

THE ROLE OF PERSONALITY FACTORS AND ATTACHMENT
STATUS IN THE SELECTION AND TRAINING OF
PSYCHOLOGICAL THERAPISTS:
A PSYCHOANALYTIC APPROACH

AVIYA SHMUELI

Thesis submitted for the degree of Doctor of Philosophy

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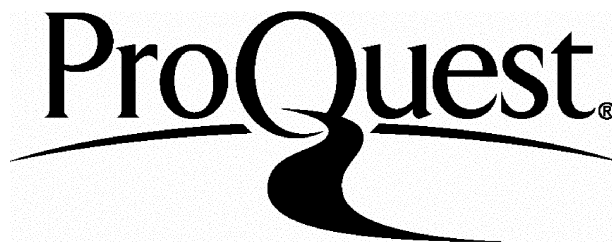
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ABSTRACT

This thesis investigated the role of personality and attachment organisation in the selection and training of psychological therapists from a psychoanalytic perspective. Six studies were therefore planned following an initial review of both the clinical and empirical literatures. The empirical literature was shown to increasingly recognise the significance of the individual therapist but to have neglected the therapist as a variable in psychotherapy research. The clinical literature indicated a history of failed attempts to arrive at empirical measures that could aid assessors in their difficult task. The available literature was therefore resplendent with measures that lacked coherent grounding in theory and adequate empirical operationalisation.

Subsequently, the central tenets of attachment theory were reviewed and recent developments in methodology, namely the development of the Adult Attachment Interview, shown to have the theoretical grounding and empirical properties required for use in examining the selection and training of psychological therapists.

Four studies subsequently assessed the selection of therapists using measures of attachment, personality, and other aspects of functioning such as theoretical orientation. Uniquely, measures were obtained on both applicants and assessors. The first study focussed upon the applicant, assessing whether successful application was a function of non-attachment related aspects of the applicant alone. The second study focussed upon the person of the assessor independent of the applicant whilst the third study focussed upon the 'fit' between applicant and assessor. The fourth study examined the attachment status of both applicant and assessor as a predictor of applicant success in application. Overall, the empirical results were found to broadly support the existing qualitative literature. Additionally, the results indicated that applicant selection was related to the interaction of attachment organisations of both the applicant and assessor.

The training of therapists was examined using ratings of competency by supervisors correlated against measures of both attachment and personality. Once again aspects

of attachment organisation were noted to be associated with increased competency although a direct relationship between security and competency was suggested rather than proven. Both attachment organisation and personality were associated with ratings of competency. A pilot prospective study showed that secure attachment alone predicted psychologists' subjective sense of reward in working with patients across all degrees of disturbance.

The studies limitations were discussed and future recommendations made.

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CHAPTER 1. THE RISE OF THE INDIVIDUAL PSYCHOTHERAPIST.

1.0 Introduction.

Over the last four decades, there has been a huge growth in the number of published research studies on psychotherapeutic interventions (Imber,1992; Omer, 1992). This growth could be traced back to Eysenck's now much criticised study (Eysenck, 1952) which suggested that not only were all psychotherapies equivalent, but that some were even detrimental to the patient. While many of the criticisms of Eysenck's study were methodological, e.g., Bergin and Lambert (1978), the study itself began a research trend toward finding specific factors which operated within the therapeutic situation and which predicted outcome. Strupp (1986) described this drive for specificity as aiming to,

“Describe more stringently, patients, therapists, techniques, outcomes and other pertinent variables”.

It was embodied in the now often quoted statement by Paul (1967),

“What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances”.

Years before, and based on his view of the pervasive nature of common factors in diverse methods of psychotherapy, Rosenzweig (1936) now famously predicted that there would only be a trend of relatively small differences from comparisons or outcomes of different treatments. This he termed the “Dodo Verdict” following the Dodo’s judgement of a race in Lewis Carol’s Alice in Wonderland that “everybody has won and all must have prizes”.

The Dodo verdict was subsequently reported by Luborsky, Singer and Luborsky (1975) following an examination of 100 comparative treatment studies which was in agreement with Rosenzweig’s prediction. The different treatments produced very

similar results and it appeared that the Dodo Verdict had received very powerful empirical support. To the present day it has remained a powerful finding, replicated on numerous occasions (Beutler, 2002). Luborsky et al (2002) in fact, reported a further study of seventeen meta-analyses of comparisons of active treatments as opposed to the more usual comparison with control groups. They argued that this was a superior study for four reasons. Firstly, that the procedure of a meta analysis could account for the different sample sizes of each participating study and the effect size of the treatments compared in each study. Secondly, that the use of studies comparing active treatments was preferable given that the background variables for the patients in each treatment would be more likely to be comparable. Thirdly, only those meta-analyses were included in which the studies used 'common' psychiatric disorders such as depression and anxiety disorders. Fourthly, only those meta-analyses were included in which 'common' types of therapy were used such as behaviour therapy, cognitive therapy and 'dynamic therapy'. Luborsky et al's primary result was to report an overall absolute effect size for Cohen's d of 0.2, which they proudly state is not significant. They concluded therefore that the Dodo Verdict remained 'alive and well'.

However, more recently, the Dodo Verdict has come under sustained criticism. This has arisen from three principle sources. Firstly, a questioning of the methodology upon which the Dodo Verdict rested. Secondly, the consistent if inadvertent findings of the influence of the individual therapist on the outcome of therapy, and thirdly, the recognition of the limitations of attempts to cancel out the factor of the therapist in the form of the manualisation of therapies. Each of these criticisms will now be briefly reviewed.

1.1 Criticisms of the Dodo Verdict Methodology.

Beutler (2002) noted how the Dodo Verdict has become a tautology in which the collapsing of hundreds of different types of psychotherapy patients and procedures into small numbers of patients and procedures is justified by the Dodo Verdict but inevitably leads once more to the Dodo Verdict. Beutler (2002) highlighted the

methodological flaws of the methodology producing the Dodo Verdict, categorising these into three classes. Firstly, the collapsing of all outpatients with no regard for factors such as personality and psychopathology into one group. Secondly, the illegitimate assumptions that two therapies sharing a common theoretical base and describing similar treatment processes are functionally equivalent. Luborsky et al (2002) for example, collapsed transpersonal, systemic, client-centred, experiential, and existential therapies into one group under the label of “dynamic”. Thirdly, that it is incorrect to assume that the actions of the therapist make little difference to outcome. Chambless (2002) added to these criticisms by highlighting the erroneous assumption made in the methodology giving rise to the Dodo Verdict that the mean difference between all sorts of treatments for all sorts of problems can be assumed to represent the difference between any two types of treatment for a given problem. She additionally criticised the exclusion of research on certain types of patients such as children and adolescents and that the generalisation of the Dodo Verdict had been extended to comparisons of treatments that had not been compared in the original studies. Rounsaville and Carroll (2002) criticise the Dodo verdict on the basis that that it pays too little attention to the issues of matching between patient and therapist and that the many design constraints concerning the efficacy of treatments reduce the likelihood of detecting large effects across active treatments. Therefore, rather than be a genuine finding, the Dodo Verdict represents more of a ‘default’ finding.

1.2 Evidence for the Influence of the Individual Therapist in Psychotherapy Outcome.

Reviewers are virtually unanimous in their opinion that the therapist-patient relationship is critical for positive outcome and that at least some of the relationship is a function of the therapist attitudes and behaviours (Weinberger, 1995). Such firm conclusions are themselves based on a growing body of empirical evidence as to the importance of the individual therapist.

Ricks (1974) published a unique follow-up study, based upon a naturalistic design, in which adolescent boys who had experienced severe problems of anxiety, vulnerability and dissociation were reassessed in adulthood. The whole sample of boys had been seen by only two therapists and at follow-up no significant differences were found between the boys who were less disturbed. However, for the more disturbed adolescents, striking differences emerged dependent upon which of the two therapists the boys had seen. Therapist A was highly successful with the more disturbed adolescents. He invested more time with the boys and made use of resources outside of the immediate therapeutic situation, was firm and direct with parents, implemented problem solving skills in patients everyday lives all within the context of a strong therapeutic relationship with his patients. By contrast, and based on case notes, Ricks (1974) suggested that Therapist B seemed frightened by his patients and tended to withdraw. Comments attributed to Therapist B suggested that he became overwhelmed by his patients' hopelessness and depression and therefore tended to therefore to become pessimistic regarding their future.

The difference between Therapist A, nicknamed "supershrink" by one of the boys, and Therapist B, nicknamed "pseudoshrink" in a subsequent review (Bergin & Suinn, 1975), become strikingly apparent at follow-up. From baseline equivalence in level of disturbance, 27% of therapist A's patients were diagnosed as schizophrenic in adulthood whilst 87% of Therapist B's patients were so diagnosed in adulthood. As Rick's (1974) concluded,

"A's Supportive ego strengthening methods produced much more profound changes than the methods of therapist B, who moved too precipitously into presumably deep material....The children considered here were already experiencing nearly intolerable degree of anxiety, vulnerability, feelings of unreality, and isolation, When the therapist increased those feelings, without helping the boy develop ways of coping with them, he may well have played a part in the subsequent psychotic developments. Therapy may lead one into health, but it may also be a part of the complex process that ends up driving one crazy" (p291).

In discussing Ricks' (1974) study Lambert and Okiishi (1997) comment that the combination of factors contributing to the style of therapist B may in fact have caused the overall deleterious effect.

The influence of the therapist alongside the difficulties in specifying the active elements in considering the therapist as a specific variable were strikingly, if inadvertently illustrated by Miller et al (1980). Using a group modality, these researchers compared the efficacy of bibliotherapy versus behaviour therapy for problem drinkers. Bibliotherapy produced a 60% success rate, while the success rate amongst the therapists ranged between 25% and 100%. The authors subsequently reported a correlation of 0.82 between what they considered therapist empathy and success rate.

In a retrospective evaluation of case files Orlinsky and Howard (1980) completed outcome ratings on 143 female patients who had received 'traditional' verbal psychotherapy from 23 psychotherapists. Psychotherapists were subsequently selected into two groups, those with whom at least 70% of patients showed improvement and none had deteriorated and those with whom a maximum of 50% of cases improved in addition to at least 10% of cases becoming worse. Using the above criteria, six 'effective' therapists were identified as opposed to five 'ineffective' therapists. Methodological limitations undoubtedly applied to the design of the study such as the non-random assignment of cases to the therapists, or controlling for degree of severity of disturbance. Nevertheless, the criteria employed by Orlinsky and Howard (1980) would make it difficult for a main effect not to be identified even though the causal mechanisms of such a difference could not be addressed. In their search for specific therapist variables, which predicted outcome, few were discovered. Age and professional degree were ruled out although experience beyond six years was associated with better outcome. The authors therefore suggested that "experienced" therapists achieved better results although also presented data which indicated that even "successful" therapists have differing success with differing patients and that therapists who produced poor results on average, had some success which was subsequently lost in the process of averaging patient improvement. Roth and Fonagy

(1996) have subsequently noted however that the difficulties in defining the concept of “experienced” require very careful attention.

Najavits and Strupp (1994) report a study in which sixteen therapists, eight psychologists and eight psychiatrists were nominated by colleagues as “caring empathic clinicians”. To each therapist five patients were assigned with each rated as being at comparable levels of difficulty and outcome, patient length of stay and in-session behaviour were assessed following 25 sessions. Therapists who had no negative outcomes and had no patients leave therapy prior to session 16 were classified as the most effective therapists. Conversely, “least effective “ therapists were those who had at least one negative outcome case and had at least two or more patients leave their therapy prior to session sixteen. Consequently three therapists were classified as most effective and four classified as least effective although this latter group accounted for six out of the thirteen patients in the sample who had a negative outcome. Most notable to the study was the fact that “non specific” traits such as warmth and understanding accounted for a larger degree of the difference between therapists than did specific technical differences. Lambert and Oshiki (1997) therefore suggested that it is these individual traits rather than the training, which were causal in the differences noted.

Similarly, Luborsky et al (1985) reported the results of a treatment comparison study for opiate dependent males but also analysed the results for the outcome of therapy as a function of the nine individual therapists treating them. The study was intentionally designed to minimise individual differences between therapists. Each therapist was trained to offer one of three selected and manualised treatment regimes; drug counselling alone, drug counselling in combination with supportive expressive psychotherapy, or drug counselling in combination with cognitive behavioural psychotherapy. Furthermore, each of the nine therapists had supervision for the course of the study in addition to having their work monitored. The overall result of the study was somewhat in keeping with the earlier Dodo Verdict (Luborsky et al, 1975) in that all treatment options produced improvement and that drug counselling in addition to either of the two other therapies produced greater change than drug

counselling alone. Strikingly however, substantial differences between therapists both within and between treatment groups were also found. Individual therapist effect sizes were defined and measured as the mean of the overall effect sizes for each patient seen by that therapist. The mean effect size for a patient was itself defined the mean of effect sizes for each of the outcome measures used. Effect size itself was measured as the pre-treatment score minus the post-treatment score divided by pre-treatment standard deviation. Considering the therapists as a group, and irrespective of treatment conducted, the average effect-size for therapists ranged from 0.13 to 0.74. The largest difference in effect-size for different therapists within one treatment group occurred within the group of therapists providing the supportive-expressive psychotherapy. Within this group, effect sizes ranged from 0.19 to 0.74.

Luborsky et al (1985) attempted to explain these “profound differences” between therapists by re-analysing the data in terms of therapist qualities but were unable to define outcome enhancing therapist qualities further than “therapist adjustment, skill and interest in helping the patient” and “the quality of the patient therapist relationship”. The difficulty in defining therapist variables was further commented upon by (Lambert, 1989) in reporting Luborsky et al’s (1986) re-analysis of the data of four major previously reported psychotherapy outcome projects in order to compute the variance in outcome accounted for by the therapist. These studies were the Hopkins Psychotherapy Project (Nash et al, 1965) in which four therapists using short-term psychodynamic treatment on a population with heterogeneous disorders, the VA-Penn Psychotherapy Project, which contrasted supportive expressive psychotherapy with cognitive behavioural therapy and drug counselling over a period of six months, the Pittsburgh Psychotherapy Project (Pilkonis et al, 1984) in which nine therapists offered either individual, conjoint, or group therapy, and finally the McGill Psychotherapy Project (Piper et al, 1984) consisting of therapists offering individual or group therapy on either a long- or short-term basis. Luborsky et al (1986) focused upon outcomes for each individual therapist and any therapist-patient matches that had a significant influence upon outcome. The aim of the re-analysis was to separate the amount of the variance in outcome ratings attributable to therapeutic technique versus that attributed to variables linked to therapist characteristics. The

result indicated that, on average, only 1.9% of the variance in outcome scores was explained by therapeutic techniques, whilst 15.2% was linked to therapist variables.

Crits-Christoph et al, (1991) used a meta analytic design to examine fifteen psychotherapy outcome studies across twenty-seven treatment groups for the effects of four therapist variables; (1) use of treatment manuals, (2) average level of therapist experience, (3) the length of treatment, and (4) type of treatment. The difficulty of defining variables such as experience has been widely noted (Roth & Fonagy, 1996) and in this study experience was coded in terms of exposure to psychotherapy rather than generic professional training. They suggested that the therapist accounts for 9% of the outcome variance although there was a wide range of results with therapist effects accounting for 49% of the variance in one study. Variance in outcome attributable to the therapist was smallest where therapy was manualised and therapists experienced. Consistent with this was the increase in therapist variance when inexperienced therapists conducted non-manualised therapies. Whilst Crits-Christoph et al (1991) concluded that the impact of the therapist upon outcome has reduced over the past twenty years due to the rise of manualised treatments, they nevertheless stated that differences between treatments may in fact have been a function of the therapists involved rather than the treatment itself as reflected in other studies such as Shapiro et al (1989). They therefore suggested there was the need to minimise such effects in studies designed to compare therapies.

Lambert (1989) therefore concluded that there is sufficient anecdotal and clinical evidence that, irrespective of therapeutic technique, the individual therapist can have a positive or negative effect on treatment outcome. Lambert and Okiishi (1997) recommended that the 'key role' of the therapist should be viewed as a discrete variable in future psychotherapy research although failed to specify in what way the therapist should be conceptualised.

1.3 The limitations of the Manualisation of Psychotherapies.

Lambert and Okiishi (1997) described how, over the past two decades, psychotherapy research has tended towards examination of technical aspects of therapy and attempted to minimise the impact of the individual therapist as a potent factor in outcome. Training has aimed at providing pure technique and thus has supported the development of treatment manuals. The development of managed care systems in the United States has further encouraged this development by the implicit assumption of the direct relationship between technique and outcome. Furthermore, whilst a controversy continues over the notion of “empirically validated therapies” e.g., Shapiro, 1996, these same therapies are advocated with little concern as to the nature of the individual therapist providing the therapy itself.

From the perspective of experimental design, manualisation is understandable given that the therapist is the most complicated aspect of the question as inadvertently illustrated by Rounsaville et al, (1988). These researchers highlighted the role of the therapist by reporting on difficulties in therapists achieving a desired level of competence. The NIMH Collaborative Depression Project required all therapists to receive training in interpersonal therapy and subsequent inclusion in the research study to be based upon ratings of competence. Therapist competence was judged by independent expert evaluators using two videotaped sessions of the therapist with two different patients. Of the eleven therapists originally trained, two were requested to leave the study prior to the initiation of the treatment of patients, and a third was requested to leave the study at a later date on the basis of a failure to consistently apply treatment as prescribed. Rounsaville et al (1988) thereby emphasised that a well educated, and highly motivated small number of therapists were still unable to achieve competence at a particular style of psychotherapy.

Elkin (1999) stated that the manualisation of therapies was terminally flawed because it was virtually impossible to disentangle the effects due of differential competence, however that is measured, and other therapist characteristics from any bonefide treatment effects. As if to illustrate her point, Malik et al (2000) systematically

compared three different renditions of Beck's Cognitive Therapy (CT), all conducted within the context of a randomised clinical trial. One of the CT treatments followed the original Beck et al (1979) manual and was applied to a group of older adults diagnosed with major depression (Thompson et al, 1991). The second manual was group adaptation of CT (Yost et al, 1986), which was applied to middle aged patients with major depression. The third treatment was adapted for couples reporting depression and chemical abuse problems. All the therapists involved in each study were trained to criteria using the same compliance measure and all were supervised by experts in the CT approach through the use of audio or videotapes. Malik et al (2000) reported that whilst the specific therapies could each be clearly identified as cognitive therapy, they differed in terms of the degree to which they were therapist guided, the degree to which they had a symptomatic focus, and the management of patient affective states. Malik et al (2002) therefore argued that the collapse of therapies according to a common theoretical base was flawed in that it did not take account of differences between therapist style, therapeutic settings, and the patient population.

Havik and VandenBos (1996) stated whilst research using manualised therapies made important contributions to the field as a whole, it translated badly to the everyday situation of clinical practice. Elkin (1999) further stated that clinicians were actually engaged in matching patient and therapist, whether consciously or otherwise. She suggested that a referral is made to specific therapists whom the referrer considers competent with a particular approach or whom they consider particularly gifted in working with certain types of patient. Others such as Piper, Ogrodniczuk et al (1999) and Polkinghorne et al (1999) point out that manualising may be antithetical to the workings of a particular form of therapy such as psychodynamic psychotherapy. They describe a dilemma for the therapist who adopts a passive-receptive stance towards the patient so that the process is patient driven. If the therapist were trained to determine the content of the session, or to provide standard responses, the process between the patient and therapist would no longer be considered psychodynamic. Duncan and Fiske (1977) proposed that each participant in an interaction formulated a notion of the situation and adopted conventions and strategies consistent with that

formulation. While the therapist's formulation may be found to be fairly consistent, the formulation of the patient starting treatment may be somewhat at variance from that of the therapist. The patient may or may not modify his formulation as he became aware of that of the therapist. On the other hand, if the therapist did not perceive the incongruity between the two formulations, he could not have the choice to modify his own or attempt to help the patient to modify the patient's. When the patient and the therapist maintain separate formulations of the therapy situation, the work of treatment, manualised or otherwise may be found to be seriously handicapped.

Overall, Beutler (1997) considered that whilst randomised controlled trial designs have added to the current knowledge regarding the efficacy of various treatments, he considered that adoption of randomised trials as the 'gold standard' of research methodologies may have obscured the role of therapist variables in effective psychotherapy. Hence he considered the therapist as a 'neglected variable' deserving of greater research attention.

1.4 The Elusive 'Good' Therapist.

Lambert and Bergin (1994) considered the therapeutic situation as so complex that improvement in patients must be considered a function of the complex interaction between patient characteristics, events external to both therapist and patient, specific technique individual therapist characteristics and other factors common to all therapies, i.e. non specific factors. Simultaneously the referral to therapists is not random (Elkin, 1999) and the nature of the therapist has been a much neglected area (Bergin, 1997).

Definitions of therapist variables have struggled to achieve acceptability within both the empirical rigors of research design and the subjective meaningfulness required for application in the clinical setting. Such difficulties were well illustrated by Coady and Wolgein (1996) who reported a qualitative study on therapists' views of how they are effective. They interviewed eight therapists who had been elected by

peers as highly effective. Each therapist was interviewed twice regarding their views of “the relative importance of specific and common factors (p313)” which act to make them effective. Therapists ranged in age from between 39 and 57 years, and had worked professionally as therapists for between twelve and thirty years with the mean being twenty years. All therapists were therefore described as ‘experienced’ and all described their orientation as eclectic. Coady and Wolgein (1996) identified five general themes encompassing thirty-four categories as shown in Table 1.1.

Whilst the authors may be correct that the results represent “relationship-oriented, non-technical skills and attitudes (p318)”, they illustrate the severe difficulties of definition and conceptualisation with which the methodologies of psychotherapy research have had to contend. It confuses theory with technique, combines a multitude of theories without acknowledging the conceptual roots of any, inevitably combines techniques given that therapist technique becomes a free agent once divorced from theory, and is internally ill defined and inconsistent. In its defence, the authors states clearly that their subjects described themselves a ‘eclectic’ and the list of themes produced may would be recognisable to most clinicians, i.e. it has some face validity. Nevertheless, it is wholly unavailable to more rigorous research or any that would seek to operationalise and empirically measure one or other variable. As Berzins (1977) stated,

“The entire field of psychotherapy research suffers from a lack of co-ordination between theory and empirical data and an absence of trustworthy measures of outcome” (p35).

Table 1.1 Good Therapist's Views of How They are Helpful:
Themes and Categories (Coady et al 1996).

<u>Theme</u>	<u>Category</u>
1. Exhibit Personal/ Professional Qualities of Self	<u>Authentic & honest.</u> Caring & empathic. Curious & interested. Humorous. Attentive & intuitive. Non-impositional.
2. Emphasize Development of Therapeutic Relationship	Value relationship development with clients Develop an atmosphere of safety Follow client's pacing Encourage collaboration View clients as equals View each client and problem as unique View therapy as mutual growth experience Personally identify with client issues Establish parameters for termination
3. Focus on Client Empowerment	Maintain strengths and perspective of clients Refrain from fixing client problems Encourage client self-determination View therapy as a small part of clients' lives
4. Attend to Impact of Self.	Critically evaluate own impact Guard against imposition of own agenda Monitor appropriate personal/professional boundaries. Seek client feedback.
5. Apply Therapeutic Strategies/Interventions	Normalize client problems Maintain focus on feelings Use self-disclosure Explore influence of larger systems Address basic needs first Present ideas/suggestions tentatively Become more directive in crisis situations Help client to develop self-awareness Abandon what is not working Draw on a range of therapeutic models and techniques.

Whilst the referring of patients is not completed on a random basis (Hollander-Goldfein, Fossage & Bahr, 1989), there remain longstanding concerns regarding the contributions of the therapist. Fiske (1977) stated that,

“Our ultimate concern should be with actions of the therapist during treatment and their effects upon the patient. The therapist’s assessment of the patient, his beliefs about psychotherapy, and his age are of interest only insofar as they are related to what he actually does in the treatment interactions and how he and his behaviour are perceived by the patient” (p29).

Rounsaville et al’s (1988) inadvertent finding and subsequent concern with competency in therapists has been echoed by others (e.g., Strupp, Butler & Rosser, 1988). Elkin (1999) lamented the difficulty of separating out therapists from the therapy they provided. Lambert and Bergin (1994) commented that such data on therapists is so rare that it is impossible to estimate the true scale of this phenomenon although this inevitably suggested a focus on competence and the initial selection of therapists not only as participants in research but for selection for training. Whilst the tendency within the field has been to attempt to remove the therapist from the equation through the use of manuals, or to delineate specific factors of the therapists functioning which may have a bearing on the outcome of psychotherapy, little attention has been given to the possibility offered by the selection of therapists for training. The advantage of this perspective lies in the fact that outcomes tend to be absolute; either the applicant is accepted for training or is turned down. Whilst selection is no guarantee of becoming a competent or ‘good’ therapist, research on potential therapists has been described as a matter of great “social concern” (Fiske, 1977). Furthermore, there have been consistent calls for the development of standards in psychological therapy (Persons, Thase & Crits-Christoph, 1996; Beutler & Kendall, 1995; Tasman, 1993).

Consequently, Chapter 2 will outline the history and difficulty in the selection of therapists while Chapter 3 reviews the literature emerging from psychotherapy literature as to therapist factors considered important in promoting positive

outcomes for psychotherapies. The interplay or 'fit' between patient and therapist is the focus of Chapter 4. Chapter 5 subsequently outlines the concepts of Attachment Theory before suggesting that methodological advances in the measurement of attachment status offer opportunities that may overcome previously noted difficulties and may be useful in researching the selection of candidates for training.

CHAPTER 2. THE SELECTION OF THERAPISTS FROM A THEORETICAL AND CLINICAL PERSPECTIVE.

2.0 Introduction.

The previous chapter outlined the increasing importance with which the individual therapist is viewed as an important factor in determining the outcome of psychotherapy, irrespective of orientation. The importance of the person of the therapist (Lambert and Okiishi, 1997) and the recognition of the limitations of manualisation of treatments (Strupp & Anderson, 1997), indicate the importance of the selection processes for candidates wishing to train as therapists in the mental health field. However, whilst the selection processes for most trainings may be clearly set out as a procedure, usually involving an interview, they may be unclear in terms of articulated and theoretically linked criteria for the qualities desired in the future therapist (Strupp, 1988). This chapter reviews the literature on selection with a focus on selection for psychodynamic trainings on which there is by far the largest literature. This review does not aim at excluding other orientations and, it is hoped will show that the themes which emerge from a study on selection for psychodynamic trainings are highly relevant to other schools of psychological work. This highlights the absence of a central conceptual model that could be operationalised for use in the selection of candidates. A review of the literature on selection criteria reported in the literature is followed by a review of the methodology used in selection which itself highlights the importance of the individual selector and the need for further research in this area.

Whilst reviewing the theoretical developments that have occurred in psychoanalysis since its inception, Cooper (1985) noted that psychoanalysis itself has predominantly retained the initial paradigm set out by Freud. Cooper uses the term paradigm as did Khun (1962) in referring to the situation in which a core conception is established around which additional data can accumulate. What subsequently develops would have a greater or lesser internal coherence depending upon the initial core concept and will be subject to increasingly stringent tests. The

paradigm developed by Freud consisted of three axioms; the assumption of psychic determinism, the method through which this could be investigated namely free association, and the concept of the dynamic unconscious. Cooper subsequently argued that these basic propositions could be endlessly elaborated, revised and refined hence, for example, leading to the dynamic, economic, and topographic models of the mind. Cooper (1985) also noted that the paradigm established also ensured that psychoanalytic theory and practice maintained a close relationship. This may be well exemplified by Britton and Steiner (1996) in describing a therapists approach when working with the raw material provided by a patient. Britton and Steiner (1996) emphasise that importance of the therapist attending with free floating attention so that a particular aspect from the material, the 'selected fact', may be highlighted and around which the rest of the material available coalesces thereby revealing the patient's communication at that particular moment. This they contrasted with the therapist imposing his initial thoughts upon the material provided by the patient and thereby forcing a fit between the material and the thought to which the therapist is wedded. They considered the former as conducive to the analytic task and the latter as essentially destructive to the task.

Whilst the history of psychoanalysis has seen the fruitful expansion of different theories of psychic development within the initial paradigm, the selection of candidates for training has remained a woefully underdeveloped area for the past thirty years. Namnum (1980) noted that whilst there had been considerable interest in the question of selection in the late 1950's and 1960's, this had been followed by a decline of interest, possibly due to frustration, and was also matched by a decline in the number of applicants. Thus post 1968, little research on the selection of therapists was completed.

2.1 The Criteria for Selection.

2.1.1 General versus Specific Characteristics.

Greenacre (1961) described that training in the early years of psychoanalysis was tentative and informal by standards of today. The prospective analyst's intensity of desire formed the basis of selection or even self-selection. For example, Greenacre (1961) cited Freud's training of Eitingon by twice-weekly conversations during evening walks prior to Eitingon travelling to Berlin to pursue psychoanalytic work. The literature on the selection of candidates indicated an attempt to define specific characteristics against a background of general characteristics considered desirable such as 'maturity of personality, integrity of character, and aptitude for psychological work' as used in the 1932 Congress of the International Psychoanalytical Association.

Sachs (1946) for example, stated that candidates required the same general characteristics as any other profession such as honesty, intelligence, reliability, and sufficient professional and cultural training. In particular however, he considered the "will to face one's own unconscious... [and] ... the absence of such a degree or magnitude of blind spots as would inhibit an intimate acquaintance with the mechanisms and contents of the unconscious or would substitute theoretical academic interest for it". The difficulty lay in the fact that the extent and nature of blind spots could not be determined in advance and only defined in the course of an analysis. Consequently, he recommended a personal analysis for all candidates implying that this should be commenced prior to training and be used to assess the candidates' suitability. Furthermore, Sachs was specific in suggesting that a lively interest in activities that required an intuitive psychological element such as poets and artists was advisable in potential analysts.

Similarly, Sharpe (1947) considered an essential requirement for candidates was an intense curiosity with regard man's mental and emotional life and that this would hopefully develop into a continual and patient search for psychological truth in the course of training. Kohut (1968) stated that the applicant must give evidence of the

potential presence of a vivid interest in psychological matters, especially concerning the inner life of people, that this be motivated by libidinal forces but with sufficient aggression to maintain it in adversity. Anna Freud's (1967) statement echoed this general view;

"If you want to be a real psychoanalyst you must have a great love of the truth, scientific truth as well as personal truth, and you have to place this appreciation of truth higher than any discomfort at meeting unpleasant facts, whether they belong to the world outside or to your own inner person" (p553).

As recently as 1996, the production of lists of required factors persisted. Kappelle (1996) examined which factors selectors in the Dutch Institute of Psychoanalysis considered most important in the decision on acceptance for training. He consequently devised two sets of questions, one containing general questions such as those on character traits, empathy, introspection, and the other a list of anamnestic questions. The first list comprised 24 questions, the second 36 questions. Selectors were required to rate each on a three-point scale of very important, important, or less important. Kappelle (1996) reported his primary finding that completion of the questionnaire raised significant disquiet with numerous incomplete responses provided. Kappelle (1996) therefore attempted to compile a list of the top ten items recorded and these are presented in Table 2.1. There were no items that were significantly more chosen than any other.

**Table 2.1 List of Top Ten Items on Character Trait Questionnaire
and Anamnestic Questionnaire (Kappelle, 1996)**

Character Trait Items.

1. Capacity for introspection.
2. Reliability
3. Empathy
4. Analysability
5. Autobiographical data
6. Quality of relationship
7. Growth of contact in the interview
8. Impression/principal character traits
9. Capacity for self expression
10. Capacity to recognise anxiety

Anamnestic Items.

1. Relationship with parents
2. Relationship with siblings
3. Relationship with partner
4. Parental family
5. Sexual development
6. Sexual experience
7. Social contacts at various stages of life
8. Current work experience
9. Symptoms of infantile neurosis
10. Feelings about sexual identity

Difficulties arose however in attempting to operationalise and identify these desired qualities and the lists of qualities becoming increasingly long as a result of the prioritisation of one or other construct. Furthermore, the constructs selected were often only loosely conceptually connected to each other or general to a point that they could be located within every school of thought. Heimann (1954) was very specific about the qualities desired in a candidate although each of the factors identified would be difficult to clearly evidence. The identified factors were:

1. A deep conviction of the dynamic nature of the unconscious. Greenacre (1961) therefore suggested that this implied a period of initial analysis prior to acceptance towards the training.
2. An intuition and innate psychological flair.
3. Curiosity in human beings combined with a respect for other's individuality.
4. Capacity to make and maintain object relationships over a considerable period of time.
5. Capacity to recognise limitations in the self and to tolerate the frustrations involved in personal problems capable of long term rather than immediate solution.
6. Absence of denial with regards one's own problems.

Similarly, Eisendorfer (1959) defined eight qualities that he considered as potentially indicative of the capacity to become a therapist. These factors indicated a greater focus on the process between assessor and applicant and therefore may be considered as more available to evaluation within an interview;

1. The subtlety with which the applicant reveals himself.
2. Selective specificity of his spontaneous productions.
3. The degree of spontaneity.
4. Evidence of genuine curiosity about the unconscious.
5. Appearance of self-examination in regard to his own feeling, problems, and ability.
6. His estimate of the nature of psychoanalysis.
7. Capacity for articulate communication.
8. Cultural background.

Extending this theme, Tolentino and Zapparoli (1968) were very specific in stating their view that the common element in all candidates must be their suitability to be analysed. However, they could only define this in terms of the candidate having “a type of character or neurosis that allows a diagnosis of personality which lends itself

to successful analysis.... [or] ... favours the development, the growth and the cure of the symptoms present.” (p555).

The difficulties in specifying and operationalising criteria led some authors to consider the different manifestations of specific concepts that they considered as central. Kernberg et al (1972), for example, considered the concept of ego strength as particularly important for undertaking the psychoanalytic psychotherapies and training. This was supported by Beenan et al (1979) who considered ego-strength as indicated along three dimensions;

1. The degree to which interpersonal relations were based on secure adaptation, depth and normal drive gratification.
2. The degree of integration, stability and flexibility of intra-psychic structure.
3. How far intrapsychic problems are expressed in serious manifest symptoms.

Alternatively, the concept of ego-ideals as models for psychoanalysts was not new and had been previously summarised by Gitelson (1948) as the analyst having;

1. A capacity to bear the anxiety that meeting another human being as an unknown system generates.
2. The capacity to answer with his own caring impulse the anaclitic need of the patient,
3. The capacity to accept in the patient the potential trend towards development and self-sufficiency, concealed by regression and the defensive system.

Tolentino and Zapparoli (1968) added two further factors to this list;

4. The possibility of using the regression in the service of the ego.
5. The possibility of using with the patient repairing mechanisms and series of identifications.

Kappelle (1996) suggested that within the subjectivity of selection also lies that 'voice of experience' and it is therefore possible to create a list of desirable features in an applicant whilst simultaneously knowing that no one applicant may possess all of these. Identified characteristics were divided into present capacities and areas for continuing future development. Required capacities include those for introspection, identification, empathy, self-analysis, and insight into own limitations, availability for further development in maturation, integration, self-discipline, forging sound long-term object relationships, healthy curiosity, motivation and analysability. Kappelle (1996) therefore regarded the central question as whether it was possible to predict that the qualities mentioned above will develop in the applicant were they to begin an analytic training. He further lamented that the identification of desirable applicant characteristics has predominantly arisen from the subjective views of experienced analysts and are therefore not amenable to formal empirical investigation.

Overall, whilst many of the specific characteristics noted could be considered as aspects of the capacity to relate to others, there had not as yet been developed a model of how the organisation of these capacities could be assessed with regard an individual's suitability for treatment.

2.1.2 Normality vs Psychopathology.

The concept of normality, and its counterpoint psychopathology, offered some opportunity at having a paradigm for selection that could simultaneously be operationalised. Two different and inter-linked approaches to the question of normality in the candidate, over and above the difficulty in its definition, appear in the literature. One view suggests that normality is required and necessary (Freud, 1937; Bird, 1968), the other stating that normality is the potential inhibitor of the creative and imaginative spirit that, perhaps with the freedom of hindsight, allowed the development of psychoanalysis (Knight, 1953).

The founding of the Berlin Psychoanalytic Institute in 1920 led to the Hans Sachs becoming the first training analyst and the formal theoretical acknowledgement of the

need for the analyst to undergo analysis. Whilst the practice of selection remained based upon the friendly co-operation of the foremost analysts of the time, central to the theoretical discussion was the question of whether candidates should be selected on the basis of their 'normality'. Sachs (1946) thereby considered there to be a high degree of similarity between the analysis of training candidates and those of neurotic patients and consequently believed that there was no essential difference between the analysis of training candidates and that of neurotic patients. He stated that;

“Psychoneurotic trends in our present state of civilisation are so universal that a person who is practically free of them is a rare exception... [is] less likely to be found among those who want to be analysts because of the vivid interest in psychoneuroses....[and] is regularly motivated by one's own neurotic problems” (p159).

Sachs consequently concluded that the presence of neurosis in the candidate was not a handicap to training but was to be expected and was probably helpful. Conversely, Sachs (1947) also noted that importance of a degree of intactness and integration despite the presence of neurosis. He warned against those candidates who illustrated a tendency to avoid emotions, illustrated chronic neurosis since childhood without remission during adolescence, had psychotic and psychopathic trends, had definite perversions and addictions, or a rigidity of character based on a firm defence of narcissistic traits. This perhaps attempted to echo and refine Freud's earlier statement in *Analysis Terminable and Interminable* (Freud, 1937) in which he argued for a high degree of normality in analysts;

“There is some reason in the demand for a high degree of psychic normality and correct adjustment in the analyst as evidence of his qualifications for his work. He must be in a superior position to that of his patient if he is to serve as a model for the latter in certain analytic situations, and, in others, to act as his teachers. Finally ... the relationship between analyst and patient rests on the love of truth as its foundation, i.e., on the acknowledgement of reality, and it precludes every sort of sham and deception” (p387.)

Other authors were less concerned by the degree of 'normality' or psychopathology of the would-be therapist's psychic reality and more concerned with the concrete manifestations of one or the other. Gitelson (1948) for example, stated that 'normal candidates' whose normality is based on rigidly held and deforming defences, must be assessed on the basis of positive criteria that include achievements made despite the presence of neurosis. He further added,

"What has survived of creativity, effective energy, of emotional flexibility and resonance, and of interpersonal interest, regardless of the formal diagnosis? One should look for these qualities in the initial interviews and let the analysis take care of the rest" (p209).

Bird (1968) questioned the prior positive evaluation of psychopathology such as that by Knight (1953) who stated that,

"In the 1920's and early 1930's those who undertook psychoanalytic training were of a somewhat different breed from the current crop of candidates ... many gifted individuals with definite neuroses or character disorders were trained... many of these have become our best teachers, theoreticians, and clinicians.... Some have been problem children in the institutes and in the Association and have caused raised eyebrows in the general public" (p218).

