **1 2 3 4 5** *very much*

---

16) Have any further therapeutic orientations stood out in your teaching?

YES NO

17) If so, please describe briefly:

18) Have you been exposed to any further therapeutic orientations on placement?

YES NO

19) If so, please describe briefly:

20) Do you identify with any other therapeutic orientations?

YES NO

21) If so, please describe briefly:

22) Please state your preferred orientation(s), and briefly describe what the main influences were in the development of your preferred standpoint (if any):

23) Have you (either in the past or currently) been in personal therapy?

YES NO

24) If so, how beneficial did you find it?

not at all **1 2 3 4 5** *very much*

25) Briefly describe the therapeutic orientation of the therapy/ therapist:

Please rate the statements below on the extent to which you agree or disagree by circling one number where:

1 = strongly disagree *2 = disagree* *3 = neutral* *4 = agree* *5 = strongly agree*

---

26) When qualified, I will always select a therapeutic orientation for an intervention that is suited to the client.

not at all **1 2 3 4 5** *very much*

27) My work as a qualified clinical psychologist will always be based on the available evidence base.

not at all **1 2 3 4 5** *very much*

28) My preference for therapeutic orientation is influenced by who I am and the experiences I have had.

not at all **1 2 3 4 5** *very much*

Appendix 5 – Counsellor Theoretical Position Scale (CTPS)

(Poznanski & McLennan, 1999)

Counsellor Theoretical Position Scale

The following statements represent a range of theoretical and procedural views expressed by psychological therapists. Please indicate the extent of your agreement or disagreement with each statement by circling one of the following numbers for each statement:

1	*2*	*3*	*4*	*5*	*6*	*7*
strongly disagree	*moderately disagree*	*somewhat disagree*	*neither agree nor disagree*	*somewhat agree*	*moderately agree*	*strongly agree*

---

1) Unconscious motives should be considered as essential aspects of psychological theory.

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

2) Unconscious motivation is a very important aspect of human behaviour.

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

3) The emotional process in psychological therapy is a vital agent of change.

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

4) Interpretation of symbolic meaning enables illumination of the depth of human experience.

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

5) The concept of unconscious processes is of limited therapeutic value.

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

6) I generally prefer to practice a goal-directed approach to psychological therapy.

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

7) Understanding a client's childhood is crucial to therapeutic change.

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

8) **Psychological therapy should focus on "here-and-now" experiences: there is no need to focus on the client's past.**

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

9) **Human beings need to know meanings rather than simply factual information.**

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

10) **It is essential to focus on feeling and meaning as communicated by the client.**

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

11) **People can learn effective coping skills without necessarily having to go into the depths of their private experience.**

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

12) **Introspective and intuitive methods in psychological therapy are more useful than explanations which do not go beyond observable behaviour.**

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

13) **Self-knowledge deepens our understanding of life.**

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

14) **An effective clinical psychologist demonstrates sensitivity and personal involvement towards the client.**

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

15) **Careful re-examination by a client of his/ her personal history can alter the client's present emotional life.**

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

16) **It is important for a clinical psychologist to feel strong personal and emotional involvement with a client.**

strongly disagree **1 2 3 4 5 6 7** *strongly agree*

17) Search for meaning and wholeness in life is the essence of human existence.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

18) Establishing a client's awareness of his/her own emotions and desires is a beneficial therapeutic outcome in itself.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

19) Clinical psychology is much more an art than a science.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

20) Clinical psychologists usually take on an active role in structuring the interview.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

21) Emotional stability is a product of one's logical and consistent thinking behaviour.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

22) Cognition is the most powerful factor in determining experience.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

23) An understanding of the reasons for one's behaviour is crucial to behavioural change.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

24) Knowledge is valid only if it is based on logic and/ or reason.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

25) Irrationality is the fundamental cause of psychological dysfunction.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

26) Clients need to be guided and given information in order to achieve their therapeutic goals.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