Bird (1968) consequently questioned the reasons for why the process of self-selection would have ceased if as Knight (1953) suggested it produced such gifted individuals. He wondered whether the introduction of formal selection procedures was itself a response to the public demand for reliability and stability from an emerging profession. The public may have otherwise symbolically raised an eyebrow.

Simultaneously, Bird (1968) also described the situation with regard what were described as "normal" applicants who were accepted, trained, and eventually graduated but who were "mediocre candidates, relatively unanalysable and seldom

really skilled at conducting an analysis" (p515). Whilst Bird stated that this was presented as a problem for the future of psychoanalysis, he noted that,

"...in the meeting's [a 1962 selection meeting] discussion, so many perceptive comments were made about how unsuitable "normal" applicants could be detected that it seems surprising any at all are accepted. Yet they are. And, because they are, the thought has to be entertained that they do not "slip through" by accident but are "slipped through" on purpose" (p516).

He concluded that the "normal" group of stable, attractive and essentially non-scientific individuals was precisely what was needed as the core of a developing profession and hence the development of a certain tendency towards their selection. This echoed Greenacre's (1961) conclusion that the term 'normal' referred to those candidates who were free from overt neurosis.

Kohut (1968) approached the question of normality by stating that psychoanalysis was very familiar with the intertwining of pathology and normal desirable psychological functioning. An excess of 'normality' can in effect be quite abnormal and hence he suggested that the definition of suitability for psychoanalytic work may occur in terms of psychopathology. Kohut suggested that the precise psychopathology *pre se* did not account for the capacity to be a good psychoanalyst, but that this capacity is 'an outgrowth of a specific, controlled responsiveness, emanating from the periphery of the pathological sector. He illustrates his point thus,

"The depressive's capacity to feel kinship to the sadness and suffering of people, the tendency toward identification with others, has been adduced in support of the claim that the good analyst is basically of the depressive constitution, as long as the propensity remains controlled and within bounds" (p552).

The position of 'normality' in training was further complicated by the fact that the ill-defined concept was also used as a measure of outcome for psychoanalysis. Freud (1937) considered the desired result of a training analysis as follows,

“The training analysis has accomplished its purpose if it imparts to the novice a sincere conviction of the existence of the unconscious, enables him through the emergence of repressed material in his own mind to perceive in himself processes which otherwise he would have regarded as incredible, and gives him a first sample of the technique” (p385).

Whilst Freud was discussing an outcome, his statement may also be considered as defining the capacity to achieve a meta-position on the individual's own mental functioning as a desirable quality in the prospective candidate. With regard the question of neurosis in the candidate and the necessity for a training analysis, Freud (1937) considered the analysis as protective of the candidate against the impact of close contact with the repressed impulses and instinctual demands which may be violently awakened in the course of an analysis and whilst subsequently working as an analyst. Greenacre (1961) subsequently emphasised that once normality was considered an outcome, so the predictive nature of selection comes to the fore and hence its considerable vulnerability.

2.1.3 A Functional Model.

The selection of applicants for training on the basis of an explicit functional model has only more recently been initiated. Kohut (1968) made a plea for selection to be made more on the basis of functional models rather than characteristics per se. He suggested;

“To state, for example, that empathy is present or not in an applicant, or even to estimate the degree of its potential availability, signifies little. What counts is whether its use is under the ego's control, in which specific areas it is effective, and whether it can lead to the meaningful, balanced and comprehensive understanding of others” (p551).

Furthermore, he more closely defined the nature of the ‘psychological gift’ noted in many candidates by stating that the use to which the ‘intuitive understanding’ is put

must be a focus rather than its presence or absence, "...that is to say, is it used largely for narcissistic gratifications and defensive purposes, or has the individual grown through its use in self-understanding and the development of such interests, as those in the arts" (p37).

Kohut (1961) implicitly suggested that the definition of a good analyst is extremely difficult per se given that there were 'many types of analysts' in addition to different types of excellence. Kohut (1961) proposed a broad genetic and structural model of the good analyst as having a self-image that had developed on the basis of wholesome early experiences of maternal acceptance and empathic care, with a resulting strong and deep sense of nameless narcissistic security. Such development was later followed by disturbing experiences that left him with uncertainties about himself. These uncertainties may, for example lie in his sense of his socio-cultural role, but create a peripheral looseness, changeability and impressionability. A 'central firmness' is therefore combined with a 'peripheral looseness' and this allows the analyst to orient himself to the many different perspectives and facets of his patients whilst not losing contact with the fundamental requirements of healthy development.

Consequently Kohut also stated the corollary of this view, namely that irrespective of the nature of events that led to however great the cathexis of curiosity (cf Sharpe, 1947), the central motivation must predominantly be a libidinal and not an aggressive one,

"The future analyst's conscious or unconscious wish to understand should thus be based on love for psychological truth and should neither be primarily determined by the urge to show up the seamy side in order to destroy, belittle, or degrade, nor - in reaction formation to the sadistic impulse - by the need to cure, to soothe, to heal" (p552).

Eisendorfer (1960) implicitly described the use of functional models as guide to selection in suggesting that the interviewer had a conscious or preconscious image of what he considered a good analyst even though this was inevitably narcissistically

coloured. He stated that in the process of a selection interview, this image constantly hovered over the impressions made by the applicant's self-revelations, and that these gradually coalesced into an approximation of a character image. The interviewer's representation of a model of the applicants functioning therefore slowly developed and interviewer's task was to determine in what ways the two images agreed. A decision would then be made on the basis of this level of agreement. Similarly, but far more concisely, Bird (1968) noted that selection was based upon a 'like me' experience and that "for better or worse the interviewer has to compare the candidate with himself".

Hence, whilst the literature on selection had noted specific criteria, the recognition that selection of candidates for training may occur on the basis of unspecified functional models rather than specific criteria alone had only recently been openly acknowledged.

2.2 Methods of Selection.

Greenacre (1961) noted that selection inevitably occurred on the basis of future expectation and that it was therefore, by definition, problematic to expect any candidate to possess all the characteristics considered necessary to be a good therapist even if these were definable. The central question remained one of prediction concerning development and the explicit expectation was one of some level of disturbance in the candidate. Ekstein (1940, cited in Greenacre, 1961) suggested that a period of trial analysis be instituted as a method by which factors that may be masked in interview situations, such as a rigidity of defences in relation to narcissistic problems, which lessen analysability may be noted. Greenacre (1961) noted however, that it was unlikely that the question of motivation could be adequately addressed in a trial analysis given that such a focus could overly direct and distort the process of analysis itself.

However, the 1932 Congress did suggest that selection should be done by a committee rather than on the basis of individual recommendations given the recognition that training analysts themselves retain a degree of neuroticism and therefore inevitably

have blind spots, which need to be accounted for.

Bird (1968) noted that information about candidates often originates from four principle sources; an application form and references from others; a personal interview; the results of formal testing procedures; and a period of analysis. Klein et al (1965) examined letters of recommendation for training as a potential predictor of suitability and found that these were of some but limited value. Of the subgroup of applicants accepted for training on the basis of letters of recommendation (rated 'neutral to cautious'), three quarters failed to complete their training. Furthermore, none of this group were rated 'superior in their work'. However, none of those accepted for training on the basis of enthusiastic letters scored 'below average in their assessments during training. Bird (1968) considered the application form and references to be of highly limited value, their principal use being to set the selection process in motion. Kappelle (1996) noted that selection on the basis of suitability for courses in psychoanalytic theory and seminars would be highly unlikely to yield significant information given that the majority of applicants are university graduates and were therefore likely to be of sufficient intellectual functioning.

Both Bird (1968) and Klein et al (1965) stated that the individual, as opposed to group, personal interview remained the principal instrument of selection. In Klein's study, selectors rated applicants suitability on a four-point scale. When matched with subsequent success in completing training, the ratings had a low but statistically significant predictive value. H. Klein et al were, however, clear about the limitations of their study which they described as; problems in the specification of desired personality qualities and the difficulty of finding an objective method of describing them, difficulties with the operationalisation of these qualities into psychological tests, and problems of creating specific independent criteria for the study. Bird (1968) noted that nearly all training institutions pinned their faith on the personal interview as this appeared reassuring. He considered all other measures to have a precursory or ancillary function to the interview although he noted that styles of interviewing could vary greatly between interviewers. It was common for an applicant to have a number of individual interviews with different interviewers each of whom may have a

different style of interviewing. One style consisted of the evaluation interview being conducted as per a psychiatric assessment, with a formal structure to the interview and a diagnosis proffered at the end. Bird stated that whilst this method was at some odds with the psychoanalytic method generally, it has produced some “highly perceptive analytic comments about the applicant's suitability” (p523). By contrast was the casual and non-directive style in which the course of the interview was directed by whatever the applicant brought to it. This style was closer to the practice of analysis resulting in the interviewer experiencing a sample of the applicants mind in action. At some point in-between the above two styles, lay the probing ‘active data finding’ style aimed at uncovering hidden material. In discussing this style, and in the absence of specific evidence, Bird (1968) once more favourably concluded that those who use this style often arrived at a “remarkably thorough analytic picture of the applicant's neurosis” (p523), out of which they then formulated opinions about his analysability and his potential talent as therapist.

A variant of the active probing style was the ‘prod and probe style’ in which the aim is not so much to uncover hidden material but to understand why the material has to be kept a secret and to observe the applicants response to being probed. Understandably, this approach produced stressful interviews in which both adaptive and maladaptive aspects of the applicants ego-functioning were illustrated. Bird (1968) considered this style as potentially allowing the interviewer to make ‘amazingly sharp’ formulations concerning the applicants potential for analytic work.

Formal psychometric assessments for suitability are virtually absent from the available literature. Bird (1968) considered their use as one of ascertaining psychopathology rather than identifying potential analytic talent, and they were therefore made redundant by the process of interviewing. Others were more optimistic such as Kohut (1968) stating that,

“The question whether quantifying devices should be used in such areas of applied psychoanalytic research as that concerning evaluation is a crucial one. In brief, the gain in precision must be weighed against the loss in meaning and significance. I am

inclined to believe that at the present time quantification is not achievable without an excessive loss in psychoanalytic relevance - yet I do not know what the future might bring and I am not opposed to experimentation” (p551).

Kappelle (1996) noted that there had been little progress since that time. Furthermore, Bird (1968) considered analysis as the only guaranteed method of evaluating analysability and potential therapeutic talent. Consequently, he stated that most training institutes required at least one year in analysis prior to further evaluations and a final evaluation as to whether an individual might begin the training. Bird (1968) concisely described the simplicity and yet complexity of the process of selection and in doing so emphasised the relational aspects of selection,

“Sooner or later in the evaluation process, regardless of what has gone on before, every applicant come up against the real test. He meets a living analyst face to face, mind to mind, in a closed-door, this-is-it encounter. This is what he has been waiting for, and this is what the analyst has been waiting for. All the rest is prologue. Now the applicant sits before the analyst, his mind as open as he dares, and the analyst, as much as he is able, tries to find out how his mind works. Then, from what he discovers, he tries to decide whether this is the mind of a future analyst” (p522).

Whilst the focus on the personal interview and possible period of initial analysis were favoured, Namnum (1980) noted that suitability for therapeutic work was sometimes assessed by the sheer ability to complete the training. Namnum (1980) reported the different percentages of acceptance and drop-outs from training available both across time and between different institutes in the USA. He reported an overall increase in acceptance rates over time with 35-40 percent of applicants being accepted in 1960 and this increasing to 60 percent by 1971-72. However, Namnum (1980) also noted that some institutes had adopted an 'easy-in easy-out' approach and thereby experienced an acceptance rate of approximately 80% alongside a dropout rate of 50%. Pollock (1976) emphasised the need for follow up procedures to assess applicants' success and failures which may then be retrospectively considered

alongside the records of the applicant's initial application. No such studies were located at the time of writing.

Kappelle (1996) concluded that the current situation was one of selection for psychoanalytic training involved selection without a clear description of the concept of a 'good analyst' and without the possibility of evaluating the selection process.

2.3 The Importance of the Interviewer/Selector.

The reliance on the individual personal interview, combined with recognition of different interviewing styles, inevitably developed a focus upon the interviewer him/herself. Pollock (1976) stated that in the course selection interview, the selector is faced with four different tasks, all occurring simultaneously. These were, the observation and gathering of data, the interpretation of data and its subsequent evaluation, and finally assessment of the predictive value of the data. Additionally he commented on the variance in interviewing style suggesting that,

“Many analysts who want to do selecting are not gifted in selection. Some are over-sympathetic: some are too trustful and friendly, some are hard-boiled; some are too suspicious and hostile; some too active and some too passive” (p316).

Greenacre (1961) thought that the gender of the interviewer may have an influential part to play in the content of the interview whilst Klein et al (1965) included gender as one of a number of factors including age, background, tolerance of anxiety and cultural differences. She further suggested that interviewers with substantial experience in terms of selection were better at predicting. More interestingly however, she stated that selectors seldom had the same level of good predictions. Some interviewers were good at predicting good candidates, while others were less good. Klein et al's (1965) results also suggested that the variance and idiosyncrasies of selection were reflected in the experiences of individuals rejected for training by one institute and accepted by another. With regard the Institute at Columbia University, 40% of applicants were accepted and 60% rejected. Both groups were

followed up with one quarter of the accepted group subsequently dropping out. Klien et al (1965) suggested that three quarters of these dropouts were due to serious mistakes in the selection process. Of those who were rejected, Klien et al (1965) reported that 62% responded to a follow up questionnaire some years later (Klien, 1985 as reported in Kappelle, 1996) and indicating that at least 39% of those rejected had subsequently been accepted and successfully completed their training with another institute. Consequently, if completion of training is regarded as an indicator of competence, it must therefore be concluded that whilst some good applicants were turned away, some poor applicants were accepted. In considering these results, Kappelle (1996) noted that the same questions that apply to the selection of applicants must therefore also apply to the selection of assessors.

Whilst Klien et al (1965) suggested that selectors' gender may be a factor, Kappelle's (1996) results indicated no bias in positive recommendations for acceptance between male and female applicants based upon the gender of the selector. On the basis of his figures, Kappelle (1996) also found no significant difference between selectors who were psychiatrists, psychologists, or from other professions on the basis of the applicants background profession. No profession appeared to favour its own although Kappelle (1996) was of the opinion that those from other professions seemed to be stricter than either psychiatrists or psychologists.

Kappelle (1996) also divided the experience of the selectors into four categories based upon the decade in which they qualified as selectors. Chi square analysis revealed a significant difference between years of experience and positive recommendation for acceptance. It appeared that more experienced assessors tended to make positive recommendations and Kappelle (1996) suggested that more experienced assessors were both given more difficult assessments to make but were possibly more willing to give the benefit of the doubt to applicants. Comparison of selection with eventual outcome of training indicated that there was no significant difference in terms of completion of training based upon the degree of experience of the selector. Consequently, whilst more experienced selectors were more likely to accept applicants for training, there was no evidence to suggest that this tendency

compromised the outcome of training in terms of the candidate eventually qualifying. There was no evidence presented as to the length taken for applicants' training based on the experience of the selector.

Kappelle (1996) further used his list of desirable qualities, See Table 2.1, to compare therapists who had a high rate of positive recommendations for acceptance for training and whose recommendations were correct by virtue of the candidate eventually completing training, with those who had a poor record of positive recommendation and successful completion of the training by candidates which they had recommended. Three pairs of therapists were selected with two in each grouping of successful predictors, mediocre predictors, and poor predictors. Whilst no statistically significant differences between the groups were reported, Kappelle (1996) stated that across both questionnaires, good predictors rated more items as less important and fewer items as very important when compared to the poor predictors. This may suggest that more the successful selectors had less of an internal agenda than their less successful colleagues and may have been able to adopt a more free floating classical analytic stance with the applicant in hand. This hypothesis may be supported by Kappelle's (1996) additional finding that selectors who obtained their training status most recently tended to rate fewer items as less important and Kappelle (1996) likewise suggested that the least experienced selectors had most need of a structured approach to selection or did not experience themselves as being able to abandon a particular internal agenda. He reported that this was in line with Klein et al (1965) who stated that experienced selectors who performed a large number of selections had the best results. Selection was therefore a combination of experience and routine.

Kappelle (1996) therefore concluded that,

“Selection should be undertaken by (older) selectors who recommend acceptance relatively often. They must combine a maximum of involvement with a retention of distance. They must not find something 'very important' too readily” (p1230).

The above conclusions therefore led to the question of how to select the selectors. From the perspective of countertransference, Tolentino and Zapparoli (1968) presented the findings of a study group at the Institute in Milan on the process of selection from the perspective of the countertransference of the selector, a senior analyst. Their findings were threefold;

1. A tendency in the training analyst to choose candidates who were already free from paternalistic influences such as academic environments or other psychotherapeutic groups. Tolentino and Zapparoli (1968) further stated that this masked a wish on the selectors part to make an initiate of the candidate which therefore may betray 'an intolerant and proselytising attitude' which did not view the presence of authoritarian influences as current manifestations of childhood ties and could therefore not comment on the potential development of the candidate, during analysis, to free himself from childhood ties.
2. A tendency to overestimate the candidate's education or academic qualification as a function of the analyst's own insecurity.
3. An exclusive ego ideal of an omnipotent type for whom psychoanalysis is an exclusive 'Weltanschauung' and who therefore tends to choose candidates who themselves are disposed to this viewpoint.

Of psychoanalysts as a whole, Tolentino and Zapparoli (1968) suggest that the only common element to the group as a whole,

"Is the possibility of sublimating aggression to the point of tolerating, as a safety system, action in an analytical sense, namely through interpretation" (p559).

It would appear therefore that the situation with regard the interviewer/selector has developed to much the same point as that with regard desirable features of the applicant. Whilst the complexity of the task of selecting has been recognised, and whilst there is general agreement that assessment of training is best completed on the

basis of a personal interview, this conclusion in itself has raised a focus upon the person of the interviewer/selector, his/her style of interviewing, and his/her own internal functioning. To date, no operationalised assessment of the internal functioning of the assessor exists even though the variability in assessors is increasingly recognised.

2.4 Conclusions.

The Committee on Psychoanalytic Education arose out of a three-year survey, 1956 to 1959, by the American Psychoanalytic Association of various Institutes' educational programmes. This was followed by the establishment of The Study Commission on the Evaluation of Applicants for Psychoanalytic Training (CEA) in 1969, a study group which attempted to approach the problem of selection by first answering the question "what makes a good analyst". Concerning itself with real rather than idealised qualities, autobiographical questionnaires were completed by a small group of analysts regarded as of the highest quality by their peers. It was hypothesised that the commonalities shown by this group would thereby provide an indication of the 'good' analyst. After several years of attempted analysis, the Study Group abandoned its attempt given the unexpected and huge diversity in the responses gathered. The "good analysts showed very little in the way of common denominators either in their personal characteristics or in their analytic work. Following fifteen meetings and the withdrawal of the European members in 1973, the final report was submitted in 1977. It concluded that,

"In regard to our scientific deliberations, CEA is far from satisfied with the traditional criteria advanced for the evaluation of applicants for psychoanalytic training, and with the results of the procedural application of these principles..... (1) The presence or absence of psychopathology in an applicant (with the exception of the grossest disturbances), especially the presence or absence of circumscribed symptoms and inhibitions, does not constitute a good yardstick for making predictions concerning his future performance as an analyst (p82).....(2) The presence or absence of certain

positive features in the candidate's personality seems to have more predictive significance than the nature and even the degree of his psychological illness" (p83).

In summarising its report, the CEA stated that,

"At present we question whether it is possible with any certainty to say more than the following: that a person who seems analyzable, says he wants to be analyst, and has accomplished in life enough so far to give promise that he can carry out what he intends to do or wants to be, should be acceptable".

Kappelle (1996) summarised this by suggesting that selection may be "limited to a judgement on the applicant's analysability and on his positive life achievements to date" and stated that the work on selection has progressed little since the time of the CEA's conclusions.

Overall, Bird (1968) focussed on the selector and noted that differences in styles of interviewing were so vast, with some only understandable to the interviewer himself, that it was inherently vulnerable process with no standard design or criteria,

"Altogether, the whole thing, from start to finish, seems like an amateur proposition, subjective, individual, catch as catch-can and untouched by any scientific hand" (p524).

The saliency of this remark is given added weight by the realisation that Bird (1968) was describing the situation for a branch of psychology, which has had a significant influence of over the field of clinical psychology as a whole. The need for an operationalisable set of criteria, with clear links to psychoanalytic theory and practice, utilised within the constraints of a selection process have never been greater.

CHAPTER 3. THE DIFFCULTY IN SUITABLY DEFINING THERAPIST VARIABLES.

3.0 Introduction.

As previously described in Chapter 1, recent years have witnessed the questioning of the usefulness of manualising treatments (Strupp & Anderson, 1997, Havik & VandenBos, 1996) and have echoed the concerns over the methodological difficulties faced in defining appropriate therapist variables of a decade earlier e.g., Strupp (1986). The intervening years have been dominated by the attempts to sharpen methodologies through minimising the variable of the therapist, who was concisely viewed as an ‘untested contaminating variable’ (Lambert et al, 1986).

Chapter 2 reviewed the literature on the selection of candidates for training and thereby implicitly described aspects of an individual’s functioning, which were considered as desirable in the functioning of a qualified psychoanalyst. This chapter approaches the same question, that is which are the desirable qualities in therapists, through examining the psychotherapy research literature on therapist variables considered predictive of positive outcomes. As will be noted, definitions of therapist variables have struggled to achieve acceptability within both the empirical rigors of research design and the subjective meaningfulness required for application in the clinical setting. Hence the available literature on the therapist alone, whilst not only being relatively sparse and only now emerging from the shadows of the treatment manual, also occasionally strikes an uncomfortable balance between the notions of efficacy and effectiveness. Furthermore, the sparse nature of the literature concerning therapist variables from a purely psychoanalytic perspective required the review to include papers which met the following two criteria; firstly the inclusion of studies in which the clinicians were psychotherapists and not psychoanalysts but in which the therapy was clearly based upon psychoanalysis¹, and secondly studied which had

¹ It should be noted therefore that the terms ‘psychoanalyst’ and ‘psychotherapist’ are used interchangeably even though, strictly speaking, the two differ in the precise elements of the training completed.

empirical rigor regarding the question of therapist variables but were not strictly of a psychoanalytic orientation.

Additionally, whilst therapist factors contributing to the successful outcome of psychotherapy have been little studied, therapist factors contributing to deterioration have been even less studied (Ackerman & Hilsenroth, 2001). Where available, such studies have arrived at conclusions, which lead to little that is possible to operationalise. Lafferty (1989) for example, divided thirty trainee therapists into two groups, 'ineffective' and other. Therapists classified as ineffective were those whose patients had negative change scores which exceeded one half standard deviation of overall change scores. Across the many therapist variables measured e.g., therapist emotional adjustment, relationship attitudes, patient involvement, theoretical orientation, therapist empathy was the most predictive of being an effective or ineffective therapist. Additionally, less effective therapists placed emphasis on terminal values such as prosperity and stimulation whilst more effective therapists tended to emphasise intellectual values such as reflection within their interaction with the patient. Whilst the conclusion regarding the capacity to empathise carries clear face validity, its operationalisation and measurement pose significant conceptual difficulties. Ackerman and Hilsenroth (2001) state that the search for factors in the therapist that lead to improved outcomes, is also in fact, the search for factors that lead to negative outcomes if the results can be viewed from this perspective.

The tendency within the field has been to attempt to delineate specific factors of the therapist's functioning, which may have a bearing on the outcome of psychotherapy. There therefore arose a body of literature surrounding 'therapist variables' (Beutler, 1986). Schaffer (1982), for example, adopted an approach consistent with that of many researchers. He differentiated three aspects to the therapist's contribution to the effectiveness of psychotherapy; the therapeutic technique, the skilfulness of the therapist which included the factors such as neutrality, verbal ability, timing, and capacity for reducing the discrepancy between therapist's and patient's viewpoints, and thirdly personal and interpersonal qualities of the therapist such as warmth, capacity for empathy, likeability and perceived

sincerity. Fiske (1977) attempted to delineate therapist variables into seven themes from which variables could be developed that were easily empiricised. These were;

1. General Characteristics such as sex, age, ethnic group.
2. Psychological attributes assessed outside the treatment room such as personality variables
3. Professional biographic variables such as professional training and experience.
4. Views about psychotherapy such as orientation, beliefs about mental health.
5. Variables specific to each patient such as therapists perceptions on the patient
6. Characteristics of the therapist's behaviour during a treatment such as verbal productivity per session
7. Contextual variables such as therapist responses to particular acts or statements of the patient.

Whilst there remained difficulties in definition, a greater focus on teasing out specific factors resulted in the specification of certain factors that were at least available to external rating such as verbal ability and neutrality. However, as with research on 'client variables', such work has had considerable methodological and definitional difficulties, even at the level of apparently well defined demographic variables.

This chapter therefore selectively reviews the range of therapist variables noted within the empirical psychotherapy literature. It is divided into sections reflecting different aspects of the therapist, which have been identified as potentially important although the constant theme becomes that of simultaneous difficulties in linking the variable with a theoretical framework and the subsequent operationalisation of that variable for reliable measurement.

3.1 Demographic Variables.

Variables such as the chronological age of the therapist have to be distinguished from age relative to the age of the patient, professional experience of the therapist, and even relative age at different life stages (Roth & Fonagy, 1996). Consequently, there

are very few meta-analytic studies of age, and most reviews (e.g., Sexton and Whiston, 1991) survey age as one variable in general reviews. Perhaps because it is so easily confounded with other variables, age is almost uniformly viewed as bearing little relationship to outcome outside of the stereotype of successful therapists being older (Beutler et al, (1994).

Similar definitional difficulties occur in studies trying to distinguish sexual attitude and gender (Parloff, 1978), ethnicity (Abramowitz and Murray, 1983), and Socio-economic Status (Mitchell & Atkinson, 1983). Research on the role of therapist gender has been predominantly confined to naturalistic designs, with gender forming one of several variables being measured. Overall, little support has been found for therapist gender being predictive of outcome (Beutler et al, 1994) even when subject samples have been very large (see for example, Beck [1988] who used a naturalistic design with 1500 patients and 244 therapists). Of the few controlled studies conducted to date, Jones, Krupnick and Kerig (1987) compared post treatment satisfaction levels of 60 women who were assigned to one of 11 male or 14 female therapists. Their quasi-experimental design used a manualised brief therapy with therapists who had approximately equivalent levels of experience. Subjects were all female and were randomly assigned to therapists. Across male and female therapists, distribution of client severity was equivalent. The results indicated a slight but greater symptomatic improvement for patients seen by female therapists although the major criticism of the study lay in the absence of male patients given that an overall superiority of female therapists could not actually be determined. Beutler et al (1994) concluded that whilst there has been little evidence in favour of therapist gender being predictive of outcome, further research is required given the results of studies such as Jones et al (1987) and the socio-political concerns surrounding perceived power differentials between male and female therapists.

The conclusions drawn on gender are paralleled by those on ethnicity. In a study by Jones (1978) ethnicity was investigated by matching therapists and patients on other variables such as socio-economic status, age, education and controlling for therapist experience, length of treatment, and ensuring 'similar' theoretical orientations. The

findings indicated that ethnic matching had no influence on dropout rates or on patient and therapist ratings of improvement. Importantly however, Jones noted that the quality of the treatment relationship varied as a joint function of the phase of treatment and the ethnic match of the participants.

3.2 Personality Traits and Coping Patterns.

Whilst a wide number of personality dimensions have been previously defined, these have often been theoretically overlapping and the absence of sound psychometric instruments for their measurement has led to the development of a wide discrepancy between theoretically postulated therapist factors that have an influence and a small number of variables that have been subject to empirical investigation (Beutler et al, 1994). Furthermore, the empirical investigations completed have been of varying quality, often with quasi-experimental and/or analogue designs. Interestingly therefore, two trends have developed within the literature; empirically driven studies which correlate a number of loosely related dimensions of personality, and theory driven studies which tend to be non-empirical and correlate theoretically with therapeutic change in patients. The former have been in decline due to the fact that even when employing shotgun methodologies, there have been too many potential variables to measure and to incorporate into a coherent theoretical framework with which to underpin the results. Not surprisingly, a large number of non-significant findings have been reported. Two primary examples of this are Antonuccio, Lewinsohn and Steinmetz (1982) and Whitehorn and Betz (1960). Antonuccio et al (1982) conducted a post hoc analysis of patient outcome as a function of therapist variables for 100 depressed patients. Therapy was regarded as homogenous and experience and skill levels were controlled for. None of the therapy personality traits measured were significantly related to treatment efficacy. The study by Whitehorn and Betz (1960) has been widely cited due its influence on subsequent research. Reliable predictions were made as to the differential response of schizotypal and neurotic patients based upon the patterns of therapists' response to a vocational interest inventory. However, whilst producing such predictions, Whitehorn and Betz (1960) were unable to provide sufficient theoretical explanation for their results.

Studies which have been theoretically driven have understandably suffered from a lack of replication as illustrated by Berzins et al (1977) in which theoretical descriptions have survived over time in the absence of empirically based validation. Berzins et al (1977) reported an initial study in which contrasting patterns of dependency and autonomy between patient and therapist enhanced the efficacy of psychotherapy. The improvement in dependent subjects was enhanced if treated by autonomy-oriented therapists. Patients focused upon independence showed greater improvement if treated by “attachment focused” therapists. The distinction between autonomy and dependence was subsequently incorporated into Jungian psychoanalysis thus illustrating how theory driven research allows for the selection of dimensions that seem to carry greater ecological validity.

Some studies have attempted to account for flexibility in the therapist by defining a number of interlinked dimensions. Berry and Sipps (1991) used a naturalistic design to study therapist-client match on the Myers Briggs Type Indicator based on the ‘circumplex’ defined as a number of theoretically derived dimensions such as thinking vs. feeling, sensing vs. intuition, which were considered as indicators of successful therapist-patient matches. Nine therapists and fifty-five patients were included in the study with data analysis focusing upon the relationship between patient-therapist match and patient status at the termination of therapy. The authors failed to support any of their hypotheses and arrived at a global therapist factor which they termed ‘unconditional positive regard’ which when coupled with patient self esteem accounted for the majority of the variance observed. Such findings have led to attempts to operationalise dimensions as defined in the circumplex into observable therapist states rather than inferred personality ‘traits’.

Alternatively, considering extreme positions at one point held the promise of providing the stability of a personal trait, which could then be accounted for. Dominance or dogmatism in treatment have for example, been thought of as adverse to patient improvement in therapy. Studies addressing these dimensions have however provided very mixed results. Henry et al (1990) completed post hoc analyses of fourteen patient-therapist dyads and concluded that poor outcome was associated with

internalised dogmatic and controlling introjects. Within the area of group therapy, other researchers have found the exact opposite (Tracey, 1985, Zimpfer & Waltman, 1982) although these studies have used different populations, patients at a student university counselling centre in the former and adolescents in the latter. Yalom and Lieberman (1971) argued that authoritarian and dominant group leaders tended to produce negative change and supported this with data from a naturalistic study on the outcomes from five groups all of whom had such leaders and all but one produced “causalities”. Subsequent replications (Kaplan, 1982; Bentley et al, 1975) failed to replicate the findings although noted that group leaders were not as confrontational as in the first study.

Similarly, whilst Rotter’s (1966) ‘Locus of Control’ concept has received much attention within the literature, results from a wide number of studies have produced very mixed results. This has been further compounded by the adoption of naturalistic designs, in addition to different treatment modalities and subject populations. Antonuccio et al (1987), for example, suggested that external locus of perceived control was beneficial in therapists involved in group treatment for patients suffering from depression in that it enhanced group cohesiveness. They did not consider it to enhance overall outcome. Foon (1985; 1986) reported non-significant relationship between outcome and initial locus of control or initial similarity in locus of control between therapist and patient. Interestingly, similarity in locus of control at termination of therapy was significantly correlated with improvement suggesting that a process of convergence of client therapist perceptions is a factor in achieving benefit.

Overall, conclusions found in the literature, (e.g., Beutler et al, 1994), were highly general and tended to state that constructs such as dogmatism versus flexibility, dominance versus openness, or locus of control could not be treated isomorphically and that their effect would be in interaction with other as yet unidentified therapist variables.

3.3 Psychological Mindedness and ‘Conceptual Level’.

Much psychological work has often colloquially been referred to as involving the ability to ‘read between the lines of behaviour’ (Dollinger, 1983). Wolitzky and Ruben (1974) highlighted the inter-changeability of several terms used to describe such a capacity including ‘introspectiveness’, ‘self-awareness’, ‘self reflection’, and ‘capacities for self observation’. Non-clinically oriented work has also used the term ‘conceptual level’ to refer to the same aspect of functioning (e.g., Holloway and Wampold, 1986).

Whilst such a capacity in both patient and therapist has been thought of as important when considering the prospects of a successful treatment (Coltart, 1988), the term ‘psychological mindedness’ was originally coined by Appelbaum (1973) who defined it as,

“A person's ability to see relationships among thoughts, feelings, and actions, with the goal of learning the meanings and causes of his experiences and behaviour” p(54).

Appelbaum's (1973) definition represented an attempt to coalesce a number of indicators and counter-indicators to psychotherapy mentioned in the literature (e.g., Freud, 1937; Fenichel, 1945; Waldhorn, 1960) into one construct. It also superseded previous references to ‘psychological ability’ (e.g., Wedeck, 1947) or such definitions as that of Holt and Luborsky (1958) who defined psychological mindedness as,

“An interest in, orientation toward, and/or ability to grasp the psychological dimension of experience; particularly, an understanding of behaviour in terms of its motivation” (p109).

Whilst Holt and Luborsky's definition implicitly referred to an intentional stance central to mental states, Appelbaum's (1973) definition attempted to delineate a greater number of components within a unified framework. To this end the four sub-components of cognition were put forward; intuition, empathy, motivation to

understand, and the 'ability' to operationalize insights in the service of the psychotherapeutic process. However, Appelbaum was unable to specify the interrelation of these components and subsequent definitions replicated this difficulty.

Attempting a different approach, Wolitzky and Ruben (1974) chose to keep notions of interest and ability separate and therefore defined psychological mindedness as,

“A tendency to understand or explain behaviour in psychological terms, that is, to view behaviour as expressing and communicating information about the needs, wishes, purposes, intentions, conflicts, defensive strategies, of the person in question, oneself, or another” (p27).

More recently, definitions such as McCallum and Piper (1990; 1997) stressed an understanding of intrapsychic dynamics. They defined psychological mindedness “as the ability to identify dynamic (intrapsychic) components and relate them to a person's difficulties”. However, as with Appelbaum's definition, the terms used are either too nebulous to operationalise or over-inclusive so making any measurement difficult. Furthermore, the absence of a more established theoretical grounding for this concept left basic questions about psychological mindedness unanswered. As Appelbaum (1973) states,

“Are we talking about a capacity or an actuality? Is psychological-mindedness constitutional or acquired, autonomous or conflict or a function of conflict, culturally or nosologically influenced? How is it different from insight or introspection?” (p38).

The literature on psychological mindedness therefore became concerned with two central questions, the development of the capacity and the measurement of this capacity.

3.3.1 Theories on the Development of Psychological Mindedness.

Theories regarding the development of psychological mindedness have been put forward for as long as a capacity such as psychological mindedness has been identified. These have predominantly divided along two axioms; a genetically determined and driven capacity or a capacity created across the course of development from interaction with the environment. Reik (1948) for example, considered the capacity as being essentially genetic and in born in the same way that he considered a musical talent. Conversely Henry (1966) adopted a more interactionist approach suggesting that mental health professionals had experienced a 'special sense of isolation' at some point in their lives which had enables them to develop a heightened awareness of inner events. Henry's (1966) argument was not for a psychopathological route to psychological mindedness, but a development out of an experience of 'cultural marginality' which itself resulted from birth into different cultural and religious groupings e.g. Judaism. Essentially he argued that the individual had to develop from a stance of being on the outside looking in.

Other researchers have put forward theories based upon the notion of adaptation to psychopathological events. Menninger (1957) suggested that mental health professionals and in particular psychiatrists had experienced an excess of a sense of 'loneliness, unlovableness and rejection'. Miller (1981) attempted to be more specific in stating that the presence of an insecure mother causes infants, who were initially endowed with a high capacity to 'perceive and respond intuitively' to use and further consolidate this capacity thereby maintaining their environment. Explanations from a purely psychopathological perspective have also been put forward. Sharaf (1960) argued that children who acted as confidants for their mother had the affective experience of oedipal triumph over the father. The subsequent realisation that this may not be the case at a deeper level, leads to a long-lasting distrust of a 'mother who promises but doesn't deliver' and the setting in motion of a life long quest for concealed negative aspects or potential betrayal in any relationship.

More recently, Hatcher and Hatcher (1997) conceptualised psychological mindedness as a complex cognitive ability defining it as “the capacity to achieve psychological understanding of oneself and others”. They conceptualised the development of psychological mindedness as being genetically predetermined but considered that it could be fostered or inhibited by social experience. This latter aspect resulted from the incorporation of the ideas of Kennedy (1979) who postulated that psychological mindedness involved both the cognitive capacity to understand oneself and others and the capacity to tolerate painful feelings.

Menna and Cohen (1997) considered the development of psychological mindedness as being the development of the cognitive mechanisms that individuals apply to understand social situations. Their model was that of the development of social perspective taking and was assessed by having children and adolescents respond to dilemmas concerning conflicts with peers and authority figures. The responses were scores on three dimensions: a structural level which referred to the continuum of increasing differentiation from others and intrapsychic integration, functional steps which referred to the problem solving strategy used, and interpersonal orientation which referred to which of the characters accommodated whom in story. Menna and Cohen (1997) supported their developmental model theory by data, which indicated that children with developmental delay, maintained the sequence of their development in the same stages outlined and that children's performance improved with age. They attributed this improvement by citing three causal mechanisms, maturational factors, experiential knowledge, and improved attentional capacities.

Menna and Cohen (1997) have argued that the overall level of PM for any individual resulted from the interaction of genetic and environmental factors. These authors argued that despite ‘heightened capabilities’ in the area of complex social cognition, patients with Borderline Personality Disorder (BPD) experienced hugely dysfunctional relationships. Westen et al (1991) discussed the discrepancy between BPD patients' potential for healthy relationships, as reflected in high scores on tasks of cognitive complexity, and their actual relationship history, which tended to be pathological. They interpreted this discrepancy as reflecting an interference from motivational and

defensive processes which were characterised by a tendency to perceive their object world as hostile. It was argued that that perception interfered with their application of cognitive skills to actual relationships. Menna and Cohen (1997) therefore generalise this idea to children who score highly on cognitive skills but whose behaviour does not reflect this.

The central difficulty however, for all definitions of PM, has been the absence links to a coherent developmental theoretic framework. Consequently, whilst the concept of PM has very high face validity, attempts at its definition have been almost atheoretical and hence lead to tremendous difficulties in its operationalisation and subsequent measurement.

3.3.2 The Measurement of Psychological Mindedness.

Attempts to measure psychological mindedness have reflected this lack of clarity and have either been purely descriptive or have used rating of performance on different asks also thought to maintain the clinical relevance of the concept. Clinicians have often relied upon naturalistic observations and responses to interpretation as evidence of psychological-mindedness. Coltart (1988) stated that psychological-mindedness was “not evidenced by a desire to be rid of psychic pain through another's work, but by an awareness that an increase in insight leads to an increase in self knowledge and a decrease (in time) of psychic pain”. Alternatively, Limentani (1972) looked for 'a patient's capacity to move freely within his own psyche'.

One of the better known measures, the Psychological Mindedness Assessment Procedure (McCallum & Piper, 1997), required subjects to view and then describe a simulated interaction between patient and therapist. The subject is then required to provide an account of what is troubling the patient in the video. The subject's account is then rated on a scale of nine levels of PM, each level incorporating the one below it. Importantly however, the criteria for each level arise out of the clinical experiences of the authors and are not overtly derived from theory.

Holloway and Wampold (1986) meta-analysed 24 studies of counselling and psychotherapy published since 1967. Most studies used subject and/or situational analogue designs in which subjects were asked to engage in tasks deemed similar to those of a therapist. Subjects who had higher levels of abstract and complex cognitive processing styles were found to be more effective in both initially learning and then performing the therapy like tasks than those who were relatively more concrete and non-discriminating.

However, in reviewing other studies on conceptual level of therapists (e.g., Lamb, 1977), Holloway and Wampold (1986) indicated that patient-therapist match might enhance the process of psychotherapy. Their own meta-analysis indicated that in studies including both therapy dyad, or analogue therapy dyad, and outcome data were included, the influence of matching on the basis of conceptual level did not reach significance. Furthermore, when replicated in clinical settings the effect sizes disappeared. This was most striking in the failure of analogue findings on therapists' conceptual level to be cross-validated in clinical settings and with clinical populations. The Holloway and Wampold (1986) study, for example, produced an effect size of .38 in the laboratory and one of .05 when transferred to a clinical setting.

The difficulties of achieving adequate operationalisation of PM was best illustrated by Dollinger (1983). Subjects initially completed standard measures of intelligence and available scales of psychological mindedness. Scores were then correlated with scores on tasks devised to measure 'psychological construing', understanding fictitious vignettes about clinically relevant defence mechanisms, and judgement of deception from further fictitious vignettes. No significant inter-correlations between measures was obtained leading Dollinger (1983) to conclude that Psychological Mindedness is not a unitary concept and that traditional trait measures of this failed to correlate with tasks of defence understanding, psychological construing, and thief detection. Furthermore, Dollinger (1983) reported a significant negative correlation between high scores of succourance and unfavourability on an Adjective Check List with scores on the Psychological Judgement task indicating that subjects who rated

themselves as having an ability for forming accurate first impressions actually did poorly at this task.

Such a discrepancy has also been noted in naturalistic observations of therapists' 'psychological mindedness'. Farber (1985) posited that individuals who are highly psychologically minded may either have been especially lonely in childhood and therefore deprived, or especially confided in and therefore valued for their capacity.

The basic difficulties of the lack of relation to theory and poor definition have led to a near abandonment of the concept of psychological mindedness as previously defined. Indeed, in recent reviews of the efficacy of psychotherapy (Lambert, Shapiro & Bergin 1986), and therapist variables in psychotherapy (Beutler et al, 1986) the term goes unmentioned and only appears once in a review of client variables (Garfield, 1986). As if in response, the latest measures of PM openly state that they are not connected to any theoretical framework but attempt to measure characteristics such as a willingness to commit to the therapeutic alliance and other such factors thought to be linked with positive outcome. Of these, the best is the PM scale (Conte et al, 1990), which comprises a 45-item questionnaire, designed to incorporate four aspects of the individual's functioning. These were motivation in problem solving, capacity for behavioural change, emotional accessibility, and interest in others. This measure therefore attempts to be atheoretical as a response to the difficulties mentioned above.

3.4 Emotional Well-Being.

It has long been become a stereotype that the psychotherapist should be emotionally healthy (Dare, 1997) although a range of views have been voiced with respect to the role of disturbance within the therapist's psychological functioning (Greenacre, 1961; Kappelle, 1996). The absence of a theoretically derived measure of therapist emotional well being has greatly limited research within this area which has generally been divided into two related areas; the effect of therapist disturbance and the influence of psychotherapy for therapists themselves. Both strands have strongly relied on naturalistic designs with all the associated weaknesses (Sherman, 1996).

3.4.1 Therapist Disturbance.

Whilst emotional well being seems more often than not to have been defined as the baseline state of the therapist (Guy & Liaboe, 1986), there is increasing evidence that mental health professionals suffer or have suffered high levels of psychic distress in their lives (Rabin, Feldman & Kaplan, 1999). Looney, Harding, Blotcky and Barnhart (1980) reported that 73% of psychiatrists in their sample reported experiencing moderate to incapacitating anxiety during their early years of professional practice. In a self report survey of professional psychotherapists by Deutsch (1985), 82% of subjects endorsed experiencing significant relationship problems at some point in their lives, 57% reported depression, 11% noted substance abuse and 2% reported a suicide attempt.

However, as Beutler et al (1994) state, only a limited number of studies have actually assessed the influence of therapist distress on outcome. As with many other dimensions, research has been hampered by a difficulty in the precise definition of 'emotional well-being' and hence its accurate measurement. Definitions struggle to be empirically precise whilst retaining clinical validity and hence a number of terms have been used which take different positions along a dimension between well being and differing manifestations of distress. Among the terms used are; self esteem (Wiggins & Giles, 1984), self- confidence (Williams & Chambless, 1990), neuroticism (Lafferty et al, 1989) and burnout (Beck 1988). Additionally, Kutz (1986) pointed out the difference between impairment as diminished functioning and incompetence, which is the lack of ability, which may or may not be the result of impairment. Sherman (1996) attempted to delineate the aetiology of impairment citing a predisposition to mental illness, aspects of the working life, and personal life events as three axes for consideration. Whilst discussing 'stress', which he recognised had become a dead metaphor, Margison (1997) emphasised the interplay between a range of different factors. Impairment can be viewed as the result of depression and/or interpersonal problems. It can result from the impact of certain aspects of psychotherapeutic work such as its complexity, which itself can impact upon prior vulnerability developed through previous experiences and innate qualities in the

therapist. Linked to the above, the degree of the therapist's capacity to understand his/her experienced states through reflection would be important in the management of role conflicts and the mismatch between demands and resources, whether these be internal or external.

The difficulties of definition and conceptualisation have led many studies and reviews (e.g., Beutler et al, 1986; Lambert & Bergin, 1983) to adopt a simplistic and stereotypic conclusion that what has been termed 'emotional health' on the part of the therapist enhances therapeutic outcome and that the converse is also true, emotional distress on the part of the therapist may inhibit patient progress even though a literature exists on the potentially important role of disturbance in the therapist (e.g., Bird, 1968).

Consequently, there have been a limited number of studies attempting to assess the role of therapist disturbance. Using a quasi-experimental design, Luborsky et al (1985) reported a composite index of therapist adjustment correlated positively with overall effectiveness. It may however be the patients' perception of therapist well-being that was important rather than the therapists actual mental state. Williams and Chambless (1990) reported that patient perception of therapist self-confidence, considered as an indication of well-being, was the greatest predictor of improvement. Using an adolescent population, and in a naturalistic design, Wiggins and Giles (1984) reported the same association in the reverse direction. Low therapist confidence led to a reduction in patient self-confidence.

Garfield and Bergin (1971) rated the effectiveness of therapists who had varying scores on selected MMPI sub-scales. The results favoured a lessening of scores of defensiveness and depression amongst patients of therapists who had the lowest levels of 'emotional disturbance'. Anchor (1977) reported that 'personality integration' was positively associated with the patients' willingness to remain in treatment while Gunderson (1978) reported that ratings of beneficial psychotherapeutic processes were highest with therapists also rated as 'comfortable' at times when the patient experienced intense affect.

Even fewer studies attempt to overtly connect therapist disturbance to an underlying model of functioning. Somewhat of an exception has been Johnson (1991) who, in studying the high rates of depression and suicide in the medical profession linked psychopathology to earlier developmental narcissistic disturbances, which predisposed the individual to adopt the grandiosity and denial of dependence that subsequently led to intense emotional distress.

Many studies have failed to report a significant association between outcome and well being and Luborsky et al (1980) stated that the discrepancy between self and ideal self concepts on the part of the therapists was associated with improvement in longer term psychotherapy. Beutler et al (1994) interpreted this finding as that of conflicted therapists doing better than 'consistent' therapists which therefore once again suggests the importance of the processes that occur within the therapist rather than the presence of a sufficient amount of a certain characteristic.

Beutler et al (1994) conclude that therapist emotional well-being may be an 'important but not necessary condition for improvement' but only in 'high functioning' patients and that further research is needed on any potential impact of emotional disturbance upon therapeutic outcome.

3.4.2 Personal Therapy for Therapists.

Since the founding of psychoanalysis, personal psychotherapy for psychotherapists has been a recommendation for psychotherapists (Bird, 1968), a requirement for training (Greenacre, 1961) and considered to facilitate clinical effectiveness (Farber 1983). However, two reviews of the literature (Clark, 1986; Greenberg & Staller, 1981) have not arrived at firm conclusions. Beutler et al (1994) concluded that, "one must consider the act of receiving personal psychotherapy as an index of a correlated group of features, including personal openness, desire to avoid professional burnout, motivation, distress, life stress, sensitivity, and faith in treatment". They concluded that the effects of a psychotherapy may be so diverse, that the important factor from the perspective of research may be to examine the individual's initial reasons for

entering therapy rather than the length of time within therapy and warn that it is not possible to equate receiving previous psychotherapy either with initially having poor mental health or with subsequent good mental health.

3.5 The Therapeutic Alliance.

There is widespread agreement that the therapeutic alliance, originally conceptualised as a positive transference from patient to therapist (Freud, 1913) and subsequently expanded into concepts such as the working alliance or real relationship based upon the particular orientation of the therapy. There is however general agreement that the alliance is one component of the larger therapeutic process and encompasses the interaction between patient and therapist, including their expectations and attitudes about one another (Ackerman & Hilsenroth, 2001). The interaction between patient and therapist is effected by the values beliefs and relational style that each brings into the consulting room. Few studies however, have examined the impact of therapist behaviour and beliefs upon the therapeutic alliance. Saunders (1999), for example, reported a study in which 268 outpatients used the Therapy Session Report Form (Orlinsky & Howard 1975) following the third session of open-ended individual psychotherapy. The results indicated that session quality was significantly negatively correlated with the Therapist Distracted Scale. Coady and Marziali (1994) reported a small study of nine outpatients. Twenty-session, psychodynamic psychotherapy in which the therapeutic alliance was rated by the patient, therapist, and an external judge all using the Therapeutic Alliance rating Scheme was reported. Their results indicated that a poor alliance was strongly related to actions of the therapist which were judged to have been belittling and blaming of the patient.

There is general agreement that a poor alliance was related to therapists who were not confident in their ability to help their patients and were tense, tired, bored, defensive, blaming, or unable to provide a supportive therapeutic environment and that this would apply irrespective of the orientation of the therapy itself (Ackerman & Hilsenroth, 2001). The breadth in the definition of the therapeutic alliance it has meant that it has been addressed within psychotherapy research as comprising a

number of separate but inter-related features such as empathy, therapist beliefs, therapeutic style and therapist interventions. Each of these will be briefly reviewed.

3.5.1 Empathy.

As with psychological mindedness, empathy represents a concept, which has been identified as a phenomenon between patient and therapist but has been difficult to define for research purposes. From a psychoanalytic perspective, it has been considered as a manifestation of an underlying process of projective identification (Hinshelwood, 1998) although others divide it into a number of connected components. Rothenberg (1987) for example, considers it to have three explanatory foci; self and object representation, intrapsychic operations, and cognition. Empirical psychotherapy researchers tend however to have used a general definition such as that of Traux and Mitchell (1971) who defined it as involving the capacity to “perceive and communicate accurately and with sensitivity both the feelings and experiences of another person and their meaning and significance” (p317). It has consequently been measured through the use of self-report questionnaires and/or observer ratings (Mohr, 1995) and has become increasingly conceptualised as an aspect of therapist interpersonal skills, possibly following Rothenberg (1987) division.

Whilst it has been difficult to conceptualise, the lack of empathy has been the therapist characteristic that has most consistently been associated with negative outcome irrespective of whether the rating was completed by the therapist, patient, or independent rater (Mohr, 1995). Consequently, although ill-defined and poorly operationalised, the clinical phenomenon of empathy has been clearly identified as a crucial therapist attribute in promoting positive outcomes.

3.5.2 Therapist Beliefs.

That an identified research variable has an effect on upon the process of psychotherapeutic interventions, sometimes at a particular phase of the process, but does not solely account for the overall change, has also been noted with other therapist variables thought to be of a more cognitive nature. Therapist attitudes and beliefs, for instance, have been a much-researched area even though methodological problems over achieving operationalised consensual definitions of these factors have proved to be considerable (Beutler et al, 1986; Beutler & McNabb, 1981). Increased attention had been given to studies, which involve religious beliefs in the hope that specific relevant attitudes could be isolated (Henning & Tirrell, 1982). Propst (1980) used a relatively homogeneous sample of depressed religious females treated by therapists using a cognitive paradigm either consistent or discrepant with these religious beliefs. Cognitive reframing emphasised religious principles while discrepant interventions focused interpretations at patients' distorted cognitions, providing more rational alternatives. Propst (1980) reported consistently better results with religiously congruent, rather than discrepant, interpretations. Subsequent studies (Propst et al, 1992; cited in Beutler et al, 1994) employed religious and non-religious therapists to whom patients were randomly assigned and therefore received either standard cognitive therapy or cognitive therapy that 'employed a religious value framework'. Religious congruency was again found to be more effective. The results however were attenuated due to the absence of a measure of therapist acceptance and/or similarity to patient beliefs. Nonetheless, in viewing religious beliefs as one form of an overriding framework, the potential importance of similar internal working models (Bowlby, 1980) between therapist and patient should be considered.

Reviewing studies of patient and therapist similarity in beliefs as a predictor of improvement, Beutler (1981) reported a rate of 76% favouring a similarity in belief systems between patient and therapist although many were analogue studies and could be criticised on grounds of clinical relevance (Beutler et al, 1986). In a naturalistic study, Arizmendi et al (1985) suggested that improvement was a complex relationship between similar academic and intellectual values and dissimilarity in sexual,

interpersonal, and attachment values. Therapist expectations of the patient, as a discrete variable, have also been consistently linked to dropout rates in global reviews of the literature although once again a meta-analysis of these studies (Berman and Norton, 1985) concluded that only 10% of the variance of outcome could be directly linked to therapist expectations. However, several researchers (Lambert & Bergin, 1983; Duckro et al, 1979; Parloff et al, 1978) concluded in favour of therapist expectations having a limited role to play and agree with Beutler et al's (1986) conclusion that a convergence process of beliefs occurs between patient and therapist but that this did not by itself predict improvement.

Therapists' relationship attitudes, which have been defined according to the Rogerian values of accurate empathy, non-possessive warmth, congruence, and unconditional positive regard (Rogers, 1957), have therefore also been a focus of research even though such attempts have also been beset by methodological difficulties of definition and issues of measurement. Berenson et al (1968), for instance, divided therapists according to levels of attitudes, which they considered to be relevant therapist attitudes. As Beutler and McNabb (1981) pointed out, such studies tended to define the facilitative attitudes according to the restricted range that characterised the sample of therapists used in the study to the cost of theory driven research. Tentative conclusions have therefore been drawn that such facilitative attitudes have an enhancing effect. A more general consensus is that the positive perceptions patients develop as to their therapist's attitude toward the therapeutic relationship are associated with positive outcome and are more reliable than an external observer's ratings (Beutler et al, 1986).

Hovarth, Gaston and Luborsky (1993) concluded that a strong therapeutic alliance was one of the factors leading to a positive outcome and within the context of emphasis on the conjoint effort of psychotherapy, the importance of a 'fit' between therapist and patient becomes increasingly to the fore.

Lambert and Okiishi (1997) concluded that whilst therapist attitudes have increasingly been recognised as relevant to outcome, their measurement has often taken second

place to the main hypotheses under study and that such factors as the alliance are viewed as moderators of improvement or factors to be controlled for rather than central to the causal mechanism for change (e.g., Shapiro & Firth, 1987).

3.5.3 Therapeutic Style.

In an attempt to incorporate the aspects of therapist functioning outside of adherence to treatment manuals, Beutler et al (1994) defined the term ‘therapeutic style’ as reflecting’

“.... those behavioural predilections that are used to communicate with another person and that are independent of the constructs espoused to be important change agents by different theoretical models” (p250) .

They were contrasted with therapist ‘interventions’ which are defined as ‘discrete procedures and techniques’ belonging to different models of psychotherapy and are essentially interactional in nature and not considered to be part of a personality trait (Beutler et al, 1994). They have been shown to vary dependent upon the nature of the patient (Fairbanks et al, 1982) and model of therapy offered (Hardy & Shapiro, 1985) even in treatments that are highly structured and guided by manuals (Stile, Shapiro & Frith-Cozens, 1988). Nevertheless, their variability is limited (Smith and Glass, 1977) in that they do correlate with trait like personality measures.

The most well-known research framework for addressing interpersonal styles has been the Circumplex Model initially developed by Leary (1957). Essentially, this model defines two dimensions of motivation lying orthogonally to each other. Studies involving such a model intrinsically describe the patient-therapist dyad, which is discussed in Chapter 4, rather than the therapist independently.

Research focussing solely on the therapist has therefore attended to verbal styles, which have been differentiated into ‘non-content’ aspects covering the number of words or sentences used, and ‘content’ aspects concerned with the topic around which

speech occurs. Beutler et al (1994) review non-content studies and conclude that this variable varies according to professional training of the therapist and that patients' verbal style tends to move towards a parallel with that of the therapist. A number of naturalistic studies have reported that both non-content and content aspects of the patient and therapist move tend to converge in successful therapy (Horn-George & Anchor, 1982; Horvath & Greenberg, 1986). Furthermore, in a study using a naturalistic design, Tracey (1986; 1987) reported that continuance in short-term therapy as opposed to drop out was predicted by high patient therapist agreement on content variables. Interestingly, this was independent of whether patient or therapist initiated a particular topic and patient-therapist agreement was also associated with greater patient improvement. Findings from this study were subsequently cross-validated on a larger sample of patient-therapist dyads using a different setting. Consequently, some convergence has been identified with remaining in therapy and improved outcome. However, it would not as yet be possible to discern whether such a process is of itself causal to improvement or simply correlated to improvement.

It has been estimated that non-verbal behaviour accounts for up to 85% of communication in groups (Kleinke, 1986). This therefore implies that they provide an easily observable indicator of emotional intensity and quality. However, difficulties in addressing the semantic behind such observed behaviours have meant that the role of nonverbal factors in the outcome of psychotherapy has not been possible to date. The difficulty in addressing non-verbal styles has also meant that addressing the combination of the two has been limited. However, the disparity, lack of fit, or non-coherence between verbal and nonverbal behaviours has been considered as indicative of emotional states that were at the time unrecognised. It is argued that such emotional states 'leak out' (Babad et al, 1989). Bernieri et al (1991) subsequently compared rated therapist helpfulness and honesty as a function of the discrepancy between content and prosaic aspects of speech when talking to a patient. Speech samples from a session were compared to speech samples of the therapist talking about the patient rather than with the patient. The results indicated that a higher discrepancy between content and prosaic speech when talking to a patient was correlated with lower rating of therapist honesty and helpfulness. Additionally, whilst the speech between patient

and therapist is clearly important, the importance and meaning of silence between them has only recently been fully recognised within the research, as opposed to the clinical, community as having a multitude of important meanings (Lane, Koetting & Bishop, 2002) but has been little researched.

Research on therapeutic style was therefore also beset by methodological difficulties in dissecting style from intervention. Elliott (1985) emphasised how even lexical qualities of language are consequent to the therapists moment-to-moment experience, intentions, and to the objectives of the particular therapy. Nevertheless such a focus on interaction led Beutler et al (1986) to conclude their review of therapist variables in psychotherapy process and outcome by stating that internal therapist experiences can exert a consistent influence upon the outcome of therapy within a wider context,

“We see little reason to depart from the conclusion of Parloff et al (1978) that demographic variables and traits exert their effects through the mediating influences of the attitudes reflected in and characteristic of people who have these traits. The nature, formation, and influence of such attitudes ... may be a more fruitful field of exploration than the simple study of extra-therapy or demographic characteristics. Current research has failed to address many intriguing hypotheses about this process” (p307).

3.5.4 Therapist Interventions

Beutler et al (1994) define these as “technical procedures that are designed to initiate therapeutic change” which therefore bridge the gap between therapist qualities and therapy process. Such a definition attempted to encompass both interpretations as part of a psychodynamic therapy or specific behavioural programmes. However, with the advent of therapy manuals, methodological difficulties of distinguishing between interventions dictated by a therapy manual and those reflective of qualities inherent to the therapist become increasingly difficult (Elkin, 1999).

This rise of therapy manual-guided therapies also led to the assumption that therapies could be empirically distinguished by what therapists actually do (Hill et al, 1992; Luborsky et al, 1982) and therefore it would be possible to establish standardised interventions independent of therapist qualities. However, Henry et al (1993) reported that whilst technical proficiency increased following manualised training, therapists' relationship skills and supportiveness towards patients may have declined. These authors further suggested that "therapists who have self reported introjects that are hostile and controlling are the most likely to develop technical proficiency with the use of a dynamic therapy manual". This was supported by Svartberg and Stiles (1992) who reported that degree of therapist compliance with manual guided psychodynamic therapy did not increase therapeutic effectiveness.

As Beutler et al (1994) state "the assumption that therapist skill or competence at applying interventions is associated with treatment effectiveness underlies the extensive effort garnered by professional training programs to provide intensive supervision to fledging psychotherapists". However, in reviewing 359 treatment outcome studies, Moncher and Prinz (1991) noted that most ignored or did not sufficiently assess therapist competence or skill as a variable in treatment efficacy. Additionally, Alberts and Edelstein (1990) lament the dearth of evidence actually linking the employment of skills taught in training to actual patient change. Worryingly, Sandell (1985) presented data which suggested that within the context of short-term psychodynamic psychotherapy, supervision may indeed impede therapist efficacy rather than enhance it. Wiley and Ray (1986) compared supervised and unsupervised trainees and noted that supervised trainees showed a greater understanding of the impact of the therapy on their patients but did not demonstrate the development of specific skills as a result of supervision.

Beutler et al (1994) arrived at 4 conclusions in considering therapist skill. Firstly, common or non-specific skills of therapists are manifested differently in different therapies. Secondly, skilfulness generally is associated with effectiveness in different treatment models. Thirdly, therapist skill is relatively distinct from both experience level and compliance with a therapy model, and finally, criteria based trainings in

specific procedures tend to increase compliance. They conclude that in order to advance, research on instrument development is needed given that contemporary methods of assessing therapist skill have varied greatly and usually as a function of the therapy model being taught.

3.6 Therapist Experience.

Therapist experience as a discrete variable has faced considerable definitional problems and is often confused with age, professional degree, the extent of training and therefore different types of trainings (Stein & Lambert, 1995; Roth & Fonagy, 1996). It is an excellent example of a theoretical construct that carries much weight but there is no real empirical evidence.

Bergin (1971) coded studies according to the level of therapist experience in 48 studies. His results indicated patient improvement in 53% of the studies using experienced therapists compared with only 18% of trials showing improvement in which inexperienced therapists had been used. One of the most often quoted meta-analyses, Smith and Glass (1977), did not however show any significance for therapist experience. Similarly, Shapiro and Shapiro (1982) found a similar result although the very small range in therapist experience as measured by the combination of length of training and subsequent practice made comparison between therapists difficult and thus restricted the generalizability of the results. Beran and Norton (1985) reported a meta-analysis of 32 studies, all selected on the basis of sound methodology. No significant difference in effect sizes between professionals and paraprofessionals was discovered post therapy or at follow-up. Lyons and Woods (1991) report a meta-analysis of 70 studies of RET. Having defined experience as a combination of professional degree, therapist training was significantly correlated with treatment effects. Balestrieri et al (1988) contrasted specialist mental health workers with family physicians. Overall specialist workers achieved better results.

Given the difficulties in 'defining experience', Stein and Lambert (1984) simultaneously employed three different coding schemes in a meta-analysis of 41

studies. Inclusion criteria for the analysis meant that only studies using bona fide clinical samples were included thus eliminating academic counselling interviews or analogue interviews. Coding for therapist level of experience was as follows; a score based on training plus experience, a subsequent 'difference in experience' score obtained by subtracting the years of experience of the experienced group from that of the inexperienced group, and a five point rating scale ranging from rating for a lay person with no training to a clinician with over three or more years of post graduate experience. Even using this relatively sophisticated analysis, Stein and Lambert (1984) produced an effect size of zero and it is possible to conclude that a consideration of experience as a measure of the accumulation of time post training did not have a significant effect upon outcome. Nevertheless, for more experienced therapists, a trend towards better outcome for more disturbed patients was identified and the 'difference in years of experience' score tended to predict better outcomes for the more experienced therapists.

In a subsequent meta-analysis of 36 studies employing the same criteria as before, Stein and Lambert (1995) found moderate effect sizes for experience as indicated by symptom change pre and post therapy (0.3) and by patient type (0.27). Stein and Lambert (1995) note that the difficulties of definition are such that any reported finding may be considered as a minimum of the true relationship between therapist "experience" and outcome in psychotherapy.

Roth and Fonagy (1996) therefore recommended that experienced and non-experienced therapists be best differentiated in terms of the probability of patients prematurely terminating therapy rather than the absolute outcome achieved.

3.7 Conclusions Arising from Psychotherapy Research.

Overall, there have been consistent, if inadvertent, findings indicating the role of the therapist in influencing outcome. These have ranged from naturalistic studies (e.g., Ricks, 1974) to meta-analytic studies in which the degree of the variance accounted for by the therapist is much larger than previously considered (e.g.,

Lambert and Okiishi, 1997). Such developments have resulted in the perspective on the therapist as a variable undergoing important conceptual rehabilitation from being an “untested contaminating variable” (Lambert et al, 1986) to being the ‘neglected variable’ (Beutler et al, 1997) in psychotherapy research.

Psychotherapy research studies have however lagged behind this rehabilitation. Investigations of the therapist factors have traditionally attempted to isolate direct factors but have therefore been seriously hampered by issues of definition, measurement and experimental design. This has been repeatedly shown in studies on therapist personality and coping styles, important clinical concepts such as psychological mindedness, emotional well-being and psychological disturbance in the therapist, and therapeutic style and beliefs. Consequently, research on specifically defined therapist characteristics has yielded few and rarely repeated results. Nevertheless, the factor of the therapist, rather than being conceptualised as a combination of different factors, is now viewed as ‘more than the sum of its parts’ (Beutler, 1997). There is interest in defining the therapist as a unified variable that would include emotional well-being and therapeutic style. Lambert (1989) stated that the therapist is more than the sum of the dimension (and interaction of dimensions) than is usually stated in the traditional process and outcome research.

However, at present the field lacks a method of measurement of therapist factors that can bridge both empirical and clinical requirements and can allow for both empirical investigations without losing clinical meaning and utility.

CHAPTER 4. THE FIT BETWEEN THERAPIST AND PATIENT.

4.0 Introduction.

Even outside the psychoanalytic literature, the concept of the importance in the relationship between patient and therapist has received considerable recognition. Strupp (1986) pointed out that both therapist and patient are part of numerous subsystems, e.g. relationships with family, spouse, at work, some of which may function, in someone's opinion, differently at different times but which are all also subject to numerous external environmental circumstances. Essentially he considered the central ability of an effective therapist is to create an interpersonal context, which centrally fostered learning for both the patient and the therapist. Such a context would be subject to influences both internal and external of both therapist and patient. Hunt et al (1985) implicitly supported the notion that similarity in conceptual level between patient and therapist influenced the process of psychotherapy in reporting a 60% dropout rate in therapeutic dyads that were dissimilar in conceptual level as compared to a rate of 24% in matched dyads. Differences in symptomatic improvement were also seen at 12 weeks of treatment with matched dyads indicating greater symptomatic improvement although this difference disappeared at 24 weeks. The authors concluded that similarity in cognitive style was an important factor concerning initial engagement in psychotherapy but would not be the only factor involved in overall improvement at termination.

The difficulty of defining therapist variables that could span clinical, theoretical and empirical paradigms was the focus of Chapter 3. However, common to all psychological therapies is recognition of the importance of the relationship between patient and therapist irrespective of the degree to which the relationship is considered central to the potent therapeutic aspects of the therapy itself. A consistent finding of the psychotherapeutic literature has been the beneficial aspects of a positive therapeutic alliance (Martin, Garske & Davis, 2000) and the implicit

focus on the degree to which patient and therapist seem suited to each other or alienated from each other.

This chapter therefore reviews the literature on the 'fit' between patients and therapist. It initially describes the clinical phenomenon of the fit before describing the decline in research on the matching of patient and therapist. The two main reasons for this decline were seen as the theoretical weakness of attempts to match patient and therapist and the low clinical relevance of attempts to match therapist and patient. The chapter ends in describing recent developments, which have raised the clinical utility of the concept and make it worthy of further attention through research.

4.1 The Phenomenon of 'Fit'.

Kantrowitz (1993) has noted that the success of a psychoanalytic treatment has traditionally been assumed to be dependent on the psychological characteristics of the patient, and the skill of the therapist in facilitating and then resolving the transference neurosis. Furthermore, that subtle differences or emphases in technique occur with different patients has long been recognised (e.g., Wesley, 1958) and most therapists will admit that they are able to work better with some patients and less well with others. Anna Freud (1954) stated that therapists never react and respond to any of their patients in exactly the same way. The manner of making interpretations, the extent to which one is humorous or serious, the extent to which a real relationship is allowed to exist alongside the transference relationship, the degree of the patient's and therapist's ease are different for each therapeutic pair. According to Anna Freud, these variations were neither planned nor intended but constituted the reaction to subtle nuances and pressures from the patients' personality. Sandler's (1976) concept of 'role-responsiveness', considered the patient to subtly and unconsciously prod the therapist into reactions and behaviours that repeated experiences and relationships that have been crucial to the patient in the past. The analyst's response to these pressures would vary and was often not based on a conscious awareness of what was happening. When therapists

responded to patients in ways that were uncharacteristic of them, this could have been considered a compromise formation between the therapist's own personal tendencies and his unconscious and unintentional acceptance of the role the patient was trying to get him to assume in the transference. According to Sandler, the extent of the therapist's response, the roles to which he would respond, the relative proportion of contribution from the therapist's own psychopathology, and the pressure from the patient would vary for each patient-analyst pair. (Cooper, 1985) extended the degree of consideration of the therapist's personality in stating that patients consciously or unconsciously expressed their resistance to analysis by "fitting or thwarting the analyst's characterologic needs" (p581). Thus the personality of the therapist became one of the building blocks for the expression of the patient's unconscious conflicts. The degree to which the person of the therapist is considered as central to therapeutic success has therefore ranged from the classical view of the therapist as a 'blank screen' to a more interactional two-person conceptualisation. In this context, Tartakoff (cited in Panel, 1981), stated that the influence of the patient-analyst match on the process and outcome of psychoanalysis has become a subject for study and this clinical perspective has been recently echoed by more empirically oriented research approaches (Lambert, 1989; Beutler et al, 1997).

The acknowledgement of the importance of the interaction between the therapist and patient, was followed by elaboration of the idea that the 'fit' or 'match' between therapist and patient was an important factor in the therapeutic process. Whilst theoretical differences exist between whether the whole relationship may be considered as transference (Joseph 1985) or whether a distinction may be made between different aspects of the therapeutic relationship such as the real versus the transference relationship (Sandler, Dare & Holder, 1973), Tartakoff (cited in Panel, 1981) stated that considerations of transference and countertransference, while central to the psychoanalytic situation, were not enough to account for all of the therapist's cognitive and emotional responses to the patient. While the therapist's self-understanding gained through analysis was critical to his work, the personal attributes of the therapist were also critical in determining what the

therapist responded to and communicated in treating the patient. Tartakoff (cited in Panel, 1981) viewed the 'fit' or 'misfit' of patient and therapist as a crucial factor in determining the outcome of the therapeutic endeavour.

Berzins (1977) had noted that the concept of therapist-patient matching had loose denotative boundaries although generally reflected the idea that certain patient-therapist pairings led to a more favourable outcome (see also, Kantrowitz, 1993). The 'match' or 'fit' between therapist and patient has thus been conceptualised as referring to a spectrum of compatibility and incompatibility of the patient and therapist which is relevant to the psychoanalytic work (Kantrowitz, 1995). The interplay of the participants therefore made each analytic treatment have its own unique character. It is considered to be a reality that creates a context, which significantly influences the subsequent development of all other dimensions of the therapeutic process. Although psychotherapists may consider match to be distinct from such entities as therapeutic alliance, transference, and counter-transference, the boundaries between these concepts are far from clear. Although match is a concept that intuitively resonates of most psychodynamic clinicians, like many fundamental psychodynamic terms, it has no consensual definition (Dolinsky, 1998).

In terms of empirical research, the statistical interaction between patient and therapist variables that had to be the decisive factor and the ideal research design would include conjoint assessment of therapist and patient variables and their interaction, each term evaluated relative to one or more measure of outcome (Berzins, 1977). However, ignorance of the relative importance of single therapist, technique, or patient variables let alone their interaction represented the greatest obstacle to moving from the theory regarding dyadic compatibility in psychotherapy to empirical confirmation or de-confirmation. Ethical justification of a concern with therapist-patient matching principally emphasised the importance of avoiding 'psychonoxious' (Berzins, 1977) pairings in the conduct of therapy. Matching therefore required a great deal of effort that would have to lead to better outcomes than prior or adventitious procedures.

Matching has been recognised as occurring within departments although the principles upon which this tended to happen were purely pragmatic such as which therapist had a vacancy, or the demand of teaching or training commitments. In cases of stalemate or mismatch, patients often left the therapy, and most therapists have at some time heard patients describe stories of unsuccessful interactions with previous therapists. Accounts of these mismatches were usually expressed in terms of the interpersonal characteristics of the previous therapist rather than specific interventions (Berzins, 1977). Psychotherapeutic training has, however, encouraged the therapist to consider these characterisations as manifestations or extensions of the patient's psychopathology rather than as carrying any validity outside of the patient's functioning. Berzins (1977) suggested that most therapists view themselves as 'universalists', behaving in a manner consistent with the belief that every patient would gain some benefit from entering treatment with them. This of course would be consistent with Luborky's (1975) Dodo Verdict on psychotherapy.

Meaningful empirical evidence of the influence of 'fit' between therapist and patient has been sparse. Hollander-Goldfein et al (1989) reported a study in which 97 patients were given the option to choose among three therapists, after interviewing each. They reported that neither demographic variables nor patient perceptions of similar personality characteristics determined choice of therapist. Patient choices appeared to be made on a combination of whom patients believed to be the most competent and understanding and who demonstrated qualities that they wished to emulate. However, the importance of the patient-therapist relationship or match was illustrated in the unexpected finding of a significant correlation between the therapist's rating the patient as likeable and the patient subsequently choosing that therapist. These findings were echoed by those of Dolinsky et al (1998) who reported on 50 patients in twice-weekly psychodynamic psychotherapy. Matching variables included demographic variables and patient and therapist ratings of attitudes towards therapy and perceptions of similarity and differences between themselves and the therapist. They concluded that if the patient was engaged in treatment, the match was viewed as positive irrespective of whether patient and therapist perceived each other as similar. However, these researchers did not

include a measure of the therapeutic alliance in their design and it is probable that their result was in fact a measure of the overall alliance rather than identifying a discrete finding

Few examples of clinically relevant and operationalised therapist-patient matching projects exist within the literature with the Indiana Matching Project (Berzins, 1974) representing an exception. This project represented a four-year (1967-1971) attempt to develop, implement and evaluate a therapist-patient matching procedure and algorithm in a college clinic devoted to short-term crisis intervention oriented psychotherapy. All the therapists were devoted to a philosophy that patients' problems were to be modified in three to four weeks and that therefore the selection of matching variables was guided by these boundary conditions. Factor analytic and 'rational' procedures were used to derive relevant measures from a 50-item likert style questionnaire and various personality measures. Consequently, measures of interpersonal anxiety, depressive and somatic complaints, approval and advice seeking expectancies and audience and relationship expectancies were developed. Therapist predictor scores were focussed on therapist's relatively stable personality characteristics, given their shared therapeutic philosophy, whilst patient predictor scores were based on situation and symptomatic factors. Outcome was assessed by completion of six post-therapy patient ratings and seven post-therapy therapist ratings. The results disclosed several replicable main effects, for example, therapist acceptance and caution and patient advice seeking were associated with greater improvement in both patient sexes. Favourable pairings generally conjoined submissive, inhibited, passive patients with dominant, expressive, active, cue-and structure-emitting therapists and sometimes vice versa, suggesting that improvement in brief psychotherapy was facilitated by pairing patients with therapists whose personalities embodied ingredients that complemented the patients' needs deficits, expectations, or interpersonal stances.

This study was purely intended to generate guidelines for future patient therapist matching within the clinic itself and not intended to be part of a therapy outcome study. Consequently no follow-up data was gathered although the algorithm

developed to match new patient with therapists proved to increase ratings of successful treatment and reduce mismatches. Given its design, and brevity of intervention, no measures of factors such as the therapeutic alliance were taken even though both clinical (e.g., Malan, 1979) and research evidence (e.g., Orlinsky & Howard, 1986) suggested that early sessions formed the 'honeymoon' period and were only predictive of outcome.

4.2 The Decline in Research on Therapist-Patient Matching.

Following the late 1970's, research on patient-therapist match greatly declined as psychotherapy research attempted to control, for the 'confounding factor' of the therapist (Bergin & Garfield, 1986) with the development of treatment manuals and the adoption of large-scale studies of outcome (e.g., Weber et al, 1985a; 1985b). These studies attempted to circumvent the subtleties of different outcomes through the use of large sample sizes.