27) Improving the client's level of social adjustment ought to be the main therapeutic aim.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

28) Clinical psychologists should maintain a detached and objective approach during psychological therapy interviews.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

29) It is unwise for a clinical psychologist to respond to a client in a spontaneous, not thought-through manner.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

30) Any claimed mental process can be translated into a statement describing observable behaviour.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

31) Valid information comes only from empirical research.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

32) Nothing is true if it is illogical.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

33) The brain is the prime mover in human social development.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

34) Logical analysis and synthesis of information is crucial to one's survival.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

35) Emotional involvement by a therapist defeats the purpose of therapy.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

36) Intense negative emotions are manifestations of unrealistic and non-logical cognitions.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

37) It is preferable that a clinical psychologist remains personally uninvolved in the therapeutic relationship.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

38) Specific training in psychological therapy techniques is vital to therapeutic outcome.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

39) Perceptions define human experience.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

40) Higher intellectual processes over-ride more primitive functions of feeling and behaviour.

strongly disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	*strongly agree*

Appendix 6 – Organicism-Mechanism Paradigm Inventory

(OMPI)

(Germer et al., 1982)

Organicism-Mechanism Paradigm Inventory

This is a questionnaire about how people relate to their world. Listed below are pairs of statements concerning thoughts, attitudes and ways of behaving.

Please read each statement carefully and circle the one which pertains to you more closely. No statement is more correct than the other.

1.
a) Schools should be where a child learns to think for him/herself.
b) Schools should be where a child learns basic information.

2.
a) Things really look different if we change how we see them.
b) Things really look different only if they are changed.

3.
a) Organisms change by forces from outside themselves.
b) Organisms can change themselves.

4.
a) A good judge is purely objective.
b) A good judge is not objective and knows it.

5.
a) Great discoveries come from scientific imagination.
b) Great discoveries come from scientific experimentation.

6.
a) All things stay basically the same over time.
b) All things change from one moment to the next.

7.
a) A business executive needs time to analyse the facts.
b) A business executive needs time for creative thinking.

8.
a) Before making a big decision, I like to sleep on it.
b) Before making a big decision, I like to get all the information.

9.
a) Progress in science occurs when there is a new way of looking at events.
b) Progress in science occurs when an important observation is made.

10.
a) A criminal is just a burden to society.
b) A criminal has a function in society.

11.
a) Our knowledge is limited by our observations.
b) Our knowledge is limited by our imagination.

12.
a) Living is a process of using up the available supplies.
b) Living is a process of exchanging supplies back and forth.

13.
a) Events are sometimes just the same as before.
b) Events are always new and different in some way.

14.
a) Divorce is often a phase in each partner's growth.
b) Divorce is usually the result of incompatible personalities.

15.
a) Facts are more useful than a good idea.
b) Facts are less useful than a good idea.

16.
a) Each relationship I have is different.
b) Each relationship I have is much like the previous one.

17.
a) Things are changed only when they are directly affected.
b) Things are changed by everything else.

18.
a) We learn by carefully examining individual facts.
b) We learn by finding order in an array of facts.

19.
a) To live independently of other people is not a realistic goal.
b) To live independently of other people is a realistic goal.

20.
a) War can be understood by examining what purpose it served.
b) War can be understood by examining its causes.

21.
a) The world is like a large, living organism.
b) The world is like a large, complex machine.

22.
a) A child discovers the world by being praised and punished.
b) A child discovers the world by testing his/ her dreams and fears.

23.
a) I can change things in my family only by planned action.
b) I can change things in my family just by being who I am.

24.

a) A child's world is different than mine.

b) A child's world is like mine, but he/ she knows less.

25.

a) Man is made by his/ her environment.

b) Man and his/her environment affect each other.

26.

a) To resolve a family dispute, it is important how we look at the facts.

b) To resolve a family dispute, it is important to discover all the facts.