The decline in research of therapist-patient match resulted from two central difficulties; the essential theoretical weakness of the results obtained to date, and the related difficulties in translating these results into guidelines directly relevant to the clinical situation. Each of these will be considered briefly below.

4.2.1 The Theoretical Weakness of Attempts to Match Therapist and Patient.

Meltzoff and Korneich (1970) observed that studies of compatibility in psychotherapy have examined variants of the notions of similarity, i.e., 'it takes one to know one', or of complementarity i.e., 'opposites attract'. Whilst this intuitively appealed to lay notions of compatibility, it was distinctly bereft of theoretical underpinning. The essential procedure was to assess both therapist and patient on the same pre-therapy variable(s) in the hope that the degree of dyadic similarity would prove predictive of the patient's responses to therapy. Since any pattern of results emerging from this paradigm can be made sense of retrospectively, the need for theoretically anchored predictions and replication of

single studies was extremely important but relatively ignored. From the lack of theoretical underpinning there consequently developed the added problem of upon which variables to match therapist and patient. The selection of independent variables for their 'symmetrical' applicability to both participants presupposed that the variables are equally important for therapist and patient. An 'asymmetrical' conception of the matching problem held, in contrast, that some variables were more important for therapists than for patients and vice versa. Gurman and Razin (1977) considered this to be a central distinction leading to the consideration of personality in symmetrical research and 'roles' in asymmetrical research. They stated that "for example, any therapist could have a diagnosis or even a presenting problem, if he assumed the role of the patient, as could a patient use techniques if he were a therapist in a different situation. 'Personality' or symmetric characteristics, though, cannot be so characterised. Consequently, whilst an operationalisation of research methodology may have been partly achieved, a lack of theoretical underpinning was maintained. This was well illustrated by the history of the A-B Interaction Hypothesis.

The distinction between "A" and "B" therapists originated with Whitehorn and Betz (1954) who studied therapist variables associated with differential success in the treatment of inpatients suffering from schizophrenia. Clinicians, predominantly doctors, were retrospectively ranked according to their success, and the results dichotomised into 'A' class therapists who were more successful and 'B' class therapists who were less successful. This distinction was further facilitated by the development of a 23 item 'A-B' scale which used only those items from the Strong Vocational Interest Blank (Donnay 1997) which Whitehorn and Betz (1954) found distinguished between 'A' and 'B' type therapists. The interest in further research was afforded by McNair et al (1962) who reported that B type therapists outperformed A-type therapists when working with patients who were predominantly neurotic. The 'A-B interaction hypothesis' was thereby put forward in which A-type therapists performed better with patients suffering from schizophrenia, whilst B-type therapists had better results with patients who were predominantly neurotic.

A large number of analogue, laboratory based, studies followed (e.g., Berzins, Dove and Ross 1972, Beutler, Johnson, Neville and Workman 1972) working on the assumption that if the A-B distinction referred to an individual difference, in personality or interest, results consistent with the interaction hypothesis should emerge even in highly contrived ‘helping’ situations. This hypothesis was powerfully supported on empirical grounds (see Razin, 1971; Razin, 1977 for a review), but found little support when transferred to the clinical situation. Furthermore, although the empirical power of the A-B variable to ‘produce results’ generated significant research interest, its conceptual or theoretical status remained highly elusive.

The fate of the A-B variable when considered as a variable for the therapist alone or as a variable for matching therapist to patient could be summarised by a comparison of two reviews by the same author. Razin (1971) was optimistic regarding the A-B distinction. Analogue research was consistent and promising, and work on differential personality correlates also continued to show consistent, replicable differences. A-type therapists, for example, were more feminine by cultural stereotype standards and more open to unusual perceptions but less daring and more verbally oriented. However, by 1977, Razin (1977) had almost the exact opposite opinion following a review that included “every known doctoral dissertation and unpublished study, and even older studies unavailable at the time of the 1971 review” (p319). Whilst asserting that, on the basis of the empirical evidence available, the A-B typology was not an artefact or a fluke, he remained highly perplexed regarding what it actually measured. Razin (1977) therefore sounded the death knell for the A-B variable when he summarised the preceding twenty-five years of research in four overall points regarding the A-B typology;

- (i) It was not an artefact of experimentation as it correlated with, and thus predicted a consistent constellation of personality differences.
- (ii) Whilst these differences were replicable and may have had value for research in personality, the A-B variable was not a powerful predictor of any important process or outcome parameter in real ongoing therapy.

- (iii) Other variables, such as therapist level of experience and severity or chronicity of patient disturbance were simply more powerful.
- (iv) Situations that did not resemble traditional therapy may have had some use for the A-B variable. The clinically relevant differences that did occur were based on brief encounters, early sessions, and/or untrained change agents. He suggested therefore that modalities using very brief encounters such as suicide hotlines or college-student-therapist programs, where little formal training is available, might find some value in the A-B variable.

Adopting the opposite approach, namely, the specification of one variable above all others runs the risk of inadvertently ignoring factors more central to the process of psychotherapy. Hunt et al (1985) used a double blind methodology in which 63 patients were matched with therapists using the Interpersonal Discrimination Test as a measure of cognitive match. In this prospective study, 60% of unmatched pairs terminated prematurely, whilst such termination only occurred in 24% of matched pairs. Furthermore, matched pairs showed an increased rate of initial improvement as measured by the Global Assessment Scale although overall improvement between matched and unmatched pairs was equivalent at the end of the 24-week treatment. Hunt et al (1985) concluded that cognitive match appeared to be a good variable upon which to predict engagement in or early drop out from therapy but was not able to predict longer-term outcome.

At best, this body of work reinforced the need to research the role of the therapist, and highlighted individual differences between therapists, but was unable to link the results obtained to any major body of theory.

4.2.2 The Low Clinical Relevance of Attempts to Match Therapist and Patient.

Probably the most serious methodological obstacle to the clear interpretation of results in matching studies involved the persistent use of ambiguous indices of similarity. Whilst Razin (1977) concluded that the A-B dichotomy and interaction hypothesis revealed 'only a scant few areas of possible clinical utility' (p319),

symmetrical research designs using personality inventories such as the Minnesota Multiphasic Personality Inventory (MMPI; Hathway, Mckinley, et al 1989) were simply difficult to interpret beyond generalism and lacked the detail required for direct translation to clinical work.

For example, Carson and Heine (1962) using a sample of 60 medical student therapists and 60 outpatients calculated 'dyadic profile similarity indices', Cronbach's D^2 , and related the similarity scores to a composite measure of outcome which included supervisor's assessment of improvement and occupational adjustment. Analysis of variance of outcome scores across five groups of dyads representing increasing degrees of profile dissimilarity yielded a significant F ratio. The pattern of mean scores suggested a curvilinear association between similarity and outcome, i.e. moderately dissimilar dyads achieved the best outcome, but it became difficult to define precisely the nature of this dissimilarity. Furthermore, attempts to replicate the results of this study, Carson and Llewellyn (1966) and Lichtenstein (1966) failed. Similarly, Wogan (1970) used the MMPI in a study that generated patient, therapist, and patient-therapist cross product terms as independent factors in a multiple regression design. He reported that similarity on a subtlety factor, comprised primarily of scores on the K and L scales of the MMPI, retarded therapeutic improvement. Wogan (1970) suggested therefore that similarity in defensive styles between therapist and patient tended to be counterproductive.

The theoretical and methodological difficulties encountered were not aided by the antipathy between clinical and research communities. Clinicians argued that research as representative of science should not tamper with art, whilst the researchers argued the opposite, namely, that art should not tamper with science. Berzin (1977) therefore concluded that the majority of the research to that point in time must be regarded as strictly exploratory and that,

"On both theoretical and empirical grounds, our understanding of interactive variables in psychotherapy barely exceeds common sense. Whether the independent

variables be the same for therapist and patient (symmetrical perspective) or different (asymmetrical perspective), the available evidence does not justify modifications of current, admittedly adventitious, procedures for pairing patients with therapists” (p245).

It was not surprising therefore that the history of patient-therapist matching was viewed with disdain by both researchers and therapists,

“The spectrum of reactions to the notion of therapist-patient matching thus appears to range from beliefs that science should not tamper with art [the clinicians view] to beliefs that art should not tamper with science [the researcher’s view]” (Berzin 1977, p222).

4.3 Recent Developments and Potential Rapprochement.

In considering the phenomenon of ‘fit’ between the therapist and patient, Krantowitz (1993; 1995) put aside previous notions of symmetry and considered three types of fit and the consequences of these for psychoanalytic psychotherapy. Essentially using a functional model. Kantrowitz (1993) assumed that all therapists retained some areas of only partially resolved conflict and some attitudes, values, styles, and reactions of which they are not completely aware. In keeping with Strupp’s (1986) schematic model of psychotherapy, these areas of unresolved conflict could be manifested in the therapist’s relationship with family members, colleagues, and with patients. The patient’s reaction to the therapist, beyond elements of the transference neurosis per se, would also be influenced by the experience of the therapist’s style, attitudes, values, and conflicts to the extent to which these were apparent, both consciously and unconsciously. Whilst a perfectly analysed therapist may be an ideal, Dolinsky et al (1998) noted that the concept of therapist-patient match may be rooted in the developmental perspective of “goodness of fit” between mother and child. This assumed that a child’s intrapsychic development resulted from a highly interactive interpersonal relationship, as opposed to the child’s passively absorbing the mother’s influence.

Consequently, Krantowitz (1993; 1995) outlined three possible types of match based on the influence of unresolved areas of the therapists functioning and of which the therapist was essentially unaware. Importantly, she did not specify the content of these areas, but focussed on their influence in the therapeutic process. Matches of similarity involved similar issues or traits, or similar expression of conflict and conflict derivatives in the therapist and the patient. The therapist would not be necessarily conscious these traits in himself or herself, but was therefore less likely to notice that they overlapped with similar traits in the patient. When the therapist would notice the overlap, he or she would not be likely to view the similarity as an impediment to the treatment. Consequently, the shared area may or may not constitute a major difficulty for the therapist, but it did represent an area of central difficulty for the patient. Matches of complementarity involved areas of different expression of a similar conflict, in which the therapist was unconsciously defending against the issue with which the patient is manifestly struggling. The therapist in these cases would be unaware of the shared problem area. This problem area, whilst always shared, would be central to the patient's difficulties, but might or might not be a central problem for the analyst. Both matches of similarity and complementarity would therefore be viewed as potentially impeding therapeutic progress. Conversely matches based on compensation involved areas in which the therapist's character or style provided a beneficial effect for the patient. The patient would identify with or use a quality or dimension of the therapist to balance or modify a previously negative identification or to resolve a conflict. The concept of a compensatory feature in the therapist facilitating the psychoanalytic treatment was distinguished from the concept of "a corrective emotional experience" as described by Alexander (1950) given that the analyst was not necessarily consciously aware in the analysis of his/her traits as such and these were not intentionally used for therapeutic effect.

Krantowitz (1989) had used such a taxonomy in a pilot study of the outcome of 21 cases of psychoanalytic psychotherapy. The data had not been collected for such a study and was limited in terms of small sample size, a lack of comparable data for the patients and therapists, a lack of experience of the treating analysts, an inability

to take into account the effect of supervision on the therapist, and a lack of comparability of the therapists' interviews in terms of openness and completeness. However, five cases were assessed as having similar issues to their therapists where the issues were central to the patient's difficulties from the outset. The similar issues for these five therapists and patients were narcissistic ones. These matches were characterised either by mutual idealisation and overvaluation, particularly of intellectual skills, or by a shared experience of vulnerability and neediness. Consequently, the analysis of these narcissistic issues and of the patient's aggression was severely impeded. A further two cases were assessed as having a complementary patient-therapist match in which an issue was central for the patient's difficulties and no analytic work seemed to be accomplished to resolve it. In both cases, the patients were openly provocative and aggressive, and the therapists avoided their own aggression. Three cases were assessed as a compensatory patient-analyst match, which seemed to facilitate the analytic work. In all three cases, qualities of the analyst that were initially facilitating to the analytic process, later served as an impediment as different issues came to the fore in the analytic work. All three treatments were however considered successful by the analysts. Krantowitz (1995) thus highlighted how the therapist-patient match may have influenced what issues were left at the point of termination, or the time of termination itself, because of the interdigitation of issues that had become central in this latter phase of analysis. The extent of resolution of issues varied from case to case. The focus on the role of patient-therapist match in the outcome of psychoanalysis revealed that match was identified in almost every case as playing some role but that only in 13 of the 21 cases did match stand out among other factors as centrally relevant to outcome. Whilst recognising that in putting a microscopic focus on the issue of match, Krantowitz (1995) may have found what she was looking for, Krantowitz (1995) stated her belief that match issues were always present in some way although recognised that the extent of their influence on the process that varied. The match may not necessarily be the primary reason for successful or unsuccessful outcome but appeared to be a significant factor influencing outcome.

As will be described in Chapter 5, Krantowitz's (1995) clinical description of the functioning of match between therapist and patient is congruent with the conceptualisation of mental functioning as surmised by Attachment theory in the concept of Internal Working Models and consequent styles of behaviour. Some preliminary studies have strongly supported the possibility of empirically examining this potential link.

Hardy et al (1999) attempted to examine therapist response to events identified and classified by patients as helpful during 'psychodynamic-interpersonal' therapy using the Brief Structured Recall procedure (Elliott & Shapiro, 1998) itself a variant of the Interpersonal Process Recall procedure pioneered by Elliott et al (1986). Analyses of episodes focussed upon three domains, client attachment styles, the presenting attachment issue, and therapist responsiveness. Identified episodes within sessions were then transcribed and examined in detail to establish an understanding of the narrative in attachment terms, based on the narrative, and in line with Holmes' (1997) 'story making and story breaking' analogy. Consequently, both the patient's predominant attachment style and the attachment issue most predominant within a particular episode were identified. Therapist interventions were subsequently considered in terms of whether they provided security, worked at the zone of proximal development, or promoted the integration of client experiences. In ten selected episodes, a consistent finding was of therapists responding to preoccupied attachment styles with reflection and to dismissing styles with interpretation. They noted that when working with clients at the level of proximal development, the therapist must know when to push for change, i.e. interpretation, and when to hold the client i.e. reflection. Stern (1985) called these interventions purposeful misattunement facilitating the restructuring of internal working models and attunement (reflecting clients' emotional and concerns), respectively. Hardy et al (1999) fully acknowledged the limitations of their study in that only episodes classified as helpful were selected. Furthermore, the study was not related to outcome of therapy in any way. This latter point relates to the question of therapeutic management and whether an episode identified a helpful

may be truly so or an incident of a potentially unhelpful pattern in the patient's life being repeated and potentially validated during a therapy.

Krantowitz (1995) stated therefore that it may be helpful to think of a continuum for the analyst around conflict-free and conflict-based responses that are relevant to match. Aspects of responses at either extreme may be conscious or unconscious for a given analyst. Characteristics or style may or may not reflect underlying conflictual issues in the analyst and may be experienced as disquieting to some patients and not to others. At one extreme there are issues of style which, although they develop out of the analyst's history and may be based on positive and/or negative identifications as well as constitutional factors, are primarily neutral, or conflict-free for the given analyst. Conflict-free traits might include, for example, tempo, level of activity and passivity, and verbal fluency. These traits in the analyst may have a particular dynamic meaning, positive or negative, to any given patient based on his or her personal history. At the other extreme are conflict-based responses to a patient. An example would be issues an analyst fails to see or responds to unconsciously, precisely because they are threatening and would revive painful affective experiences. The result of such a match is illustrated by the two cases we have described as complementary matches in which the analysands were openly provocative and aggressive, and the analysts avoided their own aggression. The reactions that fall in this part of the spectrum would include those customarily defined as countertransference.

4.4 Conclusions.

There exists a significant body of anecdotal clinical evidence suggesting that the match between patient and therapist plays a significant role in the successful psychotherapy (Tartakoff; cited in Panel, 1981). Previous attempts to empirically investigate this phenomenon succeeded in producing reliable results but these were highly limited in terms of their theoretical grounding and clinical relevance (Berzins, 1977). However, the recent confluence of increased interest as the therapist as a neglected research variable (Lambert and Okiishi, 1997; Bergin 1997,

Elkin 1999) and the re-conceptualisation of match as a process variable (Kranowitz, 1995), suggest that this aspect of patient and therapist interaction would be worthy of further attention. This is especially so in considering which qualities may be important to select for in the training of therapists or allow certain therapists to work most well with which type of problem or patient (Paul, 1967). As will be shown in Chapter 5, developments in attachment theory as encapsulated in the Adult Attachment Interview (Main et al, 1985) offer the opportunity to examine the question of patient-therapist fit in a more theoretically grounded but empirically reliable manner.

CHAPTER 5. ATTACHMENT THEORY AND ITS APPLICATION TO CLINICAL PRACTICE.

5.0 Introduction.

The appeal of attachment theory lies in its integration of concepts and ideas borrowed from diverse disciplines whilst remaining faithful to psychoanalytic theorising and in its compatibility with the principles of science. In the following sections, a brief outline of the historical development and central tenets of attachment theory is presented followed by a description and discussion of the measurement of attachment in adulthood and its relevance to clinical practice. The chapter concludes in stating the possibility that attachment theory may offer an opportunity to address some of the concerns regarding theoretical grounding and empirical definition and measurement outlined previously.

5.1 Historical Development of Attachment Theory.

Whilst Bowlby's initial training was grounded in the Klienian psychoanalytic school of thought, in which children's emotional difficulties were viewed as originating from fantasies and intrapsychic conflicts between aggressive and libidinal drives, his early studies (Bowlby, 1951) increasingly convinced him that external reality and family environment were at the root of emotional disturbance.

In the formation of Attachment theory, he subsequently drew upon concepts from embryology, ethology, control systems theory and cognitive science (Bretherton, 1985). He retained the notion of mother as central to the development of the child's capacity for self-regulation and conceptualised the mother as the 'psychic organiser' for the child given her initial role in performing regulatory functions for the child before these become internalised. Bowlby's initial underlying supposition was that a mother's inability to fulfil this function at a critical period would lead to maladaptive development of self-regulation in the child. Bowlby (1988) however later revised the notion of critical periods to explain the effects of maternal

deprivation in favour of a model whereby individuals can progress along one of several potential developmental pathways. A myriad of contextual and relational factors would ultimately determine which pathway is followed (Rutter, 1989).

The influence of ethology is also evident in Bowlby's (1988) attempts to draw parallels between imprinting as observed in animal species in critical periods and human attachment behaviour. Lorenz's (Lorenz, 1935) observations of imprinting in geese and other precocial birds provided a good example of the formation of a social bond as a primary function with feeding as secondary. Ascribing primacy to proximity-seeking instinctual behaviours, Bowlby (1958) also rejected the psychoanalytic view in which need satisfaction was seen as primary and attachment as secondary. Attachment was hence attributed a primary function and attachment behaviour was conceptualised as a motivational system, distinct from other motivational systems.

Whilst retaining Freud's (1953) concept of instincts, Bowlby (1958) conceptualised infant's attachment behaviours such as those of sucking, clinging, following, and smiling, as instinctual responses serving to form a bond between mother and child. The child's signals of proximity seeking were considered by Bowlby (1958) to be activated in the service of calling forth caregiving behaviour and whilst these responses were initially activated indiscriminately, they were to become integrated and preferential to the maternal figure in the second half of the first year of life.

Further, Bowlby (1969/1982) drew a distinction between attachment and social learning theory's concept of dependence. Two distinct differences between the approaches are noteworthy. Unlike dependence, attachment is not considered a personality trait but rather emphasises the relational nature of the bond to a preferred other. In addition, attachment behaviour, as distinct from dependence, is attributed a biological function of protection and hence survival and therefore put forward as a rival to other biological-motivational systems. Bowlby thus argued that the "Behavioural equipment that protects from predators is of an importance

co-equal to that of equipment that leads to nutrition or reproduction” (1969/1982, p.226)

Bowlby (1973) subsequently defined the attachment of an infant to its primary caregiver as a bond developed with some other differentiated and preferred individual who is usually conceived as stronger and/or wiser. Bretherton (1985) pointed out that ‘attachment’ as conceived by Bowlby (1973) was not meant to encompass all aspects of the parent-child relationship. Rather it referred to those aspects of the relationship pertaining to the regulation of the attached person's sense of felt security. The term attachment is therefore not synonymous with the term ‘social bond’. The role of the attachment figure as a playmate is thus considered conceptually distinct from that of the caregiver. Whilst both are considered important, attachment in the narrow sense pertains to the latter.

5.2 Central Concepts of Attachment Theory.

Borrowing the notion of a secure base from Blatz (1940), who stated that children need to develop a secure dependence on parents before launching out to the world at large, Bowlby (1973) suggested that maintenance of ‘felt security’ lay at the core of attachment theory. He outlined a homeostatic system in order to achieve this and stated that the two subsystems involved were both mutually facilitative and mutually inhibitive. An Exploratory System, which dominates when the infant uses its attachment figure as a secure base from which to explore its environment, was paired with an Attachment System which is activated when the child's ‘felt security’ is low and it will return to its attachment figure.

Bretherton (1985) elucidated further the operation of the attachment system by suggesting a continuously active system, i.e., never idle, which functions to regulate a sense of felt security through the active appraisal of incoming sensory information. In line with the notion of attachment serving a protective function, events that are continuously monitored and appraised fall into two classes; those that indicate the presence of danger or stress, and those concerning the location and

accessibility of the attachment figure. The outcome of the process of appraisal will determine the presence or absence of a threat and therefore whether proximity seeking is called for. In reaching a decision the attachment system draws on the internal working models (IWMs) of the environment, the attachment figures and the self. For example, when incoming event information suggests no threat and sense of felt security is high, the set goal of the system is to explore the environment. However, when the environment is perceived as threatening, the set goal of the system may change and proximity-seeking behaviour will be activated.

Building on idea from ethology, Bowlby (1969/1982) proposed that behavioural systems differ both in their function and in their structural complexity. A step above simple reflex is 'fixed action pattern' which is a highly stereotyped behaviour activated and terminated by specific stimuli whilst making use of feedback from the environment during its execution. Many of the basic attachment behaviours described by Ainsworth (1967) such as grasping, smiling, and crying, can be considered fixed action patterns (Marvin & Britner, 1999). However, fixed action patterns are not goal-directed, purposeful on the part of the infant, but rather have in Bowlby's terms a 'predictable outcome' as long as the behaviour is executed in an environment similar to the one in which it has evolved. A more complex and sophisticated pattern of behaviour is a 'goal-corrected' pattern. Goal-corrected behaviours also have activating and terminating conditions, and predictable outcomes although outcomes are achieved through a more sophisticated process of appraisal and choice from a repertoire of behaviours that progressively bring the child closer to achieving the 'set goal', that is, proximity to the attachment figure. In order to engage in goal-corrected behaviour, the child must have hold a complex and dynamic, internal representation of relevant aspects of the self, his/her behaviour, the environment, and the object or person toward whom the behaviour is directed. When a goal-corrected such as locomoting toward the caregiver in order to make physical contact is activated, the child continuously orients his/her behaviour and selects alternative behaviours, based in part on the feedback received from the effects of the behaviour. When the set-goal is achieved, the perceived

discrepancy between the set-goal and the organism's state is reduced to zero, the behavioural plan terminates (Marvin & Britner, 1999).

5.3 The Nature and Development of Internal Working Models.

Perhaps the most important and central concept to attachment theory was that of the internal working models (IWMs). Bowlby (1973) drew parallels between the concept of IWMs and phenomena that have traditionally been referred to as 'introjection of a good or bad object' and 'self-image', further advancing that IWMs of the self and attachment figures are actively constructed in the course of repeated interpersonal interactions. With the acquisition of locomotion, infants increasingly interact with the external world and it is these interactions, which give rise to the development of IWMs of increasing complexity. Further, as Main, Kaplan and Cassidy (1985) suggested, IWMs of the infant-parent relationship are based upon a history of 'actions' and 'action outcomes'. This conceptualisation is consonant with the Piaget's (1954) view of sensorimotor development, in which the child's understanding of the world and his/her development and organisation of schemes is based upon interactions with, and actions on, persons and objects.

In the early development of IWMs, representations of the self and attachment figures are closely tied and thus are assumed to form a single representation of the relationship. The development of self-regulation marks the development of distinct and yet complementary and mutually confirming IWMs of the self and attachment figures (Bretherton, 1985). For example, a child who constructs IWMs of attachment figures as unloving and rejecting will in turn hold a model of the self as unloved and unworthy. By contrast, a child who holds IWMs of attachment figures as loving and sensitive to his/her needs will in turn hold a complementary model of the self as worthy of love. The infant thus develops individuated and complementary IWMs for each important attachment relationship. In keeping with the notion of complementary internal working models of the self and attachment figures, Sroufe and Fleeson (1986) proposed that through repeated dyadic interactions, the child internalises both sides of the relationship. IWMs thus capture

the dynamic interaction between the infant and the external world and are actively constructed and reconstructed (Bretherton, 1985).

Main (1985) subsequently defined the nature of internal working models as a “Set of conscious and/or unconscious rules for the organisation of information relevant to attachment and for obtaining or limiting access to that information regarding attachment-related experiences, feelings and ideations” (pp.66-67). It is those rules that have been the subject of considerable theorising both within and without the attachment field.

In his formulation, Bowlby (1979) maintained that IWMs are therefore comprised of both reflex-like fixed action patterns and more complicated goal-corrected behaviour patterns which are continually adjusted. Bowlby (1973) had been influenced by Craik's (1943) conceptualisation of internal working models in arguing that “If the organism carries a small-scale model of external reality and of its own possible actions within its head, it is able to try out various alternatives, conclude which is the best of them, react to future situations before they arise, utilise the knowledge of past events in dealing with the present and future and in every way to react in a much fuller, safer and more competent manner to emergencies which face it” (p.61). In keeping with Craik's (1943) notion, Johnson-Laird (1983) suggested that working models have a protective function in that they permit the organism ‘insightful and foresightful behaviour’. Their adaptational role necessitates that they closely mirror aspects of the world they represent so that they imitate the ‘relation-structure’ (Craik, 1943) of the event they represent. It therefore follows that adaptive internal working models are those that afford the organism accurate prediction of the future and those that have not been updated may lead to maladjustment. The development of internal working models is therefore considered as an inherent part of the development of the attachment system and plays a pivotal role in guiding behaviour and expectations.

Consequently, Bowlby (1973) introduced the term ‘multiple models’ to refer to IWMs that are incompatible and contradictory and further suggested that the

formation of multiple models was the result of unfavourable interactions with attachment figures. Early inconsistent and unsupportive attachment relationships were thought to underlie the child's construction of two incompatible models, one that is conscious of thus accessible representing the parent as loving and emotionally available, and the other, excluded from conscious awareness that represents the parent as rejecting and unavailable (Bretherton, 1998). Main (1991) drew attention to the fact that the term multiple models was not intended to capture the organisational hierarchy of models or the diversity of models constructed to represent aspects of reality that would be expected within individuals but rather refers to the existence of contradictory models, representing the same aspects of reality. In his attempt to further elucidate the development of multiple models, Bowlby (1980) drew upon Tulving's (1972) distinction between semantic and episodic memory. Episodic memory was conceptualised as memory that contains real-life experiences, autobiographical events that include perceptions, affects, and actions as distinct from semantic memory, that refers to general knowledge that may be abstracted from direct experiences or acquired through instructions by others. Bowlby (1980) postulated that in response to inconsistent caregiving, some children may defensively exclude or restrict access to their autobiographical memories of traumatic events, but maintain conscious access to parental verbal accounts that are stored in semantic memory.

The concept of internal working models is by no means novel and is shared in common with other psychological theories. Theories of event representation have been particularly influential in considering the nature and properties of internal working models. Representational processes are postulated to be governed by what Mandler (1979) and Nelson and Gruendel (1981) termed event schemata and Schank and Abelson (1977) termed scripts. These are considered to contain abstracted information concerning repeated similar events. The idea is that on the basis of similar experienced episodes, for example, being breast fed, the infant begins to form a generalised episode or memory that contains expectations of how similar events are likely to unfold. As Stern (1985) points out, the generalised episode does not constitute a memory for a specific episode but is an abstraction of

multiple similar and yet slightly different specific events. Schank (1982) subsequently argued that multiple interconnected hierarchies of schemata that are graded from the very general to the very specific are constructed and continually reconstructed and revised in accordance with new incoming information. Existing schemata govern the manner in which new experiences are processed and will determine whether new schemata are required when unfamiliar events are encountered and repeated. The information from existing schemata will be fed into other structures that represent generalised event information concerning agents, actions, intentions, goals and emotions (Bretherton, 1985).

Similarly, Stern (1985) proposed that what the infant's developing representational world is concerned with are episodes that involve interpersonal interactions of different types which he termed Interactions that have been Generalised (RIGs). He contended that RIGs are flexible structures that capture several actual instances and form a prototype or average to represent them all. Stern suggests that RIGs could be conceived of as the building blocks from which IWMs are constructed.

5.4 The Overlap with Psychoanalysis.

Whilst a substantive review of areas of commonality and division between attachment theory and psychoanalysis is beyond the scope of this thesis and could not surpass Fonagy's (1999) review, it would be important to note in passing some points of contact between the two theories so as to emphasise the fact that Bowlby (1969/1982) did not abandon his links with psychoanalysis. In doing so, points of overlap are not favoured over points of divergence but are considered to serve the purpose of rooting attachment theory once more as a theory of development with the relationship between parent and infant at its heart.

Whilst the terms differ, both theories describe attachment phenomena although Erikson would use the term 'basic trust' and Sandler used the term 'background of safety' to describe the secure base. Both approaches agree that personality should be studied within a social context/environment and that maternal sensitivity is the

key to determining the quality of relationship regulation between infant and mother. Both theories agree that a well-regulated early relationship with the caregiver is predictive of the development of an autonomous and robust sense of self. This would be true of the across the broad range of psychoanalytic schools from the Kleinian tradition, to the formulations of Erikson and Winnicott. Similarly, significant common ground exists in viewing narrative as providing access to representations of relationships and in seeing security as linked to coherent experience. Finally, most analytic schools would concur with attachment theory in considering mental representations of relationships as determinants of interpersonal behaviour and account for the continuity of behaviour across the lifespan. Finally, both frameworks assume that perception and experience are distorted by conscious and unconscious expectations, which are encoded in the representational system.

As Fonagy (1999) concluded,

“The closeness of object relations and attachment theory formulations is evident in the links between secure attachment (basic trust) and therapeutic alliance, IWMs and concepts such as role responsiveness (accounting for transference and countertransference phenomena), disorganisation of attachment and clinical observation of projective identification, the notion of coherence and the overlapping notion of narrativization of one’s history and so on” (p619).

5.5 The Adult Attachment Interview.

Whilst a number of measures of attachment in adulthood have been developed, most take the form of self-report inventories (e.g., the Revised Adult Attachment Scale; Collins & Read, 1990), or the Relationship Scales Questionnaire (Griffin & Bartholomew, 1994). Responses to these are taken at face value and whilst each has produced consistent research results (Stein, Jacobs, Ferguson, Allen & Fonagy, 1998), there is only one measure that was established in order to ‘surprise the unconscious’ (Main & Goldwyn, 1985) and thereby gain sight of the manner in which an individual’s IWM may shape their autobiographical history. The Adult

Attachment Interview (AAI; Main & Goldwyn, 1985) is considered as the most robust measure of adult attachment to date. It was conceived as a way of predicting infants' Strange Situation attachment classifications and was conceptualised as requiring individuals to recount and reflect upon early attachment related relationships and experiences whilst maintaining coherent and collaborative discourse without inconsistencies and contradictions (Main, 1995).

The AAI is a semi-structured interview comprising twenty-five questions designed to assess the subject's view of early as well as present relationships and how these may have changed and developed over time. The interview has been devised so that questions are ordered chronologically from early childhood through adolescence and lastly into adulthood. Interviewees are required to provide five adjectives that describe their relationship to each parent and then offer specific episodic examples to support each adjective chosen. In addition, they are asked questions about whether they have experienced rejection, threat or abuse and whether they have suffered any major and traumatic losses and separations. Interviewees are also required to reflect upon these memories and are asked why they think their parents behaved as they did and how do they think these early experiences have affected and shaped their adult personality. The AAI attempts to capture the subject's 'current state of mind' with respect to attachment with emphasis placed on the nature of representations of attachment figures and relationships as reflected in the narrative rather than the actual/probable experiences, although these are also considered when assigning a rating.

The AAI attempts to identify analogues of attachment behaviour patterns in infancy with representational processes in adulthood as reflected most strikingly in the coherence of discourse (Stein et al, 1998). The coding system relies predominantly upon a detailed psycholinguistic analysis of individual's descriptions of both early childhood and present relationships with parental figures. The classification system yields attachment classifications that are parallel to infant attachment patterns observed in the Strange Situation Paradigm (Ainsworth et al, 1978).

Scoring of the AAI comprises the ratings of probable childhood experience on five dimensions, with each dimension being scores for each parent on nine-point scale. The dimensions of these experience scales are presented in Table 5.1.

Table 5.1 AAI Probable Experience Scales.

Probable Scales	Experience	Description
Loving		The extent to which the individual felt parental figures to be emotionally supportive and available, in particular, in times of need.
Rejection		The degree to which attachment figures engaged in the shifting away and thus rejection of the child's expression of attachment, affection, dependence and need.
Involving/Role Reversing		The degree to which one or both attachment figures allocated the responsibility for their psychological and physical welfare to the child and thus demanded attention and parenting from the child.
Neglect		The degree of the individual's experience of one or both parents as inattentive, psychologically inaccessible and preoccupied as reflected by the absence of potential parent-child interactions.
Pressure to Achieve		The degree to which the individual was pushed to achieve and excel in childhood and was threatened with withdrawal of parental affection and care if failing.

In the following stage, the present state of mind of the interviewee with respect to attachment is rated for both organised and disorganised attachment patterns. The scales are designed to evaluate the individual's mental representations of the self in relationship to attachment figures, attachment related experiences and feelings and are thus instrumental in identifying individual differences in attachment organisation. Ratings are assigned on nine nine-point scales briefly outlined below in Table 5.2.

Table 5.2 AAI 'State of Mind' Scales.

'State of Mind' Scales	Description
Idealisation	The discrepancy between the overall view of the parent at the semantic level and the probable experience of the subject as inferred in other aspects of the narrative and through specific episodic information. Essentially, it seeks to assess the extent to which the subject attempts to retain an image of the parent as "perfect" that is unsupported by autobiographical memories, and hence ratings are assigned separately for mother and father.
Dismissing Derogation	The extent to which attachment experiences and relationships are subject to derogating dismissal. A transcript is considered to contain active dismissal when experiences of death, loss and separation are treated with contempt, are described as unimportant and is often marked by very brief responses. The degree to which attachment figures are described in derogating terms or with active dismissal is rated separately for mother and father.
Involved/Involving Anger	The extent to which the subject expresses current preoccupied anger with attachment figures. It is the nature and quality of anger (Managed versus uncontained) rather than the frequency that informs a rating on this scale and ratings are assigned to each parental figure.
Insistence on Lack of Recall	The degree to which the subject makes direct references to lack of memory in an attempt to block further queries or further discussion of a given topic. Both the frequency and the strength of insistence upon lack of memory are considered important alongside the context in which lack of memory is reported.
Passivity of Thought	The degree to which subjects manifest difficulties in completing sentences, lapses into long silences and show repeated intrusions of vague expressions that are all assumed to reflect passivity of discourse. This strategy is most strikingly observed in transcripts of parents of C2 infants in the Strange Situation.
Fear of Loss	Identifies individuals who experience and express fears of loss through death of their own child but are unable to connect these to the source and consequently act upon them (e.g., being unnecessarily overprotective of their child). The scale differs from all other scales in that it is based on the adult's discussion of their own child rather than their childhood experiences but also because it was empirically derived to predict infant insecure-avoidant classifications.
Metacognitive Monitoring	The subject's ability to both monitor and report on his/her own processes of thinking and recall whilst the interview is in progress. Metacognitive monitoring is distinguished from indications of psychological awareness or seemingly insightful remarks that may have been learnt in other contexts and hence refers only to instances where the descriptions reflect active and spontaneous thinking in response to the immediate demands of the task.

Table 5.2 AAI 'State of Mind' Scales (continued).

'State of Mind' Scales	Description
Coherence of Mind	Constitutes the "overall state of mind" score with respect to adult attachment. Rating of this scale is therefore based on a consideration of all other state of mind scales and all types of incoherence identified. Whilst high correlations are expected between ratings of the Coherence of Discourse and Overall Coherence of Mind, some independence is also anticipated, particularly in considering beliefs that albeit unusual may be presented in a coherent and co-operative manner. In considering this rating a review of the transcript of discourse, fear of loss and indications of unresolved trauma and indications of irrational attachment-related beliefs is advocated in assigning this final rating.
Coherence of Transcript	Assesses the individual's ability to describe attachment-related experiences and feelings in a consistent and readily understood manner and takes into consideration both the form and the content of the narrative. Among the key aspects of coherence are the degree of collaboration of the interviewee in telling a story, the spontaneity with which episodes are retold as distinct from rehearsed stories or those originating from parents. In addition, the plausibility of the story is considered important, i.e., does the narrative hang together and is it consistent throughout or do discrepancies arise between the individual's description and the rater's evaluation of probable experience. Furthermore, it focuses on whether the overall evaluation of attachment experiences is substantiated by specific episodes or whether contradictions are present.

The coherence of the transcript is considered most informative in establishing the overall attachment status of the adult and was found most predictive of infant attachment organisation (Main & Goldwyn, 1985). Two additional scales to those outlined in Table 5.2 are employed in rating extreme experiences of state of mind including unresolved experiences of loss through death and unresolved abusive experiences. Both scales are concerned with the identification of disorganisation manifested in three central forms; a) lapses in the monitoring of reasoning, b) lapses in the monitoring of discourse and finally c) reports of extreme behavioural reactions.

Main and Goldwyn (1998) proposed applying Grice's maxims (Grice, 1975) in establishing the coherence of transcript. Grice formulated a general, overriding principle of conversation, termed the co-operative principle, which participants in

conversation are expected to adhere to. As Grice (1975) states "Make your conversational contributions such as is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which you are engaged". This principle incorporates four maxims;

- Quality: Be truthful and have evidence for what you say.
- Quantity: Be succinct yet complete.
- Relation: Be relevant, presenting what has been said so that it is understood.
- Manner: Be clear and orderly.

The maxim of quality is considered most important with optimal discourse defined as truthful and collaborative (Main & Goldwyn, 1985). Violations of these maxims are permitted when appealing to the overriding co-operative principle but otherwise indicate incoherence. Furthermore, individuals may gain credits for coherency when retelling a complex and difficult history despite existing violations.

From ratings on all of the above scales, adult attachment classifications are subsequently derived. The AAI yields five distinct main attachment patterns with further sub-classification. These are presented in Table 5.3 and mirror those that were established by Ainsworth et al (1978) using the Strange Situation Paradigm.

Table 5.3 The Adult Attachment Interview Main Attachment Classifications.

Classification	Description
Secure/Autonomous (F)	Secure adults value attachment relationships and experiences whilst remaining objective in their evaluation and reflective upon their influence. The interview on the whole is coherent and fluent and reflects little preoccupation with, or idealisation of attachment figures. Generalised descriptions of relationships with parents are consistently supported by illustrative autobiographical memories.
Dismissing (Ds)	Dismissing adults may adopt several strategies in minimising the impact of attachment relationships and experiences. They may idealise and normalise past experiences failing to support or actively contradicting generalised descriptions with specific memories. They may actively devalue and derogate attachment figures and experiences and may present themselves as invulnerable and self-sufficient. They frequently exhibit restrictions of attachment-related feelings, insistence on lack of memory for childhood and consequently are brief in their responses.
Preoccupied (E)	Preoccupied adults exhibit passive, angry or fearful preoccupation with attachment figures and experiences. Discourse is often marked by incoherence, irrelevancy, childlike speech, and pseudo-psychological terminology. Preoccupied adults may exhibit overwhelming fear and confusion by past traumatic experiences and blame excessively and inappropriately parental figures for all difficulties. Interview transcripts of Preoccupied individuals tend to be long and not readily understood.
Unresolved/Disorganised (U)	Adults classified as Unresolved are characterised by having experienced attachment-related traumas such as physical or sexual abuse or the loss/death in childhood of an attachment figure that has clearly not been resolved in adulthood. Lack of resolution is evident in lapses in monitoring of reasoning, discourse and expressions of extreme behavioural reactions to trauma. Disbelief regarding death, irrational guilt associated with sense of being causal in death, unusual attention to detail on the one hand and prolonged silences on the other may be all indications of unresolved attachment status. These may be present throughout the interview but are most striking in passages that relate to queries regarding traumatic experiences.

The Secure adult attachment classification parallels the secure classification in infancy and five sub-classifications are derived based upon the aforementioned rating scales. Adults classified as F1 typically demonstrate some setting aside of

attachment and retain a sense of early support from parents, although unexamined. Individuals classified as F2 show some detachment manifested in lack of memory, idealisation of parents, fear of loss, or mild derogation often followed by overt valuing of attachment. Very Secure adults (F3) are highly coherent in the retelling of attachment-related experiences and feelings and demonstrate little or no idealisation or angry preoccupation with attachment figures. Transcripts of F4 adults are marked by slight preoccupation that is more angry and conflicted in those classified as F5 where although moderately coherent, preoccupation with parental failing and some present anger is evident. Typically, 58% of both mothers and fathers are classified as Secure (van IJzendoorn & Bakermans-Kranenburg, 1996).

The Dismissing adult attachment classification corresponds to the Strange Situation Avoidant infant attachment classification with four Ds sub-classifications further identified. Adults classified as Ds1 normalise experiences, describe parents in highly favourable terms that are unsupported and often block further queries by insisting on lack of memory. In contrast, Ds2 adults actively devalue at least one attachment relationship and its importance and emphasise self-reliance. Adults classified as Ds3 are marked by a restriction in feeling and whilst recognition of rejection may be present, the self is described as unaffected and experiences are normalised. The final Ds4 sub-classification is assigned very rarely and marks adults who are cut off from the source of fear regarding possibilities of loss as relating to their own child. Across 33 studies employing the AAI, 24% of both mothers and fathers were classified as Dismissing (van IJzendoorn & Bakermans-Kranenburg, 1996).

The Preoccupied adult attachment classification corresponds to the Ambivalent/Resistant infant attachment classification with adults assigned one or more of the three sub-classifications. Passivity of thought processes regarding experiences of childhood intermingled with subtle indications of anger is characteristic of adults classified as E1. In contrast, E2 adults can be distinguished by their angry preoccupation with one or both parents, the use of pseudo-psychological terminology and the presence of run-on sentences. The final E3 sub-

classification is assigned very rarely, to adults who exhibit overwhelming/fearful preoccupation with past traumatic experiences. Approximately 18% of mothers and fathers are classified as Preoccupied (van IJzendoorn & Bakermans-Kranenburg, 1996).

The Unresolved adult attachment pattern parallels the disorganised/disoriented infant attachment pattern and as in the strange situation classification system adults classified as U/d are invariably assigned to a best fitting alternative attachment classification. About 19% of mother and fathers are classified as Unresolved with respect to loss or trauma (van IJzendoorn & Bakermans-Kranenburg, 1996).

Rarely (except in clinical samples) adults will show an unusual mixture of mental states that does not appear to fall within any of the above attachment patterns and will thus be assigned as Cannot Classify (CC). This classification marks a breakdown in a coherent strategy. Similar to the Unresolved category, adults who cannot be readily classified will also receive a best fitting alternative classification.

5.5.1 The Psychometric Properties of the Adult Attachment Interview.

Stability and Reliability of the Adult Attachment Interview.

Studies examining three-way stability for Dismissing, Preoccupied, and Secure classifications have repeatedly demonstrated high stability across 1 to 18 months periods ranging from 77% to 90% (Bakermans-Kranenburg, 1993; Benoit and Parker, 1994; Crowell et al, 1996; De Hass et al, 1994; Sagi et al, 1994; Steele & Steele, 1994). In examining 4-category stability for Dismissing, Preoccupied, Secure and Unresolved across a 12 months period, Benoit and Parker (1994) found 77% stability. Further, inter-rater reliabilities for the AAI are reported as high (Sagi et al, 1994; Steele & Steele, 1994) with an average of 80% across 18 studies (van IJzendoorn & Bakermans-Kranenburg, 1997).

Discriminant Validity of the Adult Attachment Interview.

Recent studies have turned to the study of the discriminant validity of the AAI. The three main attachment classifications; Dismissing, Preoccupied, and Secure have been found to be independent of various measures of IQ (Bakermans-Kranenburg, 1993; Rosenstein & Horowitz, 1996; Sagi et al, 1994; Ward et al, 1991). However, in a recent study Crowell et al (1996) found modest associations between AAI classifications and IQ. More specifically, significant differences were observed between Secure and Insecure mothers on a measure of intelligence, with the variance carried by the Preoccupied group. Adult Attachment Interview classifications have also been found to be independent of non-attachment-related autobiographical memory, both short term and long term (Bakermans-Kranenburg and van IJzendoorn, 1993; Sagi et al, 1994). Social desirability was further found unrelated to AAI classifications (Bakermans-Kranenburg and van IJzendoorn, 1993; Crowell et al, 1996) as were interviewer effects (Bakermans-Kranenburg and van IJzendoorn, 1993; Sagi et al, 1994), personality measures (Fonagy et al, 1991), and general discourse styles (Crowell et al., 1996). More recently however, AAI classifications have been found to be associated with psychiatric symptomatology reported on the Multiphasic Personality Inventory, with Preoccupied individuals reporting more symptoms and Dismissing individuals reporting fewer symptoms (Pianta et al, 1996).

Predictive Validity of the Adult Attachment Interview.

Studies establishing the relation between caregivers' classifications as assessed by the AAI and their infants' attachment organisation as assessed by the Strange Situation can be divided into three types; retrospective studies where infants' Strange Situation classifications were collected prior to the parents' AAI classifications; concurrent studies where Strange Situation and AAI classifications were assessed concurrently; and finally, prospective studies where AAI classifications were obtained prior to the birth of the child and Strange Situation

behaviour was subsequently assessed. The findings from each are reviewed in the following section.

Main et al (1985) investigated retrospectively the correspondence between mothers' and fathers' attachment classification and their infant's attachment status as assessed through the Strange Situation. Whilst a strong correlation was reported for mother-infant dyads, only a modest correlation was obtained for father-infant dyads (see also Grossmann et al, 1988).

In a sample of 45 mother-infant dyads, Ainsworth and Eichberg (1991) examined the concurrent relationship between the mothers' current state of mind with respect to attachment and their infants' attachment status at 12 months. Concordance rates were high with 90% agreement for three-way classifications (A/B/C) and 80% for four-way classifications (A/B/C/D). Lending further support for the validity of the AAI, Zeanah, Benoit, Barton, Regan, Hirschberg and Lipsitt (1993) concurrently assessed 60 mother-infant dyads and found 75% concordance for three-way classifications. Whilst, the majority of studies have reported high concordance rates for mother-infant dyads, similar to Main et al (1985), van IJzendoorn, Kranenburg, Zwart-Woudstra, van Busschbach and Lambermon (1991) failed to find significant correspondence between paternal AAI classifications and infant Strange Situation classifications, although this could be partly explained by the small sample size (only 27 dyads).

Findings from prospective studies also support the predictive validity of the AAI and thus the intergenerational transmission of attachment patterns. Fonagy et al (1991) conducted a prospective study correlating the attachment status of first time middle-class parents (100 couples), as measured by the AAI, with the attachment organisation of the first-born child at 12 months with respect to mother and at 18 months with respect to father. Fonagy et al (1991) reported a concordance rate of 75% between attachment status of the mother and the attachment status of the child but observed a weaker association for father-child dyads. In a subsequent retrospective study of an Australian sample, the Secure/Insecure correspondence

between father's and infants was 77% (Radojevic, 1994). Benoit and Parker (1994) examined the intergenerational transmission of attachment patterns across three generations in a middle-class sample of 96 infants, mothers and maternal grandmothers. The AAI was completed by mothers during pregnancy and the infants were observed at 12 months in the Strange Situation Procedure. The mothers' AAI classifications during pregnancy were highly predictive of the infants' attachment status at 12 months both for three-way and four-way classifications (81% and 68% respectively). Furthermore, mothers' AAI classifications predicted the maternal grandmothers' AAI classifications in 75% (three-way) and 49% (four-way) of cases. Convergent evidence also comes from studies of high-risk samples (Ward et al, 1991; Ward & Carlson, 1995; Zeanah et al, 1995).

In a recent meta-analysis, van IJzendoorn (1995) identified 18 studies that have found high concordance rates between infant and parent attachment classifications. A combined effect size of 1.06 in the expected direction was obtained for the two-way, Secure versus Insecure split (75% match). Concordance between infant and parent classifications for the three-way cross-tabulation was 70%.

More recently, Sagi et al (1997) highlighted the influence of ecological factors upon the intergenerational transmission of attachment patterns in Israeli Kibbutzim. Marked differences in mother-infant concordance rates between those infants experiencing communal sleeping (40% Secure/Insecure match) and those sleeping at home (76% match) were demonstrated. Other recent studies of Italian and Canadian mother-infant dyads have also reported similar concordance rates to those reported in previous studies (80%-85% for Ammaniti et al, 1996).

5.5.2 Mentalisation/Reflective Functioning as Measured within the Adult Attachment Interview.

Fonagy, Steele, Steele, and Target (1997) defined reflective functioning as "the psychological process underlying the capacity to mentalize" (p.5) and considered it

to arise through the child's experience of his/her mental states being reflected on, prototypically through the repeated experience of affect-laden interactions with the primary caregiver.

The development of the Reflective Functioning scale (RF) established by Fonagy, Steele, Steele, Moran and Higgitt (1991), and Fonagy (1995) constituted an important addition to the analysis of AAI transcripts. Based in part on the meta-cognitive monitoring scale of the AAI, the RF scale provides operational criteria for the assessment of individual differences in metacognitive capacity placing particular emphasis upon adults' recognition and understanding of the self and others in terms of feelings, beliefs, intentions and desires. Fonagy et al (1997) view the development of reflective functioning as rooted in secure attachment relationships and further suggest that the parent's capacity to reflect upon the intentionality of their children's behaviour facilitates children's self-control, affect regulation, and enhances communication. The RF scale has been widely applied and has yielded impressive findings suggesting that it provides powerful tool in significantly discriminating clinical from nonclinical populations (Fonagy et al, 1996), and in predicting attachment security in infancy (Fonagy et al, 1991; Steele et al, 1996).

5.5.3 Conclusions Relating to the Adult Attachment Interview.

Conceptually, the AAI identifies a single current state of mind with respect to attachment although it is unclear whether adults do in fact hold a singular, integrated state of mind with respect to attachment or whether different internal working models of mother and father are in place. Nevertheless, the system was developed based on normative populations, primarily of white, middle-class background where 58% of samples are typically classified as secure. The applicability of the system to other populations is therefore unclear and it is possible to envisage that the Insecure categories identified thus far may not adequately capture the diversity of attachment patterns observed in those populations. Finally, access to childhood memories is clearly influenced by mood

states and these states may thus colour the general state of mind with respect to attachment and lead to an Insecure attachment classification. However, the AAI has proved to be a reliable, valid and usefully predictive measure of attachment functioning

5.6 The Relevance of Attachment Representations to Psychotherapeutic Work.

5.6.1 Clinical Formulation.

The patterns of representations described by Main, i.e., dismissing, preoccupied, and unresolved in addition to secure, also have their parallel in clinical practice. Dozier et al (1999) stated that, “psychiatric disorders are nearly always associated with non-autonomous states of mind”. Slade (1999) pointed out that this did not imply that insecurity in and of itself was synonymous with psychopathology but may be considered as a significant but not determining risk factor.

Attachment classification may therefore be akin to a diagnosis in that it offers a functional model through which to understand a patients’ experience. Classification offers distinct hypotheses regarding the psychic structures along what is essentially a continuum of affect regulation and structure. At one end of the continuum lies the avoidant-dismissing category where free expression of affect, and particularly negative affect, is minimal, and the structures for regulating, containing, and suppressing affect are rigid and highly organised. Kobak and Sceery (1988) have suggested that such tight organisation serves to “deactivate” or “minimise” (Cassidy, 1994) affect that would disrupt attachment relationships. The classification in and of itself does not reflect psychopathology; such individuals may also be described as obsessional, schizoid, or narcissistic. At the other end of the spectrum lies the resistant/preoccupied category of which the hallmark is the relative absence of structures for affect regulation. Affect tends to overwhelm psychic structures, which are then useless or only transiently organizing. Affective cues to caregivers are therefore heightened in order to ensure continuing comfort

and care. Diagnostically, some individuals in this category may be described as hysterical or having a borderline personality disorder.

Midpoint along the continuum lays the secure category where structure and affect exist in balance; affect being neither excessively restricted or overwhelming the capacities for regulation. This balance is reflected in the coherence or apparent 'truth' of the individual's narrative. Whilst secure individuals can easily be considered as neurotic, it is unlikely that they will be diagnosed with any diagnosis indicative of severe character disturbance.

The unresolved attachment category does not fit easily into this continuum. Typified by incoherence and disorganization, it is somewhat like the resistant/preoccupied category and this theoretical perspective is supported by the clinical finding that individuals who are clinically identified as having borderline personality disorder, are often classified as either resistant/preoccupied or disorganised/unresolved or both (Fonagy et al, 1995). Unsurprisingly, this category has been linked with childhood trauma or loss.

Consequently the nature of a therapist's efforts to transform and enter into a patient's narrative will be profoundly shaped by the individual's attachment security. Slade (1999) stated that, "How therapists talk to patients and what they endeavour to do in their talking and in their listening will vary as a function of the patient's predominant attachment organisation"(p585). It would of course be amiss not to realise that the very way the therapist talks to his/her patients would also be a function of the therapist's IWM in addition to any influence of training.

Holmes (1998) suggested that therapy involved a process of 'story making and story breaking' in which the patient was helped to simultaneously tell a coherent story and allow this story to be told in a more therapeutic or healing fashion. Representational models would therefore have a considerable influence on the patient's capacity to both make and break stories in the light of new insights. Holmes (1998) identified three prototypical pathologies of narrative capacity. The

dismissing individual would rigidly cling to his/her story whilst the preoccupied individual would be overwhelmed by 'unstoried experience'. The patient classified as unresolved would experience great difficulty in establishing a narrative that would be strong enough to contain traumatic pain.

Slade (1999) has suggested that with the dismissing patient, therapy revolves around finding ways of allowing affects into experience and into consciousness, i.e., story breaking. Suggestions to a patient who is classified as dismissing that he/she may experience a particular feeling are met with responses that follow intellectual logic rather than remembered experience. By contrast, patients classified as preoccupied with respect to attachment organisation, show a very slow development of structures which can regulate affective states, and their subjective experience is dominated by raw emotion in the absence of structures to contain this experience. Such patients are swept on and driven by their affective state so that they jump from one issue to the next without any sense of purpose or inner focus. Fonagy et al (1996) have noted that these patients are particularly difficult to treat and have the least success in outcome studies.

Therapeutic work with the patient who is unresolved with regard trauma or loss would often involve a slow and painstaking recreation of what may have happened to them, often working from the most minimal of clues whilst simultaneously engendering terror and potential further dissociation in the patient him/herself.

5.6.2 Attachment Organisation and the Therapeutic Relationship.

Attachment organisation and history will have a profound effect upon the patient's conscious and unconscious expectations and feelings about the therapist. This is of course also true of the therapist although, in the ideal case, the therapist would possess greater awareness and insight into his/her responses to the patient.

The patient who is dismissive in terms of attachment organisation will typically find involvement in the therapeutic relationship difficult and challenging. An initial

outer shell of friendliness and self-assuredness would be superficial and would give way to a general rejection of treatment and pulling back from help that is offered. Dozier (1996) suggested that such individuals often become disorganised when they do confront emotional issues or attempt to divert the therapist's attention. By contrast, the individual who is preoccupied would heighten his/her expression of attachment needs in order to ensure the caregiver's availability. Consequently, these patients present themselves as needy and dependent, demand much of their therapist, such a phone calls between sessions, and demand extra sessions at times of a therapeutic break whereas dismissing individuals would be more likely to miss sessions and not inform the therapist of important changes in their circumstances.

It would be important to note that such ways of being in a relationship are not manifestations of the transference in the classical sense, but manifestations of the patient's primary mode of relatedness. With the preoccupied individual, what is transference is the experience of the therapist as insufficiently helpful and available (and therefore requiring the signals of distress to be heightened). This may in turn generate hostility towards the therapist as the rage and chaos of primary relationships is elicited in the transference.

5.6.3 Attachment Organization and Countertransference.

Slade (1999) stated that just as the attachment patterns function to evoke feelings in others, so too they will evoke feelings in the therapist. The patient's representational models would be vividly and immediately brought into the therapeutic relationship, and would form the basis of a range of countertransference feelings.

The Dismissing patient would replicate his/her experience of being locked out by their attachment figure. The therapist would therefore be faced with a narrative from the patient which was impermeable, and rigid, and evoking an experience of a barren psychic landscape. Should the therapist be adequately trained, and in ideal circumstances, the therapist may also experience what the patient cannot, i.e. the

hopelessness of change and of attaining intimacy. The therapist is thus provoked into experiencing those feelings of anger and ineptitude once felt by the patient as a child and continuing to form an important aspect of the child's subsequent representational world as an infant. Dozier (1990) noted that the intensity of the countertransference evoked by such patients has sometimes succeeded in driving the therapy to be prematurely terminated. Alternatively, the therapist may express the experience of being rejected by 'forgetting' to bring important matters to the patient's attention and/or behave in the very opposite manner by attempting to force the patient to acknowledge disturbing aspects of him/herself prematurely. The therapist would continuously experience the struggle to exist in the patient's psychic reality, as did the patient with his/her caregiver.

A different but similarly intense experience would be evoked with the patient categorised as Preoccupied with regard attachment behaviour. Such patients convey their own internal confusion by attempting but failing to be clear in their narrative, their attempts leading to an ever more complex and ultimately confusing and overwhelming experience. Thus such as patient evokes a countertransference in the therapist of being devoured and overwhelmed, and possibly angry as a response to these feelings. The therapist may often find him/herself provoked into attempting to organize and structure the patient's story. These attempts at story making (Holmes 1998) generally add to the confusion and the patient's own feeling of chaos. Slade (1999) has suggested that it is the therapist's long term emotional availability and tolerance of fragmentation and chaos that leads to progress rather than specific interpretations. For Preoccupied patients, the capacity to reflect upon emotions in self and others rather than respond to them is notably absent and such patients are in fact less likely to improve in psychotherapy than dismissing adults (Fonagy et al, 1996)

Fisher & Crandell (2001) subsequently extended attachment theory to the adult couple in conceptualising 'complex attachment'. Central to this theorising was the bi-directional nature of attachment behaviour in the couple wherein each partner functioned as a potential secure base for the other. Fisher and Crandell therefore

conceptualised the couple as a 'single entity' but described different patterns of couple attachment by using the categories for individual attachment as provided by the AAI. These combinations tended to correspond with variations in couple functioning that are familiar to those assessing couples clinically. A couple comprising of two secure individuals would show a capacity to shift freely between the dependent and depended-on positions and show and empathic appreciations of the partner's thoughts and feelings in both these situations. The opposite would be true of couples comprising two insecure partners, the relationship being characterised by each partner adopting rigid positions within the relationship and little movement possible. Insecure-insecure partnerships would exhibit greater manifest distress although the lack of movement possible within the relationship would make the task of free discussion particularly difficult. Couples comprising a secure and insecure partner would present more frequently, the secure partner potentially having the capacity to provide a corrective emotional experience allowing the insecure partner to engage with greater flexibility and balance.

5.6.4 The Role of the Therapist's Attachment Status.

Given that all that has been written about a 'patient' can equally be applied to the person of the therapist, Bowlby (1988) rightly viewed the therapists sensitive and empathic, i.e. secure, functioning as central to psychotherapeutic progress as this allowed the patient to differentiate between childhood projections and his/her real experience in psychotherapy.

In as much as psychotherapy is concerned with the patient's experience of separations and reunions both in the past and as part of the therapy itself, so too do such events have significance for the therapist. Many therapists have suffered early loss and abandonment and will have been reconciled to these experiences to differing extents. Furthermore, different patients will engage the therapist's attachment functioning in different ways. Slade (1999) placed the fit between patient and therapist as central to the therapeutic situation. She suggested that from an attachment perspective, the readiness to care for patients is as normal in

therapists as it is normal for patients to turn to them for care. Indeed, it may be seen as a corollary to the parental 'care-giving system' (a term coined by George & Solomon 1999).

The term 'care' implies an emotional connection that flows from therapist to patient and from patient to therapist. In a secure therapist, these feelings create and atmosphere of safety and connection. The therapist's feelings of connection to the patient as well as his or her capacity to care for the patient, may well contribute to the therapist's capacity for empathy and to the resulting therapeutic success, and may well be understood in the light of attachment processes. But in an insecure therapist, the predilection to care is as vulnerable to distortion as it is in the insecure patient; these are the perils of the counter-transference. Fisher and Crandell (2001) noted how explosive or never-ending cycles of conflict could arise in secure-insecure or insecure-insecure pairings.

However, empirical verifications of these qualitative descriptions of the clinical work situation have been few and far between. Dozier, Cue and Barnett (1994) reported that secure therapists were more able than insecure therapists to hear and respond to the dependency needs of their dismissing patients, and were less vulnerable to intense countertransference reactions towards these individuals. Secure therapists may also better manage the overt demands and explicit dependency needs of patients who are preoccupied in relation to attachment. Insecure therapists were more likely to respond to such patients' manifest rather than underlying needs. By contrast, secure therapists were more likely to respond to subtle manifestations of need and dependency.

Tyrrell et al (1999) reported a study on the influence of attachment states of mind of both patients and clinical managers on the effectiveness of therapeutic relationships and client functioning. Client and case manager attachment states of mind interacted in predicting the working alliance and client functioning. Specifically, clients who were more deactivating with respect to attachment had better alliances and functioned better with less deactivating case managers and vice

versa. Tyrrell et al (1999) consequently concluded that their findings highlighted the importance of clinicians and patients being matched in ways that balanced their interpersonal and emotional strategies. Leiper and Casares (2000) reported that secure and insecure psychologists gained differing levels of reward when working with different levels of disturbance in their patients.

Eames and Roth (2000) investigated the role of attachment status in the development of the therapeutic alliance and ruptures in the alliance at the beginning of psychological therapies in a sample of thirty outpatients. Attachment was measured by self-report using the Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994) whilst ruptures were rather poorly defined as a 'negative shift in the quality of the alliance, or an ongoing problem in establishing one' and measured using an unproven and unpublished self-report measure. The study used a naturalistic design resulting in a number of design limitations. For example, therapists with greatly differing lengths of post qualification experience treated the patients, and therapists treated different numbers of patients. Furthermore, the therapies offered ranged across orientation and total number of sessions. The results, however, were generally supportive of the role of attachment in the formation of the therapeutic alliance. The significant relationships between attachment and alliance were seen to emerge over time rather than be immediately present as might be expected from a purely clinical perspective. Patients classified Fearful were associated with lower alliance ratings whilst classification as secure was associated with higher therapist-rated alliance. Eames and Roth (2000) attempted to account for the influence of the therapist and reported no significant effect of the therapist in patient-reported ruptures but did have a significant effect on therapist-reported ruptures as might be expected. Their findings were congruent with Sattersfield and Lyddon (2000) who suggested that an attachment system characterised by anxiety about attachment and avoidance of intimacy may hinder alliance development. However, Eames and Roth (2000) were fully aware of the limitations of their study. They stated that, "the current results raise the question of whether preoccupied or dismissing attachment systems could facilitate genuinely good alliances or whether their alliance ratings could reflect a superficial view of

the alliance influenced by the sort of defences likely to be employed by such patients in the interactions with others e.g. idealisation or denial” (p430).

5.7 Summary and Relevance to Preceding Difficulties.

Attachment theory represents an integrationist developmental theory, which places at its heart the history of the relationship between infant and caregiver through postulating the existence of the exploratory and attachment systems. The infant is considered as born with a predisposition to become attached to his/her caregivers, and the ongoing history of “action and action-outcomes” gives rise to the development of internal working models of the relationship between self and other. These same models subsequently are influenced by and themselves increasingly influence subsequent perception and experience. Behaviour and patterns of thought are thus organised so as to maintain these attachment relationships upon which rests the child’s physical and psychological survival. Consequently, these relationships both external and representational, will be maintained even at considerable psychological cost to the child’s functioning. The distortions that occur in thought and affect regulation are essentially the result of the caregiver’s inability to meet the child’s need for comfort and emotional reassurance and therefore the maintenance of felt security. Hence, the nature of internal working models, and the representation of self and other, has been linked to the capacity to mentalise and thereby reflect over the functioning of the self and others. This further implies and in part explains the transgenerational transmission of attachment.

Attachment theory has been shown to have a considerable overlap with both psychoanalytic theory and to be highly relevant to conceptualising clinical practice and the functioning of both patient and therapist. As Slade (1999) stated, “a therapist’s own security manifested in the capacity to remain open to his or her experience as well as to the patient’s, is likely to be most predictive of a healthy and successful psychotherapy” (p589).

From the perspective of empirical measures, the move to the level of representations (Bretherton & Waters, 1985) enabled the establishment of a number of measures of attachment but most importantly the Adult Attachment Interview (AAI). This measure allowed for a reliable and valid empirical measure of an individual's predominant internal working model in such a way that was consistent with the developmental themes with Attachment Theory itself.

Consequently, attachment theory and its subsequent operationalisation through the AAI may offer new opportunities for the field of psychotherapy research in general and especially with regard the selection of applicants for training.

A review of the literature on the selection of therapists for training identified three themes in the history of the field, which may be congruent with attachment theory. Firstly, the identification of a potentially 'good' therapist through a list of criteria. Secondly, a debate regarding the degree of disturbance either required or deleterious to functioning as an effective therapist, and thirdly the need for selection to be based upon a model of functioning that would have some capacity to predict future functioning.

Current developments in the field of attachment theory place it in the position of potentially meeting the needs identified in the task of selection. The definition of the IWM provides a model of functioning, which may both meet the need for questions of normality (Freud, 1937) in the form of secure attachment organisation and psychopathology in the form of insecure classifications. Specific criteria such as those by Beenan (1979) regarding the degree of psychic integration and flexibility of intra-psychic structures bear more than a striking resemblance to aspects in the IWM such as coherence and the loving nature of internal representations of relationships with important others. Similarly, through the scales of the AAI, the degree and type of psychopathology may be empiricised in a form and with a specificity that was previously unavailable. Furthermore, the concept of reflective functioning, through being based in the developmental history of the

individual provides a parallel to notions of the ‘psychological gift’ or psychological mindedness required of the psychotherapist.

From a more empirical perspective, the increasing importance of the individual therapist to the outcome of psychotherapy has been emphasised (Lambert & Oshikii, 1997) simultaneously with the demise of the Dodo Verdict (Luborky et al, 1975; Chambless, 2002) and the questioning of the usefulness of therapy manuals (Harvik & VandenBos, 1996). Furthermore, the selection of future therapists has not been based, to date, on a coherent conceptualisation of the well functioning therapist and psychotherapy research has not been able to sufficiently isolate important and predictive factors in the therapist that make for good outcome. The AAI, as a valid and reliable empirical instrument, based in a theory of development, may provide an opportunity to measure more precisely the aspects of the therapist considered important but which have to date been plagued by issues of definitional clarity and poor link with theory. Aspects such as empathy and psychological mindedness, for example, are paralleled by the profile of AAI Experience scales and the notion of Reflective functioning. Therapist style may relate to the different attachment classifications with the added advantage that attachment based definitions can be simultaneously clinically meaningful and empirically measurable.

The opportunity therefore becomes available to examine the utility of Attachment Theory in providing a conceptual model with which to re-examine the qualities which may define a potentially ‘good’ therapist in terms of selection and successful training.

5.8 General Statement of Hypotheses.

The preceding review of the psychoanalytic literature on the selection of applicants for training (Chapter 2), the review of therapist factors considered as influencing the outcome of psychotherapy (Chapter 3), the relevance of the 'fit between therapist and patient (Chapter 4), and the methodological advances in Attachment Theory noted in Chapter 5, combine to give rise to three main hypotheses which guide the subsequent studies.

Hypothesis 1: The Criterion Approach to Selection.

The nature of the clinical work to which the training relates relied on the consideration of mental representations of relationships and the capacity for this to be observed as occurring within the relationship between patient and therapist. The review of the literature indicated the tendency to develop a list of criteria which the applicant had to meet. However, the literature has also suggested the absence of measures that can identify predictive factors in the therapist with respect to selection and completion of training. The literature therefore suggested that the use of a list of criterion was not optimally useful. It was hypothesised that this finding will be replicated. However, it was also hypothesised that measures of attachment status, would predict the selection of candidates given that they are conceptualised as measures of the internal representation of relationships and would therefore have a detectable bearing upon the functioning of applicant during the process of application. It was similarly hypothesised that measures of attachment status will have a direct relevance to clinicians' success in training over and above other measures of personality traits of demographic measures.

Hypothesis 2: Selection on the Basis of Normality or Pathology.

This hypothesis was in part an extension of Hypothesis 1. It was predicted that applicants who were selected would be those who have lower levels of manifest symptomatology and would be consider as healthier. Furthermore, it was predicted that applicants who were classified as securely attached with respect to attachment

would be selected for training over those classified as insecurely attached. Furthermore, it was predicted that applicants who were classified as securely attached with respect to attachment would be more successful in training than colleagues who are classified as insecure with regard to attachment relationships. This hypotheses implicitly considers secure attachment as a measure of psychological health and the hypothesis, in its broadest terms, poses the strands the

Hypothesis 3: The 'Fit' between Applicant and Assessor.

Selection of applicants for training may be a function of aspects of the applicant, the selector, or the interaction between the two. Given the nature of the training for which the applicant has applied, and the qualitative description of the experience of selection provided in the literature, namely the 'like me' experience, it was hypothesised that the interaction between applicant and selector would prove to be more predictive of the selection of applicants than the characteristics of either applicant or selector individually.

The three hypotheses stated above were not regarded as mutually exclusive and each was be examined in the studies that follow in Chapters 6, 7, 8, and 9. The results are discussed in relation to these hypotheses in Chapter 10.

CHAPTER 6. APPLICANT AND ASSESSOR PERSONALITY
CHARACTERISTICS AS DETERMINANTS OF SELECTION FOR
TRAINING.

Study 1. The Role of Personality Factors in the Selection of Psychological Therapists.

6.0 Introduction

Over the past three decades, the view of the psychotherapist as a separate and important factor within the psychotherapeutic interaction has undergone a major rehabilitation. From initially being considered as an “untested contaminating variable” (Lambert et al, 1986), the person of the therapist has now become the “neglected variable” within the field of psychotherapy research (Beutler 1997).

There has been a consistent and growing literature, often on the basis of inadvertent findings (e.g., Rounsaville et al, 1988) suggesting the importance of the role of the individual therapist. Naturalistic studies such as Ricks (1974) provided further evidence although it was the reanalysis of large scale psychotherapy studies e.g. Lambert and Okiishi (1997), that cemented the recognition that the degree of the variance accounted for by the therapist is larger than previously considered.

Investigations of the therapist factors had traditionally attempted to isolate therapist factors but have been hampered by issues of definition, measurement and experimental design. Consequently research on specifically defined therapist characteristics has yielded few and rarely repeated results. Furthermore, as Elkin (1999) emphasised, separating the influence of the therapist from the therapy itself proved enormously difficult and the manualisation of treatments had not solved this difficulty (Beutler, 1997). The therapist has subsequently become viewed as ‘more than the sum of his parts’ (Lambert, 1989) and there has been a renewed call for the investigation of the therapist as a unified variable.

Simultaneously, research into the selection of psychotherapists had virtually ceased following the 1968 report of the Committee on Psychoanalytic Education even though a re-examination of the literature indicated a trend in selection towards functional models of the mind rather than specific traits. It had not proved possible to define with greater clarity the 'like me' experience described by selectors/assessors (Bird, 1968).

However, the clinical validity of the 'like me' experience amongst selectors has been strongly noted. Furthermore and by definition, those therapists who are well regarded and considered as experienced and successful by their peers complete the task of selection. It is likely therefore that selection will occur on the basis of those factors that are thought to promote the capacity to work psychotherapeutically and therefore by implication promote positive outcome. Consequently, the study of the selection of therapists becomes a useful arena in which to look at potentially important therapeutic factors. The place of selection is therefore increasingly important for the future of psychotherapy (Kappelle, 1996) and the fact that the selection process has a definite outcome; either the applicant is accepted or declined, circumvents the difficulties of defining the nature of positive outcome for psychotherapy.

6.1 Aims.

The study aimed to re-examine whether any demographic, personality, or purely cognitive characteristics of the cohort of applicants for a psychodynamic training predicted their selection for training. The results would then be considered as to the degree to which they was consistent with the reported literature.

6.2 Methodology.

6.2.1 Design.

This was a cross-sectional study using a group comparison design comparing successful and unsuccessful applicants for training on a range of selected variables.

6.2.2 Sample.

The sample was drawn from the population of applicants to a well known Training Organisation (T.O.) in central London for training to complete the Advanced Diploma in Psychodynamic Counselling. Two principal inclusion criteria for subjects were used, firstly application itself and secondly a final decision by the training organisation on acceptance or refusal for training.

A total of 102 applicants were recorded for 50 places spread across four different training routes. A total of fifty-four applicants were accepted for training although three of these (5.6%) did not eventually take up the offer of training. However, given that the Selection Committee's decision on acceptance was an important inclusion criterion, these subjects were retained for the purpose of statistical analyses. From the whole cohort of applicants, fifty applicants (49%) volunteered to participate in the present study and will henceforth be referred to as the 'participant sample'.

Of the remaining fifty-two subjects, three subjects withdrew from the process of selection prior to a decision having been reached by the selection committee. Given their involvement in the selection procedure passed the point of invitation to participate in the study, and the decision of these three subjects not to participate in the present study, data available on these subjects was used in the comparison of subjects who had participated and those who had not, i.e. the non-participant sample. This therefore generated a total sample of 102 subjects for this comparison. The data on these three subjects was not, however, used in the

statistical analyses comparing applicants who had been accepted for training and those who had not. This produced a total sample of 99 subjects.

6.2.2.1 Demographic Descriptors.

Age and Gender.

The whole sample comprised a total of eighty-one applications from women (79.4%) and twenty-one applications from men (20.6%). As shown in Table 6.1, the participant sample comprised of 11 men and 39 women and represented 49.5% of the whole sample. The non-participant sample comprised of 9 men and 42 women and formed the remaining 50.5% of the whole cohort of applicants. There was no significant difference in the distribution of gender by participation [$\chi^2=301$, $df=1$, *ns*].

The mean age of whole sample 43.51 years with a standard deviation (sd) of 7.19 years. The mean age of the of men in the sample was 43.61 years (sd=6.10) with the oldest male subject aged 56.24 years and the youngest aged 34.52 years. The mean age of the women in the sample was 43.49 years (sd= 7.49) with the oldest female subject aged 60.61 years and the youngest aged 30.42 years. Whilst there were more women than men in the sample, and the age range of the women in the sample was also slightly larger, age distribution by gender for the whole sample was not significant [$t=0.75$, $df=1$, *ns*].

As shown in Table 6.1, the mean age for participants was slightly greater than that for non-participants; 44.42 years (sd=7.64) and 42.63 years (sd=6.69) respectively. This difference was not significant. Additionally, average age of the male participants was slightly greater that that of female participants; 45.03 years (sd=5.49) as compared with 44.26 years (sd=8.20) respectively. This difference was also not significant. This was equally true of the distribution for non-participants in which the males were on average slightly younger than the females, 41.15 years (sd=5.56) as opposed to 42.71 years (sd=6.38) respectively. Overall, there was no association

between age and gender either within or between participant and non-participant groups.

Table 6.1 Demographic Characteristics of Whole, Participant, and Non-Participant Samples.

Measure		Total Sample	Participants	Non-Participants	Significant Differences (Part vs Non Part)
Mean Age (sd)	Male	43.61 (6.10)	45.03 (5.90)	41.15 (5.56)	ns $t=2.62$ df = 100
	Female	43.49 (7.49)	44.26 (8.20)	42.71 (6.38)	
	Whole sample	43.51 (7.19)	44.42 (7.64)	42.63 (6.69)	
Gender (Total %, P-NP Row %)	Male	21 (20.6)	11 (52.4)	10 (47.6)	ns $X^2 = .30$ df=1
	Female	81 (79.4)	39 (48.1)	42 (51.9)	
	Total	102 (100)	50 (49)	52 (51)	
Social Economic Status (SES) (Total %, P-NP Row %)	I	37 (36.3)	22 (59.9)	15 (40.1)	$X^2 = 9.97$ $p < .04$ $\tau_c = .295, p < .005$
	II	21 (20.6)	14 (66.6)	7 (33.4)	
	III	28 (27.5)	10 (35.7)	18 (64.3)	
	IV	7 (6.9)	2 (28.6)	5 (71.4)	
	V	9 (8.8)	2 (22.2)	7 (77.8)	
	Total	102 (100)	50 (49)	52 (51)	
Ethnicity	White	93 (92.1)	47 (46.5)	46 (45.5)	ns $\tau_b = .711$ $p < .07$
	Non-White	8 (7.9)	3 (3.0)	5 (5.0)	
	Total	101 (100)	50 (49.5)	51 (50.5)	
Highest Level of Education (%)	To 'O' Level	11 (10.8)	7 (6.860)	4 (3.92)	See Recoding Below
	To 'A' Level	19 (18.6)	14 (13.72)	5 (4.90)	
	To degree level	30 (29.4)	18 (17.64)	12 (11.76)	
	To postgraduate level	19 (18.6)	10 (9.80)	9 (8.82)	
	Other diploma without above	19 (18.6)	1 (0.98)	18 (17.64)	
	Other diploma with above	4 (3.9)	0 (0)	4 (3.92)	
	Total	102 (100)	50 (49)	52 (51)	
Recoded Education (Total %, P-NP Row %)	Secondary Education	52 (51)	22 (21.6)	30 (29.4)	ns $X^2 = 2.39$ df=2
	Graduate	30 (29.4)	18 (17.6)	12 (11.8)	
	Postgraduate	20 (19.6)	10 (9.8)	10 (9.8)	
	Total	102 (100)	52 (51)	52 (51)	

Education.

The highest level of education achieved by each subject was measured by self-report as noted in the application forms and confirmed with the participant sample at subsequent interview. The distribution is presented in Table 6.1 and indicated that just under one third of the sample (29.4%) had completed their education to first-degree level and approximately another fifth (18.6%) had completed postgraduate qualifications. Approximately one tenth of the sample (10.9%) had completed their formal education to GCSE 'O' Level and just under one fifth (18.6%) had completed their formal education at GCSE 'A' Level. Approximately one fifth of the sample (18.6%) had completed a diploma that did not qualify as a first degree whilst a minority (3.9%) had completed a further diploma in addition to having had a first degree.

Given the small size of the sample, the level of educational ability was recoded into three groups thus also reflecting the structure of the educational system in the UK. The three groups thus generated indicated that just over half the cohort (51%) had completed their education at secondary level, approximately three tenths of the sample (29.4%) had achieved graduate status, whilst a further two tenths had achieved a postgraduate training or education. These figures are shown in Table 6.1. There was no significant association between educational level and gender [$\chi^2=3.41$, $df=2$, ns].

The results further indicated that the participant and non-participant samples did not differ significantly in terms of the highest level of education achieved [$\chi^2=2.39$, $df=2$, ns].

Social Class.

The distribution of the whole cohort by social class was measured by considering self reported occupation using the Standard Occupational Classification (OPCS 1990). The Standard Occupational Classification arranges occupational classification into five

broad categories referred to as 'Social Class based on Occupation. The categories produced are as follows;

Class I	Professional Occupations.
Class II	Managerial and Technical Occupations
Class III	Skilled Occupations both manual and non-manual
Class IV	Partly Skilled Occupations
Class V	Unskilled Occupations.

Such a classification indicated that over one third of the cohort, (36.3%), were in Class I. Over one quarter of the cohort (27.5%) were in Class III with approximately one fifth (20.6%) in Class II. The proportion of subjects in Classes IV and V were much lower and approximately equivalent, 6.9% and 8.8% respectively. Distribution of age across social class by occupation was found to be significant [$F_{(1,4)} = 2.897$, $p < .02$]. Post hoc analysis using Scheffe test indicated that the significant difference lay between Class I and Class III. Applicants in Class I had a mean age of 46.22 years (sd = 6.87) whilst those in Class III had a mean age of 41.03 years (sd = 7.3). There were no significant association between social economic status and gender [$X^2 = 7.145$, df = 4 $p < .12$].

As shown in Table 6.1, the results indicated that the participant and non-participant samples did significantly differ in terms of social class as measured by occupation [$X^2 = 9.97$, df = 4, $p < .04$]. However, these results were based on a chi square analysis in which 40% of cells had less than the minimum count required although a significant trend was noted [Kendall's $\tau_c = .295$, $p < .005$] suggesting that subjects from social economic classes I and II were more likely to participate in the study. Given the small cell sizes involved, reanalysis by collapsing classes IV and V together, thus producing four categories confirmed the result [$X^2 = 9.91$, df = 3, $p < .019$].

Ethnicity.

Data on ethnicity was only collected as part of the organisations equal opportunities policy and not part of the selection procedure. The only data consistently available on ethnicity within the selection procedure was a photograph of the applicant attached to the application form. Consequently, classification of ethnicity was only possible on a dichotomous white, non-white basis with the omission of one subject whose photograph was unavailable.

The results, presented in Table 6.1, indicated that 92.1% of the applicants were white and 7.9% were non-white. Distribution of ethnicity by gender, age, social economic status and education were all highly non significant. The results indicated that of the eight non-white applicants, three subjects participated in the study and five declined to participate. This distribution was not significant.

6.2.2.2 Non demographic Descriptors

Number of Episodes and Hours of Psychotherapy.

Each subject was required to note previous experiences of psychotherapy on their application form. The number of episodes of psychotherapy of any theoretical orientation and frequency of sessions was therefore measured using the subjects' self report on their application form. For the participant group, this was confirmed at interview.

**Table 6.2 Cross-tabulation of Number of Reported Episodes of Psychotherapy
By Participation in the Study.**

	Number of Distinct Episodes of Therapy. n (%)				Total
	No Therapy	1 Episode	2 Episodes	2+ Episodes	
Participants	1 (16.7)	22 (44)	18 (62.1)	9 (52.9)	54 (100)
Non Participants	5 (83.3)	28 (56)	11 (37.9)	8 (47.1)	45 (100)
Total	6 (5.9)	50 (49)	29 (28.4)	17 (16.7)	102 (100.0)

$X^2 = 5.09$, $df = 3$, *ns*

Kendall's $\tau_c = -.189$, *ns*

The number of discrete episodes of therapy recorded for the whole sample ranged from zero to nine. As shown in Table 6.2, the results indicated that 49% of subjects had experienced only one episode of psychotherapy and 28.4% had experienced only two episodes of psychotherapy. Equal numbers of subjects had had either no therapy or three episodes of therapy, each accounting for 5.9% of the sample. A slightly higher proportion, 7.8% had had four episodes of therapy and 1% had had five, six, and nine episodes of therapy respectively. Consequently, those categories accounting for more than two episodes of psychotherapy were collapsed into a single category that therefore accounted for 16.7% of the total sample.

Analysis of the number of episodes of therapy by gender indicated a near significant trend, [Kendall's $\tau_c = -.16$, $p < .05$] suggesting that women were more likely to seek more psychotherapy than men. Analysis of number of episodes of therapy by social economic status and by education revealed no significant association.

The highest frequency of a therapy reported by any subject was also noted. This indicated that by far the majority of subjects (61.8%) attended therapy at a frequency of one session per week and a quarter of subjects (25%) attended at a frequency of two sessions per week at some point in their psychotherapy. Eight subjects (7.8%) had attended at a frequency of three times per week. Full psychoanalysis, i.e., attendance at a frequency of four to five sessions per week, had been undertaken by two subjects (1.5%). The remaining four subjects (3.9%) had had no therapy.

Given that episodes of therapy may be of different duration and frequency of sessions, the total number of hours in therapy was estimated. This was calculated on the assumption that all therapy was once weekly unless otherwise stated and that the therapeutic year would comprise of forty-two weeks². Where a greater frequency of sessions was noted, estimates of the number of hours in therapy were calculated according to this frequency.

The results for the whole cohort indicated a very wide distribution with the mean number of hours spent in therapy being 179.02, (sd = 226.70). A huge range existed with some applicants never having been in psychotherapy whilst others have spent 1360 hours in therapy. However, number of hours in psychotherapy was not significantly associated with gender, education as recoded into three categories, or social economic status as recoded into four categories. The mean hours per therapy was considered as possibly providing a measure of the intensity and longevity of the applicants' psychotherapy may therefore be a measure that could discriminate between successful and non-successful applicants. The mean hours per therapy for all applicants were 120.83 (sd= 194.52). Once again the range was extremely large ranging from 4 hours to 1360 hours. A sizeable percentage, 11.8% had an average of 40 hours per episode of therapy which was suggestive of a once per week therapy for a period of approximately one year.

² This estimate was based on a 52 week year with a six week break at the summer and breaks of two weeks each at Christmas and Easter.

Comparison of participants and non-participants in terms of number of hours in therapy was heavily positively skewed and statistical comparison using the Mann-Whitney U test indicated no significant difference. The mean number of hours for participants was 177.26 (sd=217.69) and for non-participants was 180.71 (sd=237.16).

A similar picture emerged in the same comparison using the average hours per episode of therapy. The mean of the average number of hours per episode of psychotherapy for participants was 105.56 (sd=150.56) and for non-participants was higher at 135.09 (sd=229.63). Once again no significant difference between the two groups was detected.

Consideration was given to classification of the orientation of the therapies reported. This did not prove possible as it was sometimes not reported, and often the description of the therapy itself was non-specific such as 'integrative', 'eclectic', or 'integrationist'. Additionally, the name of the therapist was not always provided and some of the therapists noted did not appear in a recognised directory such as that of the British Confederation of Psychotherapists.

Prior completion of a course at the Training Organisation.

The training organisation offered a number of training courses at a standard considered lower than that of the Advanced Diploma. A commonly held perception within the organisation (V. Marshal, personal communication) was that completion of an in-house course prior to application would favour acceptance to the Advanced Diploma training. Completion of a possible range of T.O courses was therefore noted as reported on the subjects' application form.

The results indicated that by far the largest group (50%) had not completed any in-house courses prior to their application. Approximately one fifth (18.6%) had completed a basic Skills and Attitudes Course, and equivalent numbers of subjects had completed either the Diploma Course (7.8%) or the Access Course (8.8%).

Approximately one sixth of the sample (14.7%) had completed a combination of T.O. courses prior to applying for the Advanced Diploma training. This therefore also indicated that overall, half the sample had completed a course at the training organisation prior to the application and half had not.

Completion of any academic course at the training organisation prior to application was significantly associated with education [$X^2 = 7.9$, $df = 2$, $p < .02$]. Applicants who had completed their education to secondary level were significantly more likely to have completed an in-house course prior to their current application. Whilst a significant association with social economic status was not recorded [$X^2 = 5.03$, $df = 3$, ns], a significant tendency [Kendall's $\tau_b = -.204$, $p < .02$] was noted indicating that individuals in lower social groups were also more likely to have completed a course prior to the current application. No association between gender and prior completion of a course was noted. Additionally, analysis using figures based on the exact type of course completed did not indicate any significant trend between the two variables.

Twenty-seven subjects of the cohort (26.5%) had not completed a course at the T.O prior to their application for the Advanced Diploma and had decided to participate in the study. A further twenty-three subjects had completed a T.O. course and had also agreed to participate in the current study. Of the remaining fifty-two subjects, who had all declined to participate in the study, twenty-four had (23.5%) had not completed a course at the WPF whilst twenty-eight subjects (27.5%) had done so. Fisher's Exact test indicated that there was no significant association between participation in this study and prior completion of a course at the training organisation [$X^2 = .628$, $df = 1$, ns].

Training Organisation Ratings.

The training organisation's selection procedure had comprised two group interviews; a general discussion group regarding the nature of psychoanalytic treatment and the proposed training, and a group discussion regarding a fictional case report. The

conductor of each respective group, who was always a senior therapist, made a number of different ratings following the group events. Each applicant was subsequently also interviewed on an individual basis by a different senior therapist. A summary of the ratings is provided in Appendix 1.

The ratings indicated that there was no significant difference between the group of participants and the group of non-participants in terms of acceptance or rejection by the T.O. [$X^2 = .486$, $df = 1$, *ns*]. This was also true for the overall recommendation made on the basis of the Case Discussion group interview [$X^2 = 3.25$, $df = 2$, *ns*], and for decisions made on the basis of the Individual Interview [$X^2 = .14$, $df = 2$, *ns*].

Participants and non-participants in the study only differed significantly on two ratings; Counselling Skills, and Attitude in the case discussion group. The results indicated that individuals rated with stronger counselling skills were more likely to participate in the study [$X^2 = 6.36$, $df = 2$, $p < .04$]. Furthermore, a significant tendency was noted that applicants with weaker case discussion Attitude ratings were less likely to participate in the study [Kendall's $\tau_c = .223$, $p < .02$].

Participant and non-participant subgroups did not differ significantly on any of the following ratings; Practical Counselling Experience, Counselling Skill, Personal Therapy, Academic Ability, Source of Funding, Case Discussion Potential, Case Discussion Ability.

Acceptance for Training.

Table 6.3 presents the frequency of acceptance for training and participation in the study. As shown in Table 6.3, there was no significant association between acceptance for training and participation in the present study [$X^2 = .486$, $df = 1$, *ns*].

**Table 6.3 Cross-Tabulation of Decision on Acceptance or Rejection for
Training by Participation or Non-Participation in the Study.**

	WPF Accept/Reject n (%)		Total
	Rejected	Accepted	
Participant	21 (42)	29 (58)	50 (100)
Non-participant	24 (49)	25 (51)	49 (100)
Total	45 (45.5)	54 (54.5)	99 (100.0)

$X^2 = .486$, $df = 1$, *ns*

Fisher's Exact Test (2 sided), *ns*

6.2.3 Measures.

National Adult Reading Test. (NART).

The NART (Nelson, 1982) consists of a list of fifty phonetically learnt words which the subject is required to pronounce. The number of correctly pronounced has been reliably correlated with the subject's optimum level of intellectual functioning as measured by the Weschler Adult Intelligence Scale, Revised Version (Weschler, 1981). The NART has been shown to be reliable and valid (Nelson, 1982). A copy of the items of the NART is available in Appendix 1.

Eysenck Personality Scales (EPS).

The Eysenck Personality Scales (Eysenck & Eysenck, 1991) is a 105-item questionnaire completion of which requires a dichotomous 'yes' or 'no' response to all items. Scoring produces a rating on four scales: Neuroticism (N), Extraversion-

introversion (E), a Lie scale (L) and a Psychoticism (P) scale. The scale has been widely used and figures on standardization, validity and reliability are reported in Eysenck & Eysenck (1975; 1991). A copy of the EPI is available in Appendix 1.

Opinions about Psychological Problems (OPP).

The Opinions about Psychological Problems Questionnaire (Barker et al, 1983, Pistrang & Barker, 1992) is intended to provide a measure of the extent to which an individual conceptualises the cause and treatment for psychological problems in either 'medico-social' or 'psychological' terms. It consists of two sections: 47 statements relating to the possible causes of psychological problems followed by a further 47 questions about the possible forms of help for psychological problems. Each item is rated on a six point scale ranging from 'disagree strongly' to 'agree strongly'. Relevant item scores are averaged to form seven sub-scales within each section labelled psychodynamic, humanistic, behavioural, cognitive, organic, social and naive. Pistrang & Barker (1992) report an internal consistency estimate, alpha coefficient, of 0.60 in a student population and of 0.80 in a patient population. A copy of the OPP is available in Appendix 1.

Good Therapist Questionnaire (GTQ).

The Good Therapist Questionnaire was an adaptation of the OPP and was exploratory in nature. The causal statements of the OPP were rephrased into statements regarding views on how a good therapist may function with patients. The GTQ consisted of 42 statements, 29 of which were parallel the psychodynamic, cognitive, behavioural, and humanistic scales of the OPP. Items reflecting the organic and economic and naïve causal attributions were omitted. A further 13 statements were added to establish an eclectic scale, some of these taken from Sundland's Therapist Orientation Questionnaires (Sundland and Barker 1962). The wording used throughout the questionnaire reflected that of the OPP although a sentence stems such as "A good therapist." or "Effective therapy." were added. This measure was highly exploratory in nature and a copy is provided in Appendix 1.

The Psychological Mindedness Scale (PM).

The Psychological Minded Scale (Conte et al, 1990; Conte et al, 1996; Conte and Ratto, 1997) consists of a 45 item self-rating scale designed to specifically measure an individual's suitability for dynamically oriented psychotherapy. Conte et al (1990) reported high coefficient alpha scores for internal reliability (.87) in a sample of 250 psychiatric outpatients and Conte et al (1993) reported very high test-retest reliability scores over a period of two weeks (.92). Conte and Ratto (1997) reported a number of validity studies indicating significant but low correlations with expected changes increase in global functioning and decrease in symptomatology. Items are rated on a 4-point scale ranging from strongly-agree to strongly-disagree. An individual's score is obtained from a summation of all scores with some items requiring a reversal of scoring. A copy of the Psychological Mindedness Scale is available in Appendix 1.

Interview Report Form (IRF).

The Interview Report Form was a minor adaptation of the Therapy Session Report: Patient Form (TSRPF, Orlinsky and Howard 1975; 1986) that contained 167 items taking approximately 20 minutes to complete. Forms for both patient and therapist and were constructed with a view of therapy as a special type of social relationship, giving participants equal status as interpreters of what occurred in the session. The report forms have been used widely in the field and were viewed as a viable measure of subjective experience in the therapy session (Mintz et al, 1973; Levine and Herron, 1990). The TSPRF was developed to assess the immediately preceding therapy session. The only adaptation made for the present study was to change its wording to suit an individual interview rather than a session of psychotherapy. The content of any item was not altered. The TSRPF, henceforth referred to as the IRF, was used to investigate five separate aspects of therapy aiming to inquire as much information about the session and current therapeutic relationship as possible. The five aspects of therapy sessions assessed are (i) session dialogue or content; (ii)

affective involvement (what the patient felt and his/her perception of the interviewer's feelings; (iii) the behavioural relationship; (iv) non-verbal exchange; (v) session development items which assess such variables as applicants' motivation and anticipation of the interview, how freely the applicant was able to speak, in-session rapport, how helpful the interviewer was and how well the patient was faring psychologically at the time of the session. The purpose of the questionnaire was to address the raw experience of the applicant rather than ask the applicant to make evaluative judgements. A copy of the IRF is available in Appendix 1.

Symptom Checklist 90- Revised (SCL90-R).

The Symptom Checklist 90- Revised (Derogatis et al, 1973; Derogatis, 1994) is a 90 item self-report rating scale requiring 10-15 minutes for completion. Each item relates to one of nine symptom dimensions believed to underlie the majority of symptom behaviours of psychiatric outpatients. These dimensions are Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. Subjects are required to rate the frequency with which they experienced each symptom. For the purposes of the study, the instructions to subjects were altered slightly, requesting them to rate items in accordance with their general experience of themselves rather than over the past few weeks. Figures on reliability, construct validity, and content validity are well published (Derogatis, 1994). A copy of the SCL90 is available in Appendix 1.

Beck Depression Inventory (BDI).

The Beck Depression Inventory (Beck et al, 1961) was developed as a self-administered, 21 item questionnaire. Each item relates to a symptom or attitude of depression and consists of four statements of increasing severity. The subject is required to choose which statement applies most to him/her over the past three months. The clinician then rates each item on a 0-3 rating scale, the total score being a summation of the scores on each item. Once again, the instructions to

subjects were altered slightly, requesting them to rate items in accordance with their general experience of themselves rather than over the past few weeks. Widely reviewing the BDI, Beck et al (1988) reported a mean internal consistency estimate, coefficient alpha, of 0.87 and an adequate mean test-retest reliability ($r=0.60$). A copy of the BDI is available in Appendix 1.

Other Data Gathered.

(i) Rating Forms.

The training organisation developed assessment forms for each of the stages of the assessment procedure. Each applicant is graded on a three category scale of 'Strong', 'Average', 'Weak' for each of a number of dimensions across the two group interviews. The 'Practical Group' covers the dimensions of Practical Counselling Type Experience, Previous Counselling Skills Course Experience, Personal therapy, Funding, Academic Ability, and Ability to relate to group. Rating for the 'Case Discussion Group' covers the dimensions of Attitude to Clients (ability to empathise), Potential to think Psychodynamically, Ability to relate with group'. The 'Case Discussion' rating also includes an overall rating of 'Accept', 'Possible' and 'No'. The personal interview produced equivalent ratings and all ratings are collated and reviewed on a final 'Applicant Grade Sheet' prior to the final decision being made. A copy of all the WPF evaluation forms is provided in Appendix 1.

(ii) Previous Experience of Psychotherapy.

Information from the application form also allowed for an estimate to be made of the number of episodes and total hours of psychotherapy experienced by each applicant prior to application. Additional information such as completion of a previous training course at the institution was also available.

(iii) Recommendation.

Given that ethical considerations precluded participation in the study in parallel with application to the T.O., the possibility emerged the subject responses would be coloured by the experience and outcome of the application process. Whilst this was clearly a limitation of the study, each subject was asked at interview whether, if a good friend was interested in completing an advanced training in counselling, would the subject recommend the T.O. This question attempted to assess the possible influence iatrogenic effect of the application process itself.

6.2.4 Procedure.

All applicants were contacted by letter informing them of the study. To prevent the study interfering with the application process, applicants were initially informed of the study once they had formally applied to the training body but were only formally recruited to the study once they have completed the application process. All subjects were volunteers and non were paid or induced in any way to participate in the study. All information was obtained under strict conditions of confidence and the T.O. was not provided with any data on any one individual subject. Each participant then completed the measures noted previously at individually arranged meetings.

6.3 Results

6.3.1 Age and Gender

As shown in Table 6.4, applicant age was not a predictor of acceptance for training. Successful applicants had mean age of 45.03 years (sd=5.9) whilst unsuccessful applicants were slightly younger, having a mean age of 41.15 years (sd=5.56). This difference was not significant [$F=2.28$, $df=1$, ns]. Similarly, applicant gender did not predict acceptance. Of the twenty male applicants, nine (45%) were rejected whilst the remaining 11 (55%) were accepted for training.

Similarly, thirty-six women, 45.6% of female applicants were accepted whilst forty-three female applicants (54.4%) were rejected. This distribution was not significant [$X^2 = .002$, $df=1$, *ns*].

**Table 6.4 Demographic Characteristics as Predictors of
Acceptance for Training.**

Measure		Applicants Accepted for Training	Applicants Rejected for Training	Significant Differences (Accepted vs Non Accepted)
Mean Age (sd)	Male	45.03 (5.90)	41.15 (5.56)	ns $F=2.28$ $df = 1$, 96
	Female	44.26 (8.20)	42.71 (6.38)	
	Whole sample	44.42 (7.64)	42.63(6.69)	
Gender (Row %)	Male	9 (45)	11 (55)	ns $X^2 = .002$ $df=1$
	Female	36 (45.6)	43 (54.4)	
	Total	45 (45.5)	54 (54.5)	
Social Economic Status (SES) (Row %)	I	25 (67.6)	12 (32.4)	ns $X^2 = 4.88$
	II	9 (47.4)	10 (52.6)	
	III	14 (51.9)	13 (48.1)	
	IV & V	6 (37.5)	10 (62.5)	
	Total	54 (54.5)	45 (45.5)	
Ethnicity (Row %)	White	48 (53.3)	42 (46.7)	ns $\tau_b = -.119$
	Non White	6 (75)	2 (25)	
	Total	54 (55.1)	44 (44.9)	
Highest Level of Education (Row %)	To 'O' Level	5 (45.5)	6 (54.5)	See Recoding Below
	To 'A' Level	12 (63.2)	7 (36.8)	
	To degree level	16 (55.2)	13 (44.8)	
	To postgraduate level	13 (68.4)	6 (31.6)	
	Other diploma without above	7 (35)	13 (65)	
	Other diploma with above	0 (0)	1 (100)	
	Total	54 (54.5)	45 (45.5)	
Recoded Education (Row %)	Non University	24 (48)	26 (52)	ns $X^2 = 2.80$ $df=2$
	Graduate	16 (55.2)	13 (44.8)	
	Postgraduate	14 (70)	6 (30)	
	Total	54 (54.5)	45 (45.5)	

6.3.2 Education.

Level of education prior to application did not appear to predict acceptance into training. As shown in Table 6.4, 48% of subjects educated to secondary level were accepted into the training programme. Similarly, 55.2% of subjects educated to graduate level and 70% of those educated to postgraduate level were accepted for training. This distribution was not significant. [$\chi^2 = 2.8$, $df=2$, *ns*].

6.3.3 Social Economic Status.

In collapsing social classes IV and V together, Social Economic Status was recoded from five to four categories. The subsequent analysis revealed a significant trend towards the acceptance of applicants from higher social classes, namely Classes II and I, as shown in Table 6.4. Whilst applicants from Class I represented 37.4% of the whole sample, 67.6% of these applicants were accepted for training. Similarly applicants from Class II represented 19.2% of the participant sample, 47.4% of these applicants were accepted for training. Conversely, whilst applicants from social classes IV and V represented 16.2% of the participant sample, 62.5% of these applicants were rejected for training [Kendall's $\tau_c = -.223$, $p < .038$].

6.3.4 Ethnicity.

Whilst the number of non-white applicants was very small, ethnicity did not appear to discriminate between applicants accepted or rejected for training. Forty-eight subjects (53.3%) of white background were accepted for training. Of the eight non-white applicants, six (75%) were accepted whilst the remaining two (25%) were rejected. Whilst the number of non-white applicants precluded valid use of Chi-square, no significant trend as indicated by Kendall's τ_b was observed.

6.3.5 Intellectual Functioning.

As presented in Table 6.5, intellectual functioning as measured by the NART was significantly and negatively correlated with social economic status [$r = -.518, p < .001$] and positively correlated with age [$r = .513, p < .002$]. The mean Full Scale IQ score for applicants accepted for training was 117.68 (sd= 6.67) whilst that for applicants rejected was slightly lower at 114.84 (sd= 9.75). Univariate analysis of variance was used to control for the influence of age and social economic status indicating that this difference was not significant [$F = .035, df = 31, ns$]. The minimum score of intellectual functioning was 96 whilst the maximum was 128. Given this range and the overall high level of scores, a median split analysis was conducted producing two groups comprising 20 applicants in the lower IQ group, thirteen accepted for training, seven rejected for training, and 15 applicants in higher IQ group, nine applicants accepted for training and six applicants rejected. This distribution did not reach statistical significance.

Similarly, estimated Verbal IQ significantly correlated with both age [$r = .515, p < .002$] and social economic status [$r = -.473, p < .004$]. As shown in Table 6.5, the mean Verbal IQ score for successful applicants was 116.05 (sd=6.24) and that for unsuccessful applicants was 113.38 (sd=8.94). Controlling for both age and social economic status, the difference between the groups was not significant [$F = .015, df = 31, ns$] and a median split analysis, using the median value of 116, was also not significant. Estimated Performance IQ was also correlated with both age [$r = .480, p < .003$] and social economic status [$r = -.532, p < .001$]. The mean Performance IQ score for successful applicants was 115.05 (sd=6.24) and for unsuccessful applicants 113.38 (sd=8.94). No significant difference was noted between the groups [$F = .022, df = 31, ns$] and a median split analysis, using the median value of 117, was also not significant.

The mean discrepancy between verbal and performance IQ scores was $-.23$ (sd= 1.41) for applicants accepted and $.23$ (sd= 1.8) for applicants rejected. Whilst the

difference in the direction was difference was noted, the discrepancy between the two groups did not prove significant [Mann Whitney U = 118.5, *ns*].

**Table 6.5 Comparison Between Participants Accepted and Rejected for
Training on Measures of Intellectual Functioning,
Psychological Mindedness and Personality**

Measure		Whole Sample (sd)	Applicants Accepted for Training (sd)	Applicants Rejected for Training (sd)	Differences (Accepted vs Rejected)
NART	FSIQ*	116.62 (7.94)	117.68 (6.67)	114.84 (9.75)	$F_{1,43} = .04$ ns
	Verbal IQ*	115.00 (7.19)	116.05 (6.24)	113.38 (8.94)	$F_{1,43} = .12$ ns
	Performance IQ*	115.05 (7.34)	115.81 (5.99)	113.61 (8.97)	$F_{1,43} = .06$ ns
Psychological mindedness		148.97 (14.96)	147.75 (16.11)	150.75 (13.33)	ns $U = 243.5$
Eysenck Personality Inventory Scales (Z Scores)	Extraversion	.018 (.80)	-.054 (.865)	.123 (.699)	$t_{1,47} = -.76$ ns
	Psychoticism	1.64 (1.75)	1.56 (1.87)	1.76 (1.57)	$t_{1,47} = -.41$ ns
	Neuroticism	.497 (.908)	.533 (.905)	.443 (.935)	$t_{1,47} = -.34$ ns
	Lie°	-.061 (.84)	-.264 (.145)	.233 (.174)	$F_{1,46} = 4.79$ $p < .03$
	Criminality	.46 (.91)	.507 (.947)	.394 (.882)	$t_{1,47} = .43$ ns
	Addictiveness	.14 (.80)	.192 (.782)	.066 (.860)	$t_{1,47} = .53$ ns
	Composite	2.70 (2.83)	2.48 (3.08)	3.01 (2.47)	$t_{1,47} = .67$ ns

Key: * Controlled for Age ° Controlled for SES ° Controlled for Sex

6.3.6 Eysenck Personality Scales (EPS)

The four main scales of the EPS, Psychoticism, Extroversion, Neuroticism, and Lie scales, each have published norms based upon age and gender. Consequently, all raw scores were converted to standardised scores with reference to the appropriate norm, prior to further analyses. As shown in Table 6.5, only the Lie Scale of the EPS correlated with any demographic characteristic. The results indicated a gender

difference in that male applicants recorded an average z score of 0.41 (sd= .88) whilst female applicants recorded a lower score, $z = -.20$ (sd=.79) which was also lower than the mean for their reference population. The difference between these scores was significant [$t = 2.19$, $df = 1$, $p < .03$].

The results indicated that after controlling for the effect of gender, successful and unsuccessful applicants differed significantly on the EPS Lie Scale with successful applicants recording a mean z score of $-.26$ (sd=.14) whilst unsuccessful applicants scored a mean z score of $.23$ (sd= .17). This difference was significant [$F = 4.79$, $df = 1$, $p < .03$]. Successful applicants did not significantly differ from unsuccessful applicants on any other scale of the EPS. However, successful applicants recorded a lower mean z score on the Psychoticism Scale than unsuccessful applicants although this was also greater than the mean for the reference population. Successful applicants also recorded a lower mean z-score than unsuccessful applicants on the Extraversion scale with successful applicants scoring below the mean for the reference population and unsuccessful applicants scoring above the mean for the reference population. The converse was true of the results of the Neuroticism, Criminality, and Addictiveness scales on which the mean score for successful applicants was higher than that for unsuccessful applicants. On each of these scales, both successful and unsuccessful applicants recorded mean scores above the mean for their reference population.

An overall composite measure of personality was calculated by summing the z scores for each of the six scales. The results indicated that there was no significant difference between successful and unsuccessful candidates on this measure [$F = .354$, $df = 1$, ns].

6.3.7 Cognitive Style

Cognitive style was measured through the use of the Opinion about Psychological Problems Questionnaire as described in section 6.2.3. As indicated in Table 6.6, preliminary analysis showed that only one of the scales was significantly associated with any demographic variable; the Naive Solution scale being significantly

correlated with age [$r=.374$, $p<.008$]. Age was therefore controlled for in subsequent analyses.

**Table 6.6 Mean Item Scores Opinions About Psychological Problems:
Comparison of Applicants Accepted and Rejected for Training.**

Opinion about Psychological Problems		Whole Sample Mean (sd)	Applicants Accepted for Training Mean (sd)	Applicants Rejected for Training Mean (sd)	Differences (Accepted vs Rejected)
Origin of Problem Scales	Behavioural	-.21 (1.31)	.24 (1.42)	.17 (1.18)	ns $t=-.194$ $df=47$
	Cognitive	-.14 (1.26)	-.10 (1.24)	-.21 (1.31)	ns $t=-.302$ $df=47$
	Humanistic	.01 (1.25)	-.05 (1.34)	-.18 (1.15)	ns $t=-.347$ $df=47$
	Naï ve	-1.6 (0.87)	-1.7 (.794)	-1.52 (.981)	ns $t=-.739$ $df=47$
	Organic	-2.32 (.918)	-2.39 (.947)	-2.22 (.890)	ns $U= 235.0$
	Psychodynamic	.94 (1.07)	.10 (1.18)	.99 (.921)	ns $t= -.252$ $df =47$
	Social	-1.90 (1.07)	-2.00 (.914)	-1.76 (1.11)	ns $t=-.835$ $df=47$
Best Solution	Behavioural	.59 (0.667)	.39 (1.21)	.90 (1.19)	ns $t= -1.47$ $df=47$
	Cognitive	1.06 (1.01)	.89 (1.04)	1.31 (.924)	ns $t= -1.48$ $df =47$
	Humanistic	2.35 (0.77)	2.36 (.591)	2.34 (.991)	ns $U= 263$
	Naï ve*	-1.53 (0.96)	-1.67 (.940)	-1.31 (.963)	ns $F= 3.61$ $df =46$ $p< .064$
	Organic	-1.86 (.738)	-1.99 (.599)	1.66 (.883)	ns $U= 204$
	Psychodynamic	2.06 (0.86)	2.15 (.849)	1.98 (.892)	ns $U= 267.50$
	Social	1-.31 (1.12)	-1.56 (1.08)	-.950 (.883)	ns $t=-1.94$ $df=47$, $p< .058$

Key: * Controlled for Age

The results indicated that 26 subjects (53.1%) had a cognitive style that could be described as Psychodynamic in style with regard their thoughts about their own problems. Twelve subjects (24.5%) had a predominantly Behavioural style whilst eight subjects (16.3%) conceptualised their difficulties as predominantly Humanistic. Only one subject (2%) conceptualised his own difficulties in a manner closer to a cognitive model than any other. This distribution differed from that generated by self-reported approaches to solutions. Twenty-seven subjects (55.1%) identified themselves as having a Humanistic style of thinking whilst only twenty subjects (40.8%) identified themselves as thinking in Psychodynamic terms. Only one subject (2%) classified himself as behaviourally oriented with regard conceptualising help for himself, and similarly, only one subject (2%) identified the cognitive model as most helpful to himself.

Two approaches were adopted to examine the relationship between cognitive style and acceptance for training. Firstly, each scale was considered separately to consider whether it was predictive of acceptance for training. Secondly, subjects were divided into two groups on the basis of whether a psychodynamic orientation was rated higher than any other orientation, given that they were applying for a psychodynamic training.

The results were consistent with the overall mean scale scores for the whole sample. As indicated in Table 6.6, the mean scale score for the psychodynamic problem scale was the highest positive mean score, indicating general overall agreement with psychodynamic items, whilst most other scales had a negative mean scale score. The mean scale scores of the organic and behavioural problem scales were particularly negative indicating fairly strong disagreement with these styles of conceptualisation. The mean scores for the solution scales were also consistent with the categories. Humanistic solutions were most favoured followed by psychodynamic solutions. Organic solutions were the most strongly disagreed with were solutions based on social conceptualisations and 'naïve' solutions.

As shown in Table 6.6, no single scale of the OPP was able to differentiate between applicants accepted and those rejected for training. Successful and unsuccessful applicants scored approximately identical scores on all scales. However, the standard deviations of all scales were very large indicating a considerable range in scoring.

Within the solution scales, some differences between successful and unsuccessful applicants approached significance. Successful applicants disagreed more strongly with regard naïve solutions to problems than did unsuccessful applicants and this difference approached significance ($p < .06$). Similarly, successful applicants disagreed much more strongly with regard social solutions to problems than did unsuccessful applicants and this difference once again approached significance ($p < .06$).

When considering preferred orientation to problems, and as shown in Table 6.7 there was no clear association between a psychodynamic style of thought and acceptance for training. However, as presented in Table 6.8, when considering preferred orientation towards solution, a significant tendency against a psychodynamic orientation was observed [Kendall's $\tau_b = .27$, $p < .05$]. Of those subjects who most favoured a psychodynamic solution, 75% were rejected whilst only 51.7% of those who favoured other solutions were rejected.

**Table 6.7 Cognitive Style Towards Problems as Predictor of Acceptance
for Training.**

	WPF Accept/reject N (%)		Total
	Accepted	Rejected	
Psychodynamic Orientation	13 (50)	13 (50)	26 (100)
Non Psychodynamic Orientation	16 (69.6)	7 (30.4)	23 (100)
Total	29 (59.2)	20 (40.8)	49 (100)

Fishers exact, *ns*

Kendall's $\tau_b = .267, p < .05$

**Table 6.8 Cognitive Style Towards Solutions as Predictor of Acceptance
for Training.**

	WPF Accept/reject N (%)		Total
	Accepted	Rejected	
Psychodynamic Orientation	5 (25)	15 (75)	20 (100)
Non Psychodynamic Orientation	14 (48.3)	15 (51.7)	29 (100)
Total	19 (38.8)	20 (61.2)	49 (100)

Fishers exact, *ns*

Kendall's $\tau_b = .267, p < .05$

6.3.8 Views on a Good Therapist

Whilst being an exploratory measure, the scales of the GTQ were substantially based on those of the OPP and had high face validity. Additionally, the Cronbach alpha statistic was used to assess internal reliability. Cronbach alpha scores for each scale were as follows; Psychodynamic (.77), Cognitive (.82), Behavioural (.94), Humanistic (.55) and Eclectic (.84). Consequently, the scales were considered as valid and reliable even though the Cronbach alpha for the Humanistic scale was slightly low.

The results indicated that the Eclectic scale correlated significantly with Education [$r = .34$, $p < .02$] and was associated with gender [$t = 2.25$, $df = 1$, $p < .03$]. Additionally, the Humanistic correlated significantly with SES [$r = .32$, $p < .02$]. Controlling for both these correlations the results indicated that successful and unsuccessful applicants differed significantly on the Eclectic Scales with successful applicants being much more focussed than unsuccessful applicants the other scales. The full results from the GTQ are presented in Table 6.9.

Table 6.9 The Good Therapist Questionnaire: Comparison of Mean Scale Scores for Applicants Accepted and Rejected for Training.

The Good Therapist Questionnaire Orientation Scales	Whole Sample. mean (sd)	Applicants Accepted for Training. mean (sd)	Applicants Rejected for Training. mean (sd)	Differences (Accepted vs Rejected)
Behavioural	1.86 (0.41)	1.75 (0.35)	2.02 (.043)	ns $t = -.246$ df = 47
Cognitive	2.03 (0.43)	1.97 (0.42)	2.12 (0.43)	ns $t = -1.23$ df = 47
Humanistic*	2.78 (0.24)	2.70 (0.54)	2.62 (0.44)	ns $F = 0.164$ df = 47
Psychodynamic	2.55 (0.39)	2.49 (0.39)	2.62 (0.39)	ns $t = -1.16$ df = 47
Eclectic*°	2.14 (0.25)	2.09 (.914)	2.22 (0.41)	$F = -4.77$ df = 47 $p < .03$

Key: * Controlled for SES ° Controlled for Education
 ° Controlled for Sex

6.3.9 Psychological Mindedness

The distribution of scores was negatively skewed with the mean score for psychological mindedness for successful applicants being 147.75 (sd= 16.11) whilst that for unsuccessful applicants was slightly higher at 150.75 (sd 13.33). This difference was not significant [Mann Whitney U = 243.5, *ns*]. The range of scores was quite large, the minimum score being 109 and the maximum score 175, the median value being 152. A median split analysis indicated that there was no significant association between the degree of self-reported psychological mindedness and acceptance onto training.

6.3.10 Experience within the Personal Interview.

Analysis of the results of the Interview report Form (IRF) indicated that two of the scales correlated significantly with demographic variable. The Therapeutic Satisfaction scale was significantly correlated with Education [Spearman rho = $-.321$, $p < .026$] and Patient Role was significantly correlated with SES [Spearman rho = $.328$, $p < .023$]. Subsequent analyses controlled for these two factors and the results indicated that successful applicants were more collaborative when discussing heterosexual relationships, involved themselves in less painful self exploration, were considerably more hostile to the assessor when he/she was experienced as noncommittal. Furthermore successful applicants perceived the assessor as significantly friendlier than did unsuccessful candidates. The full results are presented in Table 6.10. Additionally, near significant differences between successful and unsuccessful candidates were noted in the Toying With The Therapist scale in which unsuccessful applicants experienced the interview as one in which they could manipulate the therapist and feel aloof to him/her. Successful candidates also rated themselves as less passively dependent upon the therapist although this difference only approached significance ($p < .06$).

**Table 6.10 Main Constructs of the Interview Report Form
as Predictors of Acceptance for Training.**

Scales of the Interview Report Form	Whole Sample (sd)	Applicants Accepted for Training (sd)	Applicants Rejected for Training (sd)	Differences (Accepted vs Rejected)
Therapeutic Satisfaction*	11.76 (1.53)	11.30 (.256)	12.47 (.317)	$F=8.18$, $p < .006$
Painful Self-exploration	4.03 (.393)	3.96 (.431)	4.15 (.301)	$U=168.5$ $p < .02$
Toying with the therapist	.488 (.360)	.413 (.341)	.602 (.366)	ns $U=185.5$ $p < .057$
Collaborative exploration of heterosexual involvements	.815 (.349)	.890 (.358)	.702 (.310)	$U=175.5$ $p < .04$
Courting a therapist who is seen as rejecting.	1.04 (.165)	1.07 (.175)	1.00 (.143)	ns $U=221.00$
Erotic transference resistance	1.55 (.285)	1.51 (.292)	1.61 (.272)	ns $U=229.00$
Patient Role Ambivalence*	.946 (.365)	.888 (.366)	1.03 (.355)	ns $U=219.50$
Passive Dependence	.964 (.311)	.897 (.315)	1.07 (.282)	ns $U=188.50$
Hostile provocation towards seemingly noncommittal therapist	.996 (.205)	1.07 (.221)	.883 (.107)	$U=115.00$ $p < .001$
Intrusiveness with a therapist felt to be tense and embarrassed.	1.18 (.110)	1.16 (.104)	1.20 (.119)	ns $U=232.00$
Therapist perceived as mean and attacking.	4.70 (.978)	4.37 (.966)	5.19 (.792)	$U=147.00$ $p < .007$

Key: * Controlled for Education • Controlled for SES

6.3.11 Psychiatric Morbidity: The Symptom Checklist 90-R.

The raw scores obtained for each of the scales of the SCL90 were converted to t-scores using the adult non-patient reference population (Norm B), which was also gender specific. These t-scores were subsequently used in further analyses.

Due to the relatively small sample size, Spearman rho correlation was used to assess correlations with demographic data. This indicated a number of the subscales of the SCL90 were weakly but significantly correlated with age. These scales were Obsessive-Compulsive scale [Spearman rho=.34, $p < .02$], Interpersonal Sensitivity scale [Spearman rho=.29, $p < .04$], Depression Scale [Spearman rho=.28, $p < .05$],

Anxiety scale [Spearman rho=.40, $p < .005$]. Two of the three overall global indices were also weakly but significantly correlated with age. These were the Global Severity Index [Spearman rho=.29, $p < .04$] and the Positive Symptom Distress Index [Spearman rho=.30, $p < .04$].

Analysis of the responses also indicated the significant influence of gender on most of the scales of the SCL90. Male applicants scored significantly higher than female applicants on the following scales; Obsessive compulsive [$p < .002$]. Interpersonal Sensitivity [$p < .001$], Depression [$p < .002$], Anxiety [$p < .002$], Phobic anxiety [$p < .001$], Paranoid ideation [$p < .01$], Psychoticism [$p < .001$], Global severity index [$p < .001$], Positive Symptom Distress Index [$p < .043$], and Positive Symptom Total [$p < .004$]. There was no significant gender difference on only two of the scales, Somatization and Hostility. The mean scores of the eleven male applicants was over one standard deviation above the mean on the following scales; Obsessive compulsive (mean=67.64, sd=10.82), Interpersonal Sensitivity (mean=71.27, sd=10.28), Depression (mean=66.82, sd=11.86), Anxiety (mean=66.00, sd=10.25), Paranoid Ideation (mean=60.00, sd=11.16), Psychoticism (mean=64.82, sd=11.45), Global severity index (mean=67.09, sd=11.61), and Positive symptom distress (mean=64.45, sd=7.65). There were no scales of the SCL90 on which the mean for female applicants was more than one standard deviation above the mean.

Accounting for age and gender differences, the results of a comparison between successful and unsuccessful applicants are presented in Table 6.11. The results indicated that there was no significant difference between successful and unsuccessful applicants on any of the scales of the SCL90 and in particular, scores on the global indices were not significantly different. The scores for both successful and unsuccessful applicants were very close on all scales, the greatest difference occurring on the Somatization scale although this difference amounting to only 4.16. All mean scores for both successful and unsuccessful applicants were either at or above a t-score of 50, i.e., the mean for the reference population. Scores for both successful and unsuccessful applicants the Obsessive Compulsive, Interpersonal Sensitivity, and

Depression Scales were nearly one standard deviation above the mean. This in addition to the relatively large standard deviations recorded, suggested that a further analysis separating out those with very high scores was warranted.

Table 6.11 Comparison Between Participants Accepted and Rejected for Training on Standardised Measures of Psychiatric Symptomatology.

Measure		Whole Sample (sd)	Applicants Accepted for Training (sd)	Applicants Rejected for Training (sd)	Differences (Accepted vs Rejected)
Beck Depression Inventory*		4.88 (4.65)	5.68 (5.07)	3.95 (3.84)	ns $F=.965$ $df=46$
Symptom Checklist 90. (Subscale T-Scores Norm B)	Somatization	52.06 (9.62)	53.76 (9.84)	49.60 (8.97)	ns $t= -1.50$ $df=47$
	Obsessive Compulsive*°	59.71 (9.99)	59.52 (10.11)	60.00 (10.05)	ns $F=.656$ $df=45$
	Interpersonal Sensitivity*°	60.44 (10.14)	60.97 (10.22)	59.70 (10.23)	ns $t= .002$ $df=45$
	Depression*°	58.06 (11.17)	57.62 (12.05)	58.70 (12.05)	ns $t= .699$ $df=45$
	Anxiety*°	57.18 (11.05)	58.06 (10.11)	55.90 (12.46)	ns $F=.018$ $df=45$
	Hostility	52.42 (10.23)	52.68 (9.92)	52.05 (11.03)	ns $U=268.5$
	Phobic Anxiety°	51.51 (9.29)	50.82 (8.98)	52.50 (9.83)	ns $F= .729$ $df=46$
	Paranoid Ideation°	53.61 (9.55)	54.00 (10.06)	53.05 (8.98)	ns $F=.053$ $df=46$
	Psychoticism°	55.55 (10.73)	55.86 (11.48)	55.10 (9.80)	ns $F=.009$ $df=46$
SCL90 Global Severity Index*°		57.67 (11.28)	57.48 (11.49)	57.95 (11.25)	ns $F=.479$ $df=45$
SCL90 Positive Symptom Distress Index*°		52.79 (10.41)	51.89 (9.72)	54.05 (11.45)	ns $t= 2.31$ $df=45$
SCL90 Positive Symptom Total°		57.24 (9.80)	57.75 (10.78)	56.50 (8.40)	ns $t= -.438$ $df=47$

Key: * Controlled for Age ° Controlled for SES ° Controlled for Sex

Reclassification of scores into those below and above one standard deviation above the mean indicated that a relatively high proportion of the participant sample experienced high levels of symptomatology. With regard the overall Global Severity Index, 38.8% of the sample lay one at one standard deviation or higher above the mean. The percentage of the sample scoring over one standard deviation above the mean ranged from 16.3% for the Phobic Anxiety scale to 51% for the Obsessive Compulsive scale. Subsequent reclassification using the higher criteria of one and a half standard deviations above the mean, these percentages ranged from 8.2% for the Paranoia scale to 28.6% for the Interpersonal Sensitivity scale. Levels of clinical symptomatology did not, however, differentiate between successful and unsuccessful candidates. Non-significant results were recorded for all scales in comparing candidates at both levels of reported symptomatology. The only near exception to this was the reclassification of somatization scores using the criteria of one standard deviation above the mean. This indicated that whilst 52.6% of those subjects scoring within the average range were accepted, 81.8% of those subjects score one standard deviation above the mean were accepted. This is presented in tabular form in Table 6.12 and a near significant tendency was noted [Kendall's $\tau_b = .267, p < .055$]. Whilst the cell sizes of this distribution weaken the validity of this result, it should be noted that when the same analysis was conducted using the criteria of one-and-a-half standard deviations above the mean, only five participants recorded such a score but all five were accepted for training.

**Table 6.12 High Levels of Somatization as Predictor of Acceptance
for Training.**

SCL90 Somatization Scale	WPF Accept/reject n (%)		Total
	Accepted	Rejected	
Score within average range.	20 (52.6)	18 (47.4)	26 (100)
Score one standard deviation above the mean.	9 (81.8)	2 (18.2)	23 (100)
Total	29 (59.2)	20 (40.8)	49 (100)

Fishers exact, *ns*

Kendall's $\tau_b = .27, p < .05$

6.3.12 Psychiatric Morbidity: The Beck Depression Inventory (Beck et al, 1988).

Level of depressive symptomatology as measured by the BDI was weakly but significantly correlated with age [$r = .325, p < .023$]. Subsequent analyses controlling for age indicated that there was no significant difference between applicants accepted for training and those turned down [$F = .965, df = 46, ns$]. The mean score for depressive symptoms for applicants accepted was 5.68 (sd = 5.07) whilst that for applicants turned down was slightly lower at 3.95 (sd = 3.84). However, the range of scores within the sample was nineteen, the minimum being zero and the maximum being nineteen. This indicated that some applicants were reporting clinically significant levels of depression.

A further analysis investigated the potential association between clinical levels of depression and selection for training. The results indicated that five applicants

(10.2%) had self-reported a level of depression within the clinical range and had been accepted for training whilst one applicant had self-reported a significant level of depression and had been unsuccessful in obtaining a place for training. The majority of subjects (87.7%) did not report significant levels of depression. These results were not significant.

6.3.13 Episodes and Hours of previous Psychotherapy

Applicants' total hours in therapy at the time of application were not significantly associated with age, gender, social economic status or education.

The mean hours in therapy for applicants accepted for training was 199.11 (sd=193.8) whilst that for applicants rejected was 131.73 (sd= 193.96). This difference was significant [$U= 868$, $p < .02$] and therefore estimated total hours in therapy did appear to discriminate between applicants accepted and those rejected for training.

**Table 6.13 Cross-tabulation of Acceptance or Rejection
by Number of Reported Episodes of Psychotherapy.**

	Number of Distinct Episodes of Therapy n (%)				Total
	No Therapy	1 Episode	2 Episodes	2+ Episodes	
Accepted	1 (1.9)	25 (46.3)	20 (37)	8 (14.8)	54 (100)
Rejected	5 (11.2)	23 (51.1)	8 (17.8)	9 (20)	45 (100)
Total	6 (6.1)	48 (48.5)	28 (28.3)	17 (17.2)	99 (100.0)

$$X^2 = 7.19, df = 3, p < .066$$

$$\text{Kendall's } \tau_c = .134, ns$$

The number of episodes of therapy however was not predictive of acceptance for training. As shown in Table 6.13, approximately equal numbers of successful and unsuccessful applicants had one episode of therapy. Of those applicants who had two episodes of therapy, twice the number were accepted for training than were rejected. Applicants reporting more than two distinct episodes of therapy were distributed evenly between those accepted and those rejected for training. That the Chi square test approached significance may be an indication that when considering only applicants who had had either one or two episodes of therapy, there would be a tendency to accept those that only had one episode of therapy although such an analysis does not account for the length of therapy.

Applicants' prior experience of psychotherapy was also considered in terms of mean hours per therapy, which was considered to represent a combination of both the length and the intensity of the therapy. Such an analysis would differentiate between an applicant who reported three years of once weekly therapy with three different therapists and an applicant who reported three years of three times weekly psychotherapy with one therapist. Such an analysis indicated that the mean number of hours per episode of therapy for successful applicants was 131.76 hours (sd = 164.78) whilst that for unsuccessful applicants was 82.89 hours (sd = 131.86). This difference was once more significant [$U = 846, p < .009$].

6.3.14 Training Organisation Ratings.

Whilst a great number of ratings were made by the therapists conducting the Discussion and Case Discussion Groups of the selection procedure, these ratings were all highly non predictive of acceptance for training. No one of the scales was significantly associated with any demographic variable and all comparisons between successful and non-successful candidates on these scales were highly non-significant. It would appear that these ratings were truly random.

The above finding was in stark contrast to that of the recommendation made by the therapist who conducted the personal interview. The results are presented in Table

6.14 and show a highly significant association between the recommendation of the therapist/assessor; namely that the final decision of the Selection Committee is highly in keeping with that of the individual assessor [$X^2 = 44.13$, $df = 2$, $p < .001$]. Whilst the fact that the count within one cell was very low, thus weakening its validity, the strength of this result would warrant further investigation.

**Table 6.14 Cross-Tabulation of Acceptance or Rejection
by Recommendation of Therapist Conducting Personal Interview.**

	Recommendation of Interviewer n (%)			Total
	Reject	Possible	Accept	
Accepted	1 (1.9)	23 (43.4)	29 (54.7)	53 (100)
Rejected	28 (62.2)	11 (24.4)	6 (13.3)	45 (100)
Total	29 (29.6)	34 (34.7)	35 (35.7)	98 (100.0)

$$X^2 = 44.13, df = 2, p < .001$$

6.3.15 Recommendation.

Of the fifty subjects in the study, all stated that they would recommend a good friend to apply to the T.O. for training in advanced counselling if asked.

6.4 Discussion

The results of the present study draw a focus upon the individual interview which all applicants had as part of the application procedure. The highly significant association between individual assessors' recommendation and final acceptance for

training [$p < .001$] strongly suggested that the personal interview was the principal method by which decisions regarding acceptance for training were made. This result was therefore very much in keeping with the reported literature (e.g., Kappelle, 1996; Greenacre, 1961). Furthermore, no other rating of applicants' abilities by the training organisation could distinguish between successful and unsuccessful candidates. Analysis of applicants' experience of the interview suggested that successful candidates appeared to indulge in significantly less painful self-exploration [$p < .02$], were significantly more collaborative with regard exploration of heterosexual relationships [$p < .04$], viewed the interviewer as significantly less attacking [$p < .01$] but were also much more provoking of the interviewer when they perceived the interviewer as noncommittal [$p < .001$].

The focus on the interview is further indicated by the fact that successful candidates had had significantly more hours of therapy than unsuccessful candidates [$p < .02$] and had a greater intensity of treatment as indicated by the significant difference in the mean hours per episode of therapy [$p < .01$]. However these results were unable to distinguish whether successful applicants were simply more able to engage in the language of psychotherapy (Russell and Trull 1986) or particular method of interaction, or whether the assessor was able to accurately evaluate internal psychological functioning that was considered more suitable to working as a psychological therapist.

These results must however be viewed with considerable caution given that the Interview Report Form was completed once the subjects were aware of the outcome of the selection procedure. Consequently the results may reflect subjects' retrospective re-evaluations of the interview on the basis of knowing the outcome rather than a more accurate measure of the experience of the interview. However, if true, this interpretation would be greatly at odds with the additional result that successful candidates also experienced far less therapeutic satisfaction within the interview than unsuccessful candidates [$p < .006$]. Were subjects' ratings simply due to retrospective evaluation, the very opposite finding would be expected. Additionally, the unanimous endorsement given by the sample to a hypothetical

good friend to apply to the training organisation would not have occurred if the process of application had been significantly iatrogenic and therefore call into question the results of this study. Consequently, whilst ethical considerations required subjects to participate in the study only after the application process had been completed, this limitation of the design does not appear to have adversely affected the study itself.

The results suggest that the interview is key in determining the outcome of selection although there was no clear indication of the basis upon which the decision was taken. The results obtained suggested that selection was not a function of applicant age, sex, or personality trait and were therefore consistent with the current literature on these factors (e.g., Beutler, 1994; Beutler et al, 1994; Jones 1978).

There was no clear-cut distinction between the personality profiles of successful and unsuccessful candidates. The Extroversion, Neuroticism and Psychoticism Scales of the EPS were unable to distinguish between successful and unsuccessful applicants although the significantly lower scores on the Lie Scale for successful candidates suggested that these candidates were more generally honest. The EPS had an advantage as measure given that it's traits were defined independently of each other rather than overlapping and hence overcome this very criticism of other such measures such as the Myers Briggs Type Indicator (Beutler, 1994). A composite score of personality traits was therefore also calculated and confirmed that personality as measured by a number of traits was not able to distinguish between successful and unsuccessful applicants for training.

The cognitive style of applicants also did not distinguish between successful and unsuccessful candidates. However, the near significant results on the naïve and social solution scales suggested that successful candidates had a more focussed, formulated and internal psychological view of solutions to their own subjective difficulties. This would be in keeping with the results of the Good Therapist Questionnaire, which suggested that successful candidates were significantly less eclectic, i.e., more focussed on a psychological model than were unsuccessful

candidates. However, the results also suggested that self-reported, i.e. consciously evaluated cognitive style was not a distinguishing feature. There was no significant difference between successful and unsuccessful applicants on the basis of conceptualisation of problems, and a significant trend against selecting candidates whose self reported cognitive style towards solutions was predominantly psychodynamic. This was surprising but may be an indication that applicants were selected not on the basis of their stated beliefs, but on the basis of other aspects of their presentation such as their emotional attunement, measures of which were not present in this study.

The results further suggested that neither intellectual functioning nor psychological mindedness were features that distinguished between the applicants. Intellectual functioning was generally very high throughout the sample and psychological mindedness, as measured by self-report questionnaire was extremely high and near the ceiling score for the instrument. It did not distinguish between successful and unsuccessful candidates and given that the subjects were all applicants for a training, which valued the capacity for insight, the self report nature of the measure implied that it was very susceptible to socially desirable responses.

Global indices of symptomatology were also very evenly distributed throughout the sample although there was a near significant tendency for applicants who reported greater somatisation to be accepted for training. Within the sample of applicants who participated in the study, it was clear that over 38% of the sample reported clinically significant levels of symptomatology although overall, successful applicants could not be said to be either more or less disturbed than unsuccessful applicants. The results therefore were in keeping with the literature on selection (e.g., Knight, 1953) that high levels of symptomatology as indicative of underlying difficulties should not be an excluding factor per se to training and may possibly have been considered indicative of potential. The results raise the possibility that it is not the presence or absence of psychological disturbance that is the deciding factor, but the manner in which it is internally managed that is important.

Other findings were those to be expected. Completion of any academic course at the WPF prior to application was significantly associated with education. Applicants who had not completed their education to either graduated or postgraduate level were significantly more likely to have completed a course at the WPF prior to their current application. This may be expected in that those who had no previous academic qualification would complete a WPF course whilst those who had did not feel the need to prove their credentials. Similarly, applicants in lower social groups were more likely to have completed a course at the WPF prior to the current application.

Additionally, these results may be generalised to the whole cohort given that participant and non-participant samples were broadly equivalent. This was true of all demographic measures, the only discrepancy being a trend for subjects from social economic classes I and II to be more likely to participate in the study. This may however also reflect the population of qualified therapists and the people who are stereotypically conceptualised as seeking psychotherapy. Importantly, there was no difference between the two sample in terms of overall acceptance or rejection by the training organisation. This was also true for the recommendations made on the basis of the Case Discussion group interview [$X^2 = 3.25$, $df = 2$, *ns*], and for decisions made on the basis of the Individual Interview [$X^2 = .14$, $df = 2$, *ns*]. Consequently, it may be argued that the results are generalisable to the whole cohort applying that year to the training organisation.

Overall, these findings are very much in keeping with the literature reviewed in Chapters 2 and 3. There was no wholly objective measure that was able to distinguish between successful and unsuccessful candidates. These findings should however be viewed with caution given the small size of the sample, and require replication. Those findings that were significant tended to draw attention to the consideration of the presence of applicant and assessor engaged in an interaction. There remains the possibility therefore that selection was a function of one or more characteristics of the assessor and independent of the applicant. Alternatively, selection may also have been a function of the interaction between assessor and

applicant. Consequently, these two possibilities are investigated further in Studies 2 and 3 of the current chapter.

Study 2. Do Characteristics of the Assessor Predict Applicant Selection for Training.

6.5 Introduction.

The results of Study 1 were in keeping with previous literature which suggested that reported on the degree to which applicants' characteristics predicted acceptance for training at a well known training organisation in central London. The results suggested that a possible factor determining selection might be the selector/assessor himself. Consequently, the assessors for the cohort from which the participant sample were drawn were therefore recruited for a study.

6.6 Aim.

The examination whether aspects of the assessors themselves independently predicted the selection of candidates, this being especially important in the light of the findings regarding the importance and predictive nature of the individual therapist for the outcome of psychotherapy.

6.7 Methodology.

6.7.1 Design.

This study used a correlation design in which the proportion of applicants accepted for training by each assessor was correlated against assessor scores on a range of selected variables. This design allowed for the fact that each assessor conducted a different number of interviews and accepted a different proportion of applicants he/she interviewed.

6.7.2 Sample.

Age and Gender.

A total of thirteen female and six male assessors were available to interview the cohort of applicants described in Study 1. Of these, one assessor was officially part of the assessing group used by the training organisation but did not interview any of this particular cohort for reasons of geography. One further assessor did not participate in the study thereby creating a sample of seventeen assessors in total or 94.4% of the available sample.

The mean age of the assessors was 54.03 years (sd= 7.61) with the mean age of six participating male assessors being 53.0 years (sd = 6.38) and 54.55 years (sd = 8.38) for the eleven participating female female assessors. Whilst distribution by gender produced very small sample sizes, this difference in age did not appear significant.

Education.

The highest level of education achieved by each assessor was noted at interview and classified into three groups thus also reflecting the structure of the educational system in the UK. The three groups thus generated indicated that three assessors (15.8%) completed their formal education at secondary level, four assessors (21.1%) completed their formal education at graduate level, and eleven assessors (57.9%) completed their education at postgraduate level. Interestingly, all male assessors lay in the postgraduate group.

Social Class.

Each assessor reported that employment as a psychotherapist was his principal occupation. Classification of social class by occupation using the Standard Occupational Classification (OPCS, 1990) therefore placed all the assessors in

Social Class I and effectively eliminated the examination of social class as a differentiating factor.

Ethnicity.

Given the small size of the group of assessors, data on ethnicity was classified on a dichotomous white, non-white basis. This indicated that fifteen (88.2%) assessors were of white origin and two (11.8%) were of non-white origin.

6.7.2.1 Non demographic Descriptors

Non-demographic descriptors predominantly concerned the assessors' degree of experience as represented from a number of different perspectives.

Number of Episodes and Hours of Psychotherapy.

For each assessor the number of episodes, hours, and frequency of sessions of previous psychotherapy noted. The number of discrete episodes of therapy recorded for the sample of assessors ranged from one to four. This indicated that four assessors (23.5%) had had only one psychotherapy, six assessors (35.3%) had had two psychotherapies, six (35.3%) had had three psychotherapies and one (5.9%) had had four separate psychotherapies. Once again, although the small size of the group precluded any formal statistical analysis, the distribution by assessor gender appeared non significant and there was no clear correlation with assessor age.

The highest frequency of therapy reported indicated that approximately equal numbers of assessors completed psychotherapy at a frequency of three or four sessions per week. Only one assessor completed a psychotherapy in which the highest frequency of sessions was no more than twice per week. Six (35.3%) assessors had completed therapy at a maximum of three sessions per week and six (35.3%) had completed at four sessions per week. Four assessors (23.5%) had completed a full psychoanalysis.

Once again, the distribution of frequency of psychotherapy and assessor gender did not appear significant.

The mean total number of hours in psychotherapy for the sample of assessors was 1337.52 (sd = 498.58) with the mean number of hours per therapy being 641.23 hours (sd = 249.11). Female assessors appeared to have had more total hours of therapy than male assessors, 1398.66 hours (sd= 524.39) as opposed to 993.33 hours (sd = 390). However, the more important mean hours per psychotherapy statistic was approximately equivalent, 591.66 hours (sd = 227.19) for male assessors and 628.77 (sd = 309.98) for female assessors.

The mean number of face-to-face hours of clinical work per week that assessors completed at the time of interview was 24.37 (sd = 6.51).

Number of years Post Qualification and in Assessing Role.

The experience of assessors was also considered in terms of the number of years they had spent working as a psychotherapists since qualification and the number of years they had acted as assessors for the training organisation. The mean number of years since qualification was 12 years (sd = 3.64) with the minimum being 7 years and the maximum being 20 years. The mean number of years spent in the role of assessor was 6.08 years (sd = 3.34) although range for this variable was very large with the newest assessor having worked as such for 2 years and the most experienced assessor having completed such a role for 15 years.

Prior Completion of a Course at the Training Organisation.

It was known that a number of assessors had initially been students at the training organisation for which they now functioned as assessors. A commonly held perception within the organisation (V. Marshal, personal communication) was that completion of an in-house course prior to application would favour acceptance to the Advanced Diploma training and consequently it was considered important to note whether the

assessor had previously completed such a course. The results indicated that nine assessors (52.9%) had at one time completed an in-house course as part of their professional career whilst the remaining eight assessors (47.1%) had not. Once again, the distribution of prior completion of an in-house course did not appear significant in any way.

6.7.3 Measures.

A number of measures were used in the current study that were also used in Study 1A. These were the Eysenck Personality Scales (EPS; Eysenck & Eysenck, 1991), the Opinions about Psychological Problems questionnaire (OPP; Barker et al, 1983; Pistrang & Barker, 1992), the Good Therapist Questionnaire, and the Psychological Mindfulness Scale (PM, Conte et al, 1990; Conte et al, 1996; Conte and Ratto, 1997). The nature of each of these measures was described in Study 1A and will not be repeated at this point.

Assessor psychological morbidity was evaluated by self-report using the Symptom Checklist 90 Revised (SCL90-R; Derogatis et al, 1973; Derogatis, 1994) as in Study 1A. Once again, the instruction to assessors was to complete the questionnaire as per their experience of themselves in general rather than over the past few weeks.

The Psychoanalysts Orientation Questionnaire (POQ; Hamilton, 1990) was slightly modified and used as a further measure of assessor's theoretical orientation. The POQ consisted of twenty-two categories of influence on psychoanalytic theory e.g., S. Freud Drive Theory, British Object Relations, Kohut etc. Each subject was required to rate each category as to the degree to which they have been influenced by the said category on a five point likert scale ranging from 'Not at all' to 'To a very great extent'. Theoretical orientation was subsequently assessed on five factors; Developmental Freudian versus Bionian-Klienian, Classical Freudian versus Kohut-Self Psychology, Hermeneutics (narrative truth) versus British Object Relations, Interpersonal or external reality influences, and French Psychoanalysis. Given the acknowledged Jungian influence within the training organisation, three

categories were added to the POQ. These covered the broad schools of thought within Jungian Analytical Psychology and were; Jung Classical (Adler Henderson, Stevens), Jung Strong Developmental (Fordham, Lambert, Zinkin), and Jung Strongly Archetypal (Hillman, Lopez-Pedroza, Corbin). The mean combined score for these items was subsequently used as a measure of the influence of Jungian analytical theory. Hamilton (1990) reported that the POQ had very high face validity and that its factors well discriminated between therapists professing to different orientations. The addition of three items relating to Jungian orientation were not considered to have altered the psychometric properties of the POQ significantly.

Assessors' views on important factors in the applicant were measured using two constructed measures, the first based upon initial interviews, the second an adaptation of a previously used measure. All assessors completed an initial qualitative interview regarding their views on important aspects of the selection process. A forty-three item Indicators for Acceptance Questionnaire (IAQ) was subsequently developed covering the views of the assessors on relevant areas such as family history, educational history, employment, personal relationships, health, current state and behaviour within the interview. Assessors were required to rate each item on a scale from -2 to +2, positive ratings suggesting that positive conclusions in the particular area of discussion were regarded as an indicator for acceptance. A copy of this questionnaire is provided in Appendix 1.

Assessors subsequently completed a modified Discussion Items section of the Interview Report Form, initially adapted from the Therapy Session Report Patient Form (Orlinsky and Howard, 1975; 1986) as described in Study 1. This section originally asked subjects to tick whether a particular area arose in their discussion. A modification was made to the scoring in that assessors were required to rate each item on a five-point scale as to the degree to which the area 'routinely' arose for discussion with an applicant during a selection interview. A rating of '+2' indicated that the area always arose in discussion whilst a rating of '-2' indicated that the area nearly never arose in discussion. Assessors were then required to rank the eighteen items of this section of the IRF in terms of which was the most

important, ranked 1, and continue to rank these until the least important item was ranked 18. A copy of the modified form is provided in Appendix 1.

6.7.4 Procedure.

All assessors were contacted by letter informing them of the study and requesting their participation. Those assessors consenting to participate in the study were subsequently interviewed at which time they also completed all of the measures noted above. All subjects were volunteers and none were paid or induced in any way to participate in the study. All information was obtained under strict conditions of confidence and the training body was not provided with the data of any one individual subject.

6.8 Results

Statistical analysis comprised the correlation of assessors' scores on the above measures with the percentage of applicants accepted by each assessor, i.e. the percentage of the total number of applicants seen by that assessor that were subsequently accepted for training. This method accounted for the fact that different assessors interviewed different numbers of applicants.

6.8.1 Age and Gender

As shown in Table 6.15, assessor age was not a predictor of applicant acceptance for training. There was no significant correlation between assessor age and successful application. Similarly, assessor gender did not predict applicant acceptance with the gender of the assessor being very evenly distributed across successful and non-successful candidates.

**Table 6.15 Characteristics of Assessors as Predictors of
Applicant Acceptance for Training.**

Measure on Assessor	Pearson Correlation with Assessor's Recommendation for Acceptance	Significance
Mean Age	.041	ns
Gender	.215	ns
Recoded Education	-.304	ns
Ethnic Origin	.143	ns
Number of Episodes of Psychotherapy	-.032	ns
Total hours of psychotherapy	-.052	ns
Mean hours per episode of psychotherapy	.026	ns
Years post Qualification	.282	ns
Experience of Assessment for Training	.356	ns
Mean current face to face hours	-.143	ns

6.8.2 Education.

Assessor level of education did not predict acceptance for training, as shown in Table 6.15. There was no significant correlation between assessor gender and the probability of being accepted by a particular assessor.

6.8.3 Ethnicity.

Whilst the number of non-white assessors was very small, assessor ethnicity did not appear to be significantly correlated with acceptance for training as shown in Table 6.15.

6.8.4 Assessor Level of Experience.

The results further indicated that assessor's number of separate psychotherapies, total number of hours in psychotherapy, mean hours per episode of psychotherapy, highest frequency of therapy attended and mean number of current face to face hours of clinical work per week all do not predict successful application for training. For each separate measure, the Pearson correlation was low and no correlation was statistically significant. These results are presented in tabular form in Table 6.15.

Similarly, neither assessors' experience in terms of years of post qualification work or years in the role of assessor were significantly correlated with acceptance for training.

6.8.5 Psychological Mindedness.

Assessors' scores on psychological mindedness did not correlate with any demographic variable. The results indicated that assessors rated themselves as having very high levels of psychological mindedness with the mean score being 140.93 (sd = 7.67). The lowest score recorded was 129, whilst the highest was 157 indicating that that even the lowest score was relatively high. However, as shown in Table 6.16, self-rated psychological mindedness did not correlate significantly with the probability that an applicant would be accepted by a particular assessor and therefore cannot be considered as predictive of acceptance for training.

**Table 6.16 Mean Assessor Scores on Measures of Psychological Mindedness,
Personality, and Self Reported Cognitive Style as
Predictors of Applicant Success for Training.**

Measure		Mean Score (sd)	Pearson Correlation with Assessor's Recommendation for Acceptance	Significance
Psychological mindedness		140.93 (7.67)	-.353	ns
Eysenck Personality Inventory Scales (Z Scores)	Extraversion	-.160 (.973)	-.194	ns
	Psychoticism	2.43 (2.49)	-.077	ns
	Neuroticism	.548 (.944)	.287	ns
	Lie	-.594 (.872)	.239	ns
	Criminality	.394 (1.01)	.291	ns
	Addictiveness ⁺	.118 (.835)	-.129	ns
Opinions About Psychological Problems: Origin of Problem Scales	Behavioural	-.022 (.955)	-.097	ns
	Cognitive	-.233 (1.01)	.001	ns
	Humanistic	-.592 (.893)	-.044	ns
	Naïve *	-1.51 (.886)	-.24	ns
	Organic	-2.11 (.874)	-.063	ns
	Psychodynamic*	.901 (.936)	-.481	ns
	Social	-2.38 (.551)	.093	ns
Opinions About Psychological Problems: Best Solution Scales	Behavioural	-.656 (1.24)	-.017	ns
	Cognitive	.295 (.715)	-.314	ns
	Humanistic	2.02 (.636)	-.408	ns
	Naïve	-1.51 (.981)	.307	ns
	Organic	-1.81 (.939)	-.465	ns
	Psychodynamic	1.44 (1.14)	-.442	ns
	Social	-1.79 (1.00)	-.214	ns

Key: * controlled for gender + controlled for age

6.8.6 Eysenck Personality Scales (EPS)

As in Study 1, assessor raw scores on the main scales of the EPS were converted to standardised scores with reference to the appropriate norm, prior to further analyses. The Addictiveness scale was noted to inversely correlate with assessor age [$r_{(17)} = -.61, p < .02$] and was therefore controlled for in subsequent analyses.

For all the scales of the EPS, the distribution of z-scores was very wide. The large standard deviation scores for each scale suggested considerable differences within the group of assessors. Most noteworthy was the Psychoticism scale in which the mean z-score was over two standard deviations higher than that for the normal sample reported by Eysenck & Eysenck (1991), the median score being $z = 3.08$, and the range being 7.58. Thus some assessors could be interpreted as being extremely “tough-minded” (Eysenck & Eysenck, 1991) and able to think in socially unacceptable terms. Furthermore, even those scoring less than the mean for the sample were still scoring very highly in comparison to the normal population.

Additionally, the mean z-scores for the group of assessors indicated that assessors appeared to have been less extrovert than the norm, slightly more neurotic and slightly more honest as indicated by the negative Lie scale z-score. This was coupled with a slightly raised mean z-score in comparison to the normal sample on the Criminality scale which Eysenck & Eysenck (1991) suggested was a measure of delinquency.

Nevertheless, as shown in Table 6.16, no scale of the EPS correlated significantly with the probability that an applicant would be accepted by a particular assessor and therefore could not be considered as predictive of acceptance for training.

6.8.7 Cognitive Style

Assessor scores on the separate scales of the OPP, for both problems and solutions, were converted to z-scores and initially correlated against demographic data. Only gender appeared to be influential and only on two scales. A gender difference was

noted on the Problem Psychodynamic scale [$t=2.30$, $df = 1$, $p < .04$] in which men rated themselves more highly than women. On the other hand, women more strongly disagreed with naïve explanations about problems [$t=2.17$, $df=1$, $p < .05$]. Gender was therefore controlled for with regard these two scales.

Correlation of assessor scores against the assessor's percentage of accepted applicants are presented in tabular form in Table 6.16 and indicate that no scale of the OPP was significantly correlated with the probability of an applicant being accepted for training. However, the overall pattern of z-scores suggested that assessors tended away from using cognitive strategies centred on organic, social, or naïve conceptualisations of problems. In each case assessors scored over one standard deviation below the mean. Whilst scores on the cognitive and humanistic scales were below the mean, those on the psychodynamic scale were expectedly high. Once again however, the high standard deviation values suggested considerable variation with the exception of the organic and social scales. Even when accounting for standard deviation, assessors as a group appeared to consistently reject organic and social approaches to formulating psychological problems.

A similar picture emerged with regard cognitive styles regarding solutions to psychological problems. Assessors tended to score against using organic, social, and naïve conceptualisations and were divided over the value of a cognitive approach. Interestingly, whilst psychodynamic approaches were always supported, the humanistic perspective was the most powerfully endorsed when considering solution to problems.

Overall however, assessors' self reported cognitive orientation towards both psychological problems and solutions were not predictive of applicant acceptance for training.

The focus on a psychodynamic or humanistic conceptual style was further investigated through the use of the Psychoanalysts Orientation Questionnaire (Hamilton 1990). The results are shown in Table 6.17.

**Table 6.17 Mean Factor Scores for Assessor Psychoanalytic Orientation,
Comparison of Applicants Accepted and Rejected for Training.**

Psychoanalytic Orientation	Mean Score (sd)	Pearson Correlation with Assessor's Recommendation for Acceptance	Significance
Developmental Freudian vs Bionian-Kleinian * *	1.90 (2.02)	.24	ns
Classical Freudian vs Kohution-Self Psychology	3.69 (2.28)	.317	ns
Hermeneutics (narrative truth) vs British Object Relations	-4.24 (.901)	.094	ns
Interpersonal or external reality influences	2.68 (1.50)	.004	ns
French Psychoanalysis *	3.72 (1.41)	.298	ns
Jungian Analytical Psychology	1.75 (.695)	-.422	ns
Composite Orientation	9.51 (4.85)	.204	ns

Key: * Controlled for Gender

* Controlled for education

As a group, assessors were much more heavily influenced by the developmental theories of Freud than those of Klein but were not at all influenced by the work of Kohut or by a belief in the hermeneutic ideas of interpretation as relating to 'narrative truth in contrast to beliefs about the veridical nature of internal 'unconscious phantasy'. Furthermore, assessors favourably recorded the influences of interpersonal theorists such as Bowlby and quite a healthy interest in French psychoanalysis, principally Lacan. Finally, there was a recognisable Jungian

element to the influence on the assessors as a whole. Principally however, the group of assessors appeared to be most powerfully influenced by the Freudian and British Object Relations schools of thought and were relatively uniform in their views. Even though the sample of assessors contained only four men, thus limiting the validity of any comparisons by gender, a gender differences did emerge. Women appeared to be much more oriented to Developmental Freudian views than were the men [$t = -2.29$, $df = 1$, $p < .04$]. Additionally, education inversely correlated with the Freudian-Bionian scale [$r = -.57$, $df = 1$, $p < .03$] suggesting that assessors who had achieved lower levels of education more tended to ascribe to Klienian views, and also inversely correlated with the French Psychoanalysis scale [$r = -.69$, $p < .008$] once more suggesting that the higher the level of education achieved, the lower assessors in this sample were influenced by French Psychoanalysis. However, it must be noted that the sample size was extremely small and the purpose of such correlations was one of controlling for covariates rather than commenting on the results of the correlations per se.

Successful application to the training organisation did not however, appear to be related to the theoretical orientation of the assessor. No significant correlations between assessor factor scores and probability of acceptance by a particular assessor were recorded. This was also true of a composite orientation score calculated as the sum of all factor scores for a particular assessor.

Thus, assessor self-reported theoretical orientation, whether measured as broadly psychodynamic in comparison to other psychological models of functioning or as different orientations within the psychoanalytic paradigm, did not appear to predict successful application for training.

6.8.8 Views on a Good Therapist

The reliability of the GTQ was investigated in Study 1 and considered sufficiently robust to use again. The humanistic scale was noted to correlate significantly with

education [$r = .54$, $p < .05$] and was therefore controlled for in subsequent correlations.

The results produced by this exploratory measure were highly consistent with the ethos of the organisation and other measures of cognitive orientation. The assessors as a group considered that a 'good therapist' behaved towards a patient in a manner highly consistent with psychodynamic and humanistic principles. They were considerably less in favour of behaviour appropriate to cognitive and eclectic approaches and were actively against the use of behavioural techniques. The results for assessors' ratings by success of applicants for training are presented in Table 6.18. It was noted that the diversity of views regarding appropriate behaviour was much narrower with psychodynamic and humanistic than it was with statements relating to other orientations. This appeared to suggest a degree of diversity regarding the acceptability of behaviours not strictly associated with either humanistic or psychodynamic orientations.

Table 6.18 The Good Therapist Questionnaire: Comparison of Mean Scale Scores for Assessors by Applicants Accepted and Rejected for Training.

Scales	Mean Score (sd)	Pearson Correlation with Assessor's Recommendation for Acceptance	Significance
Behavioural	-1.11 (1.12)	.454	ns
Cognitive	.476 (1.09)	.170	ns
Humanistic *	2.24 (.47)	-.152	ns
Psychodynamic	2.33 (0.57)	-.414	ns
Eclectic	.57 (.66)	.284	ns

Key: * Controlled for education

The results further indicated that no scale of the Good Therapist Questionnaire was able to differentiate between successful and unsuccessful applicants on the basis of the assessors' responses. Assessor scores did not correlate with rates of acceptance for each assessor as shown in Table 6.18.

6.8.9 History and Presentation of the Applicant.

Indicators for Acceptance Questionnaire (IAQ).

No scale of this questionnaire correlated with any demographic variable. As shown in Table 6.19, assessors rated the applicants' behaviour within the interview as the most important aspect in predicting acceptance although this was not significant in predicting applicant selection. The mean rating for Employment History placed it as moderately positive indicator for acceptance and this was significantly correlated with the probability of acceptance [$r=.71$, $p<.003$]. Similarly, the applicants' 'current life situation' was also significantly correlated with the probability of acceptance [$r= .58$, $p<.02$] although was rated as less important than the employment history.

No other area of an applicant's presentation was significantly correlated with the probability of acceptance. It was further noted that other than 'behaviour with interviewer' and 'employment history', all areas had a mean rating that was sufficiently low to suggest that they were not considered by assessors as predictive of acceptance or rejection of an applicant. However, the standard deviation scores suggested a wide range of scores, itself indicative of a diversity of views within the assessors.

Table 6.19 The Indicators for Acceptance Questionnaire: Comparison of Mean Scale Scores for Assessors by Applicants Accepted and Rejected for Training.

Scales	Mean Rating (sd)	Pearson Correlation with Assessor's Recommendation for Acceptance	Significance
Family History	.344 (.543)	-.145	ns
Educational History	.444 (.265)	-.009	ns
Employment History	.778 (.411)	.712	$p < .003$
Relationships	.433 (.175)	.173	ns
State of Health	-.288 (.375)	-.042	ns
Current Situation	.511 (.196)	.584	$p < .02$
Behaviour With Interviewer.	1.44 (.369)	.439	ns

Manifest Content of Selection Interview.

Assessors also rated the discussion items of the Interview Report Form but were asked to rate each item on a five-point scale on the degree to which the area 'routinely' arose for discussion with an applicant during a selection interview. Mean ratings for assessors were then correlated against the probability of being accepted by that particular assessor. The findings are presented in Table 6.20 and suggested four areas of discussion were significantly correlated with successful application. Of these, the area of work and supervisors was rated as arising often and was the most significantly correlated with successful application [$r = .73$, $p < .003$]. Bodily functions and health were not guaranteed to arise in the discussion but in cases in which discussion around this topic did occur, applicants were more likely to be selected for training [$r = .61$, $p < .02$]. Discussion of dreams and fantasies and applicants' unusual experiences were also not guaranteed to arise in the interview but the results suggested discussion of these areas was moderately correlated with acceptance; [$r = .54$, $p < .05$; $r = .58$, $p < .03$, respectively].

**Table 6.20 Correlation of Assessors Rating of Interview Report Form Items
with Probability of Applicant Acceptance for Training.**

Interview Report Form Items		Mean Rating of Presence in Assessment (-2 to +2)	Pearson Correlation with Assessor's Recommendation for Acceptance	Significance
1	Social activities and relationships, friends and acquaintances	.875 (.806)	.425	ns
2	Work, supervisors, associates at work	.813 (.655)	.731	$p < .003$
3	Recreations, hobbies, interests	.313 (.655)	.366	ns
4	Domestic and household responsibilities, concerns and activities (finances, children)	.625 (1.02)	.464	ns
5	Relationship with spouse, boyfriend or girlfriend.	1.56 (.512)	-.152	ns
6	Current relations with parents, brothers or sisters.	1.19 (1.04)	.161	ns
7	Childhood experiences with family members, and feelings about them.	1.68 (.793)	.002	ns
8	Childhood experiences in school with friends and with other kids.	.687 (1.01)	.303	ns
9	Feelings and attitudes toward self.	1.56 (.624)	.327	ns
10	Body functions, health, and physical symptoms.	.25 (.856)	.611	$p < .02$
11	Inadequacies, fears or successes in getting along personally and socially.	.81 (1.22)	.309	ns
12	Sexual feelings and experiences.	.75 (1.00)	.250	ns
13	Angry and aggressive feelings and experiences.	1.25 (.683)	.232	ns
14	Feelings about being close to or needing someone.	1.18 (.910)	.306	ns
15	Dreams, fantasies.	0 (1.03)	.543	$p < .05$
16	Plans, hope and goals for the future.	.875 (.800)	.161	ns
17	Strange or unusual ideas, feelings or experiences.	-.500 (1.31)	.577	$p < .03$
18	Therapy, the therapist, being a patient or therapist.	1.56 (.629)	-.135	ns

Rankings of Interview Report Form items

Each of the items of the Interview Report Form was also ranked by assessors for its importance in selection. These rankings were then correlated with the probability of acceptance by each assessor. As shown in Table 6.21, the ranking of items in the interview content section of the IRF was totally unrelated to assessor's recommendation for acceptance to training.

The rankings were then reversed, so that the item initially ranked first was given a score of 18, and the product of item rating and item ranking calculated. Thus high positive or negative scores were a measure of the degree to which an item was always discussed and its importance to the assessor as an indicator for acceptance.

**Table 6.21 Correlation of Assessors Ranking of Interview Report Form Items
with Probability of Applicant Acceptance for Training.**

Interview Report Form Items		Mean and Range in Ranking of Item	Correlation of Ranking with Assessor's Recommendation of Acceptance	Correlation of Product with Assessor's Recommendation of Acceptance
1	Social activities and relationships, friends and acquaintances	9.0 Range = 17	ns	ns
2	Work, supervisors, associates at work	10.1 Range = 14	ns	ns
3	Recreations, hobbies, interests	13.1 Range = 13	ns	ns
4	Domestic and household responsibilities, concerns and activities (finances, children)	11.3 Range = 16	ns	ns
5	Relationship with spouse, boyfriend or girlfriend.	4.81 Range = 8	ns	ns
6	Current relations with parents, brothers or sisters.	10.73 Range = 14	ns	ns
7	Childhood experiences with family members, and feelings about them.	4.36 Range = 6	ns	ns
8	Childhood experiences in school with friends and with other kids.	6.72 Range = 10	ns	ns
9	Feelings and attitudes toward self.	3.72 Range = 9	ns	ns
10	Body functions, health, and physical symptoms.	12.1 Range = 8	ns	ns
11	Inadequacies, fears or successes in getting along personally and socially.	8.7 Range = 17	ns	ns
12	Sexual feelings and experiences.	11.09 Range = 14	ns	ns
13	Angry and aggressive feelings and experiences.	8.45 Range = 11	ns	ns
14	Feelings about being close to or needing someone.	7.20 Range = 16	ns	ns
15	Dreams, fantasies.	12.8 Range = 9	ns	ns
16	Plans, hope and goals for the future.	13.1 Range = 10	ns	ns
17	Strange or unusual ideas, feelings or experiences.	13.0 Range = 15	ns	ns
18	Therapy, the therapist, being a patient or therapist.	8.36 Range = 15	ns	$r = -.602$ $p < .05$

6.8.10 Psychiatric Morbidity: The Symptom Checklist 90-R.

The raw scores obtained for each of the scales of the SCL90 were converted to t-scores using the adult non-patient reference population (Norm B) that was also gender specific. These t-scores were subsequently used in further analyses.

As presented in Table 6.22, the results indicated that successful application for training was in no way correlated with assessor level of self-reported symptomatology. Additionally, whilst the mean scores for assessors lie all within the average range, it was clear that some raw scores placed some assessors within the clinical range on some scales.

Table 6.22 Scores of Assessors on Symptom Checklist 90 (Revised)
as a Predictor for Applicant's Acceptance for Training.

Symptoms		Mean Score (sd)	Pearson Correlation with Assessor's Recommendation for Acceptance	Significance
Symptom Checklist 90. (Subscale T-Scores Norm B)	Somatization	51.93 (6.12)	.037	ns
	Obsessive Compulsive	58.13 (7.58)	-.064	ns
	Interpersonal Sensitivity	58.06 (9.23)	.134	ns
	Depression	58.33 (7.59)	-.001	ns
	Anxiety	55.40 (9.99)	-.014	ns
	Hostility	53.00 (9.68)	-.096	ns
	Phobic Anxiety	50.93 (7.69)	-.009	ns
	Paranoid Ideation	50.33 (9.30)	.152	ns
	Psychoticism	54.13 (8.26)	.014	ns
SCL90 Global Severity Index		56.33 (8.66)	.044	ns
SCL90 Positive Symptom Distress Index		57.60 (8.64)	.033	ns
SCL90 Positive Symptom Total		49.86 (6.51)	-.185	ns

6.9 Discussion

The results of this study indicated that no single aspect of the assessor clearly predicted the selection of applicants for training. This was especially true of age, gender, education, and previous experience of psychotherapy.

Self-rated psychological mindedness amongst assessors was also non predictive but was also very high as it was with applicants. Once again, the self-report and conscious nature of this measure would tend to increase bias towards high scores on the basis of social desirability.

Whilst personality traits as measured by the EPS did not predict acceptance, assessors' overall high scores on the Psychoticism scale were noteworthy. Eysenck & Eysenck (1991) stated that the scale measured what may be termed as schizoid disorders or behaviours within the normal range of behaviour and were not to be confused with the psychiatric use of the term. They suggested that a more colloquial description of Psychoticism may 'tough mindedness' which in the context of the present study suggested that the assessors as a group were extremely tough minded. Similarly, assessors' levels of reported symptomatology, reflecting psychiatric morbidity, were also highly non predictive of applicants' success even though assessors registered clinical levels of symptomatology as did some applicants in Study 1 of the current chapter. This echoes the debate described in Chapter 2 on the necessity of some degree of psychopathology in psychotherapists as related to the capacity for creative work (Gitelson, 1948) as opposed to the need for normality so as to establish and maintain a profession (Sachs, 1946; Bird, 1968). Once again, it may be the manner in which psychological difficulties are managed by the individual that is more important than the level of disturbance per se.

Assessor's beliefs about the origins and solutions to their problems were also not predictive of the selection of applicants for training although were in keeping with the overall psychoanalytic ethos of the training organisation. Assessors' beliefs as a whole could be principally described as psychodynamic and humanistic and more specifically, heavily influenced by Freudian and British Object Relations schools of thought. Consciously reported theoretical allegiance did not appear to predict acceptance of applicants. Similarly, responses to the Good Therapist Questionnaire were equally consistent in confirming the views of the assessors that good therapists act in a manner consistent with psychodynamic and humanistic principles and not in line with cognitive, behavioural or other techniques.

As with the Good Therapist Questionnaire, the Indicators of Acceptance questionnaire has high face validity but is otherwise an exploratory measure. Nevertheless, results obtained from this questionnaire suggest, itself based upon

qualitative interviews, suggest that successful candidates were seen by assessors who more focussed upon the candidates' employment history and current situation than did those assessing candidates who were subsequently rejected. The results of the Interview Report Form were also consistent and slightly more detailed than those of the Indicators of Acceptance Questionnaire. It was clear that assessors routinely discussed the applicants' current functioning at work and used this material in considering their decisions. This was consistent with discussing the applicants' physical status and then to a lesser extent their unconscious internal experience as represented by dreams. Discussion of unusual experiences did not arise routinely but there is scope in the results to suggest that in cases in which these did occur, they were influential in assessors making their decision. The results of the Interview Report Form appear to be broadly consistent with that of the Indicators of Acceptance Questionnaire. Given that both these different exploratory measures provide broadly equivalent results would suggest that the results have added validity but that also assessors tend to discuss with applicants those areas of functioning that the assessors themselves consider important. The interview does not appear to be a free associative forum as a session of psychotherapy may appear to be, but more of a discussion concerning the applicant's functioning in key areas of his/her life. From this perspective, these results are highly consistent with the summarising statement of the Committee on Psychoanalytic Education (1959), which stated that;

"At present we question whether it is possible with any certainty to say more than the following: that a person who seems analyzable, says he wants to be analyst, and has accomplished in life enough so far to give promise that he can carry out what he intends to do or wants to be, should be acceptable".

Consequently, if the candidate has accomplished what he/she has stated that he wishes to accomplish and his current situation appears to allow him to proceed, then there should be no reason to reject the candidate. The results obtained in the current study are highly consistent with the above.

It was interesting to note further, that assessors rated the 'behaviour in interview' category in the Indicators of Acceptance Questionnaire more highly than any other category even though this particular rating did not distinguish between successful and unsuccessful candidates in this particular study. This would be consistent with the psychoanalytic orientation of the organisation and the assessors reported beliefs as indicated by the OPP and associated measures. Furthermore, it confirms the importance of the individual interview as the arena in which a decision about acceptance is principally made. However, that this feature did not distinguish between successful and unsuccessful applicants may suggest that selection does not depend on particular behaviours within the interview but more how the behaviour may be understood within the context of the interview.

The above is added to by considering the results of the product of assessors rating of the routine nature with which particular aspects of content arise together with their ranking of the importance of this material. This combined variable indicated that no area of content correlated with successful application. Furthermore, should the interview be dominated by discussion of the nature of psychotherapy, and being a therapist or patient, then this would mitigate against successful application. This latter interpretation also highlights the considerable variation in views between the assessor as indicated by the high standard deviation values obtained on most measures.

Once again however, the results need to be considered with significant caution. This was a very small sample of assessors expressing their views using some well established but also some exploratory measures. That two exploratory measures triangulated to provide very compatible results is heartening, but replications using the larger samples and repeated measures over time would be a pre-requisite for firmer conclusions.

In as much as the results of these studies can be interpreted with confidence, they do appear to indicate broad agreement within which there is also considerable variation. Overall, this study appears to have indicated two principal aspects.

Firstly, on the basis of the measures used in the study, which reflect Fiske's (1977) descriptive levels of variables, the group of assessors appear to be a highly homogenous group in terms of their overall beliefs and attitudes towards the theory and practice of psychotherapy. The majority of the measures used in this study were not able to distinguish between successful and unsuccessful candidates on the basis of assessor characteristics. Secondly, there are indications that assessors' views on the important factors in selection are in keeping with the conclusions of summarising statements of the current literature and are consistent with the importance of the individual interview as part of the selection process.

As with the results studying the applicants, these results occur in isolation from, but also point to, the importance of the selection interview as an interactive experience between applicant and assessor. Consequently, the pairing of applicant and assessor is the focus of Study 3.

Study 3. Does the Match Between Applicant and Assessor Predict Selection.

6.10 Introduction.

The results of both Studies 1 and 2 drew attention to the importance of the individual interview as the main forum at which selection occurred. Consequently, the notion of the fit between applicant and assessor becomes increasingly important.

The concept of the 'fit' or 'match' between patient and therapist has had a chequered history. Initially considered as highly promising, early notions of the matching of patient and therapist on the basis of symmetrical or asymmetrical variables were predominantly abandoned (Razin, 1977) possibly due to the lack of theoretical links and clinical relevance in the concepts as measured at the time. On the other hand, the matching of patient and therapist continued to occur on an individual basis and was clearly a phenomenon that could not be fully explained (Berzin, 1977).

More recently, the matching of patient and therapist has been described in greater refinement by Kantrowitz (1993; 2002) who reconceptualised it as a process variable rather than a more static and fixed quality. She suggested three types of fit; similarity, complementarity and a compensatory fit. Both similarity and complementary fits were viewed as potential obstacles to the therapeutic process. A compensatory match, potentially similar to both the notion of both symmetric and asymmetric fit of years before, was conceptualised as potentially benefiting the therapeutic relationship between patient and therapist. Dolinsky et al (1998) further stated that the concept of fit in psychotherapy may be rooted in the developmental perspective of the 'goodness of fit' between mother and child.

6.11 Aim.

The examination of any possible association between acceptance for training and the 'fit' between the characteristics of the assessor and the applicant.

6.12 Methodology.

6.12.1 Design.

This cross-sectional study used a group comparison design grouping success or failure in application against measures of the 'fit' between applicants to a psychotherapeutic training as matched with the assessor that interviewed them.

6.12.2 Sample.

The sample of applicants used was of a cohort of applicants to a well-known psychotherapy training organisation in London. The characteristics of the sample were as described previously in Section 6.2.2 of Study 1.

The sample of assessors used for this study was that described in Section 6.7.2 of Study 2. They were the same assessors who assessed the cohort described in Study 1. A complete description of the characteristics of the sample is presented Section 6.7.2 of Study 2.

6.12.3 Measures.

The matching of assessor and applicant was investigated across a number of measures. These were; personality traits as measured by the Eysenck Personality Scales (EPS; Eysenck & Eysenck, 1991), psychological mindedness as measured by the Psychological Mindedness Scale (PM; Conte et al, 1990; Conte et al, 1996; Conte and Ratto, 1997), beliefs about psychological problems and solutions as measured by the Opinions on Psychological Problems Questionnaire (OPP; Barker et al, 1983; Pistrang and Barker, 1992), and symptomatology as measured by the Symptom Checklist 90-R (SCL90-R; Derogatis et al, 1973; Derogatis, 1994). A complete descriptions of these measures was provided in Section 6.2.3 of Study 1.

The match between assessor and applicant was also examined on a number of demographic variables such as age and sex and other variables considered important such as total number of hours in therapy and mean hours per episode of therapy.

Furthermore, the Contents section of the modified version of the Therapy Session Report Form (Orlinsky and Howard, 1975; 1996) and called Interview Report Form (IRF), which was completed by the participant sample was matched against the ratings of these same items completed by the assessors. This allowed for an estimate of the degree of concordance in the topics discussed by the applicant and assessor to be made.

6.13 Results.

Age and Gender

The match between assessor and applicant was assessed by comparing the mean absolute difference in age between the assessor and applicant for successful and unsuccessful applicants. There was no significant difference between the two groups [$t = -1.85$, $df = 1$, ns]. The mean age difference for the group of successful applicants was 9.99 ($sd = 7.24$) whilst that for unsuccessful applicants was slightly higher at 12.93 ($sd = 8.03$).

The assessment of gender match was assessed through a 2 x 2 x 2 contingency table analysis and proved non-significant [Likelihood ratio $\chi^2 = .13$, $df = 2$, ns].

Social Economic Status and Education.

The assessment of match on the basis of social economic status was not possible given that all assessors were by definition in the same category. The examination of whether applicants' social economic status predicted acceptance for training, is also by definition, the examination of the applicant-assessor match. As stated in Study 1, a tendency to select applicants from the higher social classes was noted.

Limitations of sample size led to the recoding of applicant education into two groups, as either secondary only or graduate and above. Assessors' level of education was also recoded into two classes, up to graduate level and postgraduate level. The fit between the applicant and assessor was examined through analysis of a 2 x 2 x 2 contingency table and once again proved non significant [Likelihood ratio $\chi^2 = .08$, $df=2$, *ns*]. There was no significant association between the applicants' highest level of formal education, the assessors' highest level of formal education and acceptance for training.

Ethnicity.

A total of fifteen cases emerged in which applicant and assessor came from different ethnic backgrounds. However, a 2 x 2 x 2 contingency table and proved the match of ethnicity did not predict successful application [Likelihood ratio $\chi^2 = .18$, $df=1$, *ns*].

Previous Experience of Psychotherapy.

Applicant and assessor were matched on both the total number of hours each had spent in therapy and the mean number of hours per episode of psychotherapy. The match of previous experience of psychotherapy used was the number of hours of psychotherapy reported by each and the mean number of hours per episode of therapy for both applicant and assessor.

For each of the above statistics, the absolute difference was calculated and considered as a measure of similarity irrespective of direction of any difference. Additionally, the difference in hours between applicant and assessor, as a percentage of the total number of hours between them, was used as a measure of the compensatory match between them with respect to hours in psychotherapy.

When controlling for the significance with regard applicant number of hours in psychotherapy noted in Study 1, the results were not significant for either the

absolute and percentage difference in total hours of therapy or the absolute and percentage difference in mean hours per episode of therapy.

The results for the more important mean hours per episode of therapy were as follows. The mean absolute difference in average hours per episode of therapy between applicant and assessor for successful applicants was 520.91 (sd=269.62) whilst that for unsuccessful applicants was slightly larger at 592.37 (sd=260.43). This was not significant [$F=.40$, $df=1$, ns]. The percentage difference in mean hours per episode of therapy, i.e. potential compensatory match, was also not significant [$F=2.77$, $df=1$, ns]. Considering the percentage difference, in successful candidates, the difference accounted for 69% of the total whilst in unsuccessful candidates, the difference accounted for 80% of the total. In both cases assessors had had more therapy than applicants and whilst the difference was smaller for successful candidates, this did not appear to be a significant factor in selection.

Eysenck Personality Scales (EPS)

The approach to applicant-assessor match adopted with the scales of the EPS was to translate the difference between applicant and assessor scores into a further z-score, using a pooled standard deviation derived from the standard deviations for the respective reference populations to which assessor and applicant belonged. The results are shown in Table 6.23 and indicate that differences between applicant and assessor were not associated at all with success in application. The results indicated a wide range of scores and consequently the data was reanalysed using non-parametric statistics (Mann Whitney U test), which confirmed the results obtained.

**Table 6.23 The Match of Applicant and Assessor on the
Eysenck Personality Scales.**

Eysenck Personality Scales	Z-score of difference between Applicant and Assessor		
	Successful applicants	Unsuccessful applicants	Significance
Extraversion	.24 (1.44)	.74 (1.49)	$t_{(1,48)}=1.08$ ns
Psychoticism	-.52 (2.77)	.56 (2.61)	$t_{(1,48)}=1.22$ ns
Neuroticism	.08 (1.19)	.10 (1.05)	$t_{(1,48)}=.07$ ns
Lie°	.30 (1.21)	.50 (1.08)	$F_{(1,46)}=.53$ ns
Criminality	.10 (1.39)	.29 (1.24)	$t_{(1,48)}=.45$ ns
Addictiveness	-.08 (1.17)	-.27 (.87)	$t_{(1,48)}=-.57$ ns

Key: ° Controlled for Applicant Score.

It was noted that successful applicants appeared to have been interviewed by assessors who had a higher Psychoticism score, leading to a negative z-score, whilst unsuccessful applicants were interviewed by assessors who had a lower Psychoticism score, hence a negative z-score. Whilst the result itself was not significant, this was interesting to note given the very high levels of these scores for assessors as noted in Study 2.

Psychological Mindedness.

Both measures of absolute difference (similarity) and percentage difference (compensatory match) between assessor and applicant were not significant with regard psychological mindedness. The absolute difference for successful applicants was 13.13 (sd=10.6) and for unsuccessful applicants it was virtually identical at 13.12 (sd=9.91). The two groups were clearly not significantly different.

For successful candidates, the difference between assessor and applicant constituted 1.52% of the total psychological mindedness 'available' to the pair whilst for unsuccessful candidates it constituted 3.25%. This was also not significant [$F=1.10$, $df=1$, ns].

Cognitive Style

Difference in cognitive styles as measured by the OPP was assessed both in terms of both similarity and potential compensation but also in terms of the correlation between the two profiles of scores, thereby taking account that cognitive styles are inevitably overlapping to some degree. The results are presented in tabular form in Table 6.24.

The results indicated that only absolute similarity in Humanistic orientation towards a solution to the problem was associated with successful application 9 [$t=-2.34$, $df=1$, $p<.03$]. Interestingly, for successful candidates, the mean absolute difference was .78 ($sd=.51$) whilst for rejected candidates the mean similarity was .45 ($sd=.33$). A greater degree of similarity was therefore associated with unsuccessful application. All other results did not show a significant difference between successful and unsuccessful applicants.

The correlations between applicant and assessor for both orientations to problems and solutions were converted to z-scores using the Fisher transformation. For both problems and solutions, whilst the correlations were high and ranged from $r_{(50)}=.615$ to $r_{(50)}=.97$. However, there was no significant difference between successful and unsuccessful applicants on either the problem scales [$t= -.261$, $df=1$, ns], or the solution scales [$t= -.226$, $df=1$, ns].

Table 6.24 Applicant and Assessor Similarity and Compensatory Match on the scales of the Opinions About Psychological Problems Questionnaire

Opinions About Psychological Problems		Absolute Difference in Scores			Difference as Percentage of Total		
		Applicants Accepted for Training mean (sd)	Applicants Rejected for Training mean (sd)	Accepted vs Rejected (df= 1, 48)	Applicants Accepted for Training mean (sd)	Applicants Rejected for Training mean (sd)	Accepted vs Rejected; (df= 1, 48)
Origin of Problem Scales	Behavioural	1.42 (1.20)	.96 (.85)	$t = -1.3$ ns	-68.40 (324.56)	27.85 (92.48)	$t = 1.15$ ns
	Cognitive	1.14 (.79)	1.40 (.83)	$t = .98$ ns	44.29 (122.42)	23.72 (278.65)	$t = -.30$ ns
	Humanistic	1.37 (.85)	1.22 (.73)	$t = -.58$ ns	92.78 (273.98)	-101.87 (198.24)	$t = -1.3$ ns
	Naive	1.17 (.71)	.82 (.73)	$t = -1.5$ ns	29.78 (61.34)	-1.3 (5.14)	$t = -1.20$ ns
	Organic	.79 (.81)	.78 (.87)	$t = -.06$ ns	-2.43 (35.74)	2.34 (38.76)	$t = .40$ ns
	Psycho-dynamic	1.02 (.87)	.88 (.66)	$t = -.55$ ns	3.44 (1.65)	-11.32 (71.52)	$t = -.83$ ns
	Social	.99 (.65)	1.24 (.90)	$t = 1.02$ ns	-19.89 (32.62)	-36.26 (38.78)	$t = -1.4$ ns
Best Solution Scales	Behavioural	1.69 (1.17)	2.21 (1.12)	$t = 1.41$ ns	46.34 (584.58)	67.50 (388.03)	$t = .13$ ns
	Cognitive	1.17 (.66)	1.38 (.70)	$t = .91$ ns	125.99 (241.28)	60.40 (77.18)	$t = -1.04$ ns
	Humanistic	.79 (.51)	.45 (.33)	$t = -2.3$ $p < .03$	5.99 (24.42)	2.42 (12.63)	$t = -.54$ ns
	Naive	.81 (.72)	1.03 (.61)	$t = .97$ ns	24.23 (113.45)	-5.92 (59.16)	$t = -.97$ ns
	Organic	.76 (1.24)	1.01 (1.04)	$t = .66$ ns	28.52 (96.57)	-.46 (445.81)	$t = -.30$ ns
	Psycho-dynamic	1.14 (.94)	.79 (.69)	$t = -1.28$ ns	20.68 (100.19)	.45 (37.00)	$t = -.77$ ns
	Social	1.17 (.98)	1.46 (1.01)	$t = .88$ ns	3.64 (121.45)	-6.30 (2.50)	$t = -1.20$ ns

Psychiatric Morbidity: The Symptom Checklist 90-R.

Once again applicants and assessors scores on the scales of the SCL90 were matched for both similarity and complementarity. The results are presented in Table 6.25 and indicate that, both in terms of similarity and compensatory match in symptomatology, the match between applicant and assessor was not associated with successful application for training.

The scales for each applicant, excluding the three global indices, were then correlated against those of his/her assessor. The correlation was transformed to a z-score using the Fisher transformation and successful and unsuccessful applicants compared. The results indicated that the mean z-score for successful applicants was .30 (sd=.44) whilst that for unsuccessful applicants was .26 (sd=.47). This difference was not significant [$t=-.26$, $df=1$, *ns*].

The matching of applicant and assessor on the basis of self-reported symptomatology did not appear to be associated with successful application in any way.

Interview Report Form.

The match in the content of the interview was based on the concordance between applicant and assessor on the topics discussed. It was calculated by using the content section of the IRF and the assessor's rating of items in that section in terms of the routine nature of the item's emergence in any interview they conduct. The total score would provide an indication of the joint perception of applicant and assessor in terms of the content of the interview rather than the manner in which the interview was conducted or any particular aspect of their interaction. The results indicated that the mean match for successful applicants was 9.26 (sd=4.48) and for rejected applicants was 7.56 (sd=3.82). As indicated by the size of the standard deviations, the range of scores of match was considerable with the minimum being 2 and the maximum being 19. Nevertheless, the comparison between successful and unsuccessful applicants was not significant [$t= 1.23$, $df=1$, *ns*]. Simply because applicant and assessor know that they have talked about the same topics does not predict successful application.

**Table 6.25 Applicant and Assessor Similarity and Compensatory Match
on the Scales of the Symptom Checklist 90-R.**

Symptom Checklist 90 Scales	Absolute Difference in Scores			Difference as Percentage of Total		
	Applicants Accepted for Training mean (sd)	Applicants Rejected or Training mean (sd)	Accepted vs Rejected df= 1, 48)	Applicants Accepted for Training mean (sd)	Applicants Rejected for Training mean (sd)	Accepted vs Rejected; (df= 1, 48)
Somatization	9.57 (7.20)	9.25 (6.17)	$t=-.14$ ns	1.24 (11.26)	-4.50 (10.85)	$t=-1.59$ ns
Obsessive Compulsive	9.00 (9.04)	7.38 (6.40)	$t=-.62$ ns	2.47 (11.18)	-.48 (8.36)	$t=-.90$ ns
Interpersonal Sensitivity	9.47 (9.14)	8.06 (7.02)	$t=-.52$ ns	2.72 (10.93)	-.99 (9.05)	$t=-1.12$ ns
Depression	9.13 (7.41)	8.19 (5.97)	$t=-.42$ ns	.21 (10.68)	-.90 (8.43)	$t=-.35$ ns
Anxiety	9.60 (10.19)	10.43 (7.71)	$t=.28$ ns	2.36 (12.23)	-1.82 (11.52)	$t=-1.07$ ns
Hostility	10.78 (6.55)	10.75 (7.20)	$t=-.02$ ns	1.60 (11.52)	-1.7 (11.46)	$t=-.89$ ns
Phobic Anxiety	8.22 (7.49)	8.62 (7.90)	$t=.16$ ns	-1.00 (10.31)	-1.58 (11.06)	$t=-.16$ ns
Paranoid Ideation	9.96 (8.68)	9.94 (9.44)	$t=-.01$ ns	4.26 (11.46)	4.23 (12.06)	$t=-.01$ ns
Psychoticism	9.43 (9.73)	8.06 (8.97)	$t=-.45$ ns	.94 (11.49)	.69 (10.71)	$t=-.07$ ns
Global Severity Index	8.96 (9.08)	8.69 (7.67)	$t=-.10$ ns	1.77 (11.18)	-.39 (9.51)	$t=-.63$ ns
Positive Symptom Distress Index	9.52 (7.46)	7.56 (4.83)	$t=-.92$ ns	.95 (10.85)	-2.31 (7.48)	$t=-1.04$ ns
Positive Symptom Total	7.70 (6.72)	10.06 (7.44)	$t=1.03$ ns	3.50 (9.40)	2.11 (11.27)	$t=-.41$ ns

Prior Completion of a Course at the Training Organisation.

As had been stated in Study 1, the Training Organisation maintained within its culture the notion that completion of a course at the Training Organisation prior to the current application would aid the applicant's current application.

Whilst this cultural idea did not receive support from either applicant or assessor separately, it may have been that this idea was influential between the pair. Consequently, this was examined using a 2 x 2 x 2 contingency analysis. The results

were not significant [Likelihood ratio $\chi^2 = .50$, $df=2$, *ns*] thus once more disconfirming this idea held within the organisation.

6.14 Discussion.

The results obtained are clear in that successful application for training did not appear to be a function of the fit between age, gender, education, ethnicity, previous experience of psychotherapy as measured by the length of time in therapy, specific personality traits which may be considered as having a genetic loading, psychological mindedness, or self-reported symptomatology. From this perspective they are consistent with both the qualitative clinical and quantitative research data reviewed previously in Chapters 2 and 3.

The one significant result obtained was that in absolute difference in Humanistic orientation to the solution to problems. In this case, a greater difference existed between applicant and assessor for successful applicants than for unsuccessful applicants. This result is interesting in that it suggests that it is not the similarity between the two that is important but more the difference and hence the possibility for a process to occur between them. It may represent an instance of Kantrowitz's (1995; 2002) notion that unconscious similarity between patient and therapist may impede progress because the difference between them cannot function as a stimulus for thought and contemplation. The difficulty with such an interpretation however, lies in the fact that all the measures used were not conceptualised as measuring any aspect of functioning that was outside of awareness. Furthermore, very few of the measures had any link to developmental theories and therefore cannot be linked to Dolinsky et al's (1998) notion of "goodness of fit". Nevertheless, other results are supportive of the notion that it is a relational rather than purely static empirical quality that is important between applicant and assessor. The results from the correlation between applicant and assessor OPP problem and solution scales suggested that whilst there can be very high degrees of similarity, this in itself does not predict acceptance. This result was also consistent with that obtained for the content of the interview. The range in the results obtained for this suggested that

even when applicant and assessor were in good agreement with each other over the content of their discussion, this in itself was not associated with selection for training.

The idea that completing a course at the training organisation acts as an aid for selection has gained no support from the previous two studies and did not receive any support for the current study.

It is recognised that empirically translating Kantrowitz's (1995; 2002) notion of compensatory fit is not without its difficulties. The statistic was conceptualised so that the directional difference between applicant and assessor could be considered in relation to the total amount of the particular dimension present between them. This would be a measure of the significance of the difference as, for example, a small difference in psychological mindedness against a background of little psychological mindedness being available, has a significance greater than the sheer magnitude of the difference itself. It is fully recognised that this empirical translation does have its drawbacks. For example, in terms of hours in therapy the statistic implicitly accepts the notion that a greater number of hours of therapy are better than lower numbers, and assumes a linear progression of therapy so that the individual who has had more hours will be more developed and therefore in a position to compensate of his/her counterpart. Both these notions are worthy of substantial debate, which is somewhat out of the scope of this study. However, it would be important to note that this study would benefit from replication not only on the basis of small sample sizes but also in terms of the statistical approach to the clinical concept of compensatory match.

Overall, therefore, the results did not suggest that selection was significantly influenced by the match between applicant and assessor on the measures used. All measures produced insignificant results bar the humanistic solution scale of the OPP. The results could, however, be read as suggesting that the importance of the fit does not lie in a particular content but rather may take the form of a particular relationship.

CHAPTER 7. THE ROLE OF ATTACHMENT STATUS IN THE SELECTION FOR TRAINING.

7.0 Introduction.

The previous studies reported in Chapter 6 indicated that the traditional measures of psychological functioning such as measures of personality traits, were unassociated with successful application for training. The results indicated that assessors, applicants and the training organisation viewed the selection interview as the central forum from which a decision regarding acceptance for training emerged. However, it remained unclear whether selection was a function of the applicant, assessor, or the interaction between them. The results were in keeping with the previous literature on selection, which failed to identify 'objective' measures that could be used in assessment.

Developments in the methodologies linked to Attachment Theory, namely the development of the Adult Attachment Interview, have provided parallels in theory and in empirical measures to the issues concerning selection as described in Chapters 2 and 3. At the time of writing, no study could be located which addressed attachment organisation as a therapist variable linking it to selection for training let alone addressing the fit between applicant and assessor. The following study aimed to address this gap in the literature.

7.1 Aims.

This study aimed to examine the relationship between applicants' and assessors' attachment representational systems and whether these systems or aspects of these systems, either independently or interactively were significantly associated with selection for the advanced training in psychodynamic counselling.

7.2 Methodology.

7.2.1 Design.

This cross-sectional study used a mixed design to assess the role of applicants' and assessors' attachment functioning in relation to applicant success in selection for training. A group comparison design was used to assess the relationship of applicants' attachment to success or failure in application. A correlation design was used to assess the role of assessors' attachment status. Aspects of assessors' attachment functioning were correlated against the probability of being selected having been interviewed by the same assessor. A group comparison design was then used to compare success or failure in application against measures of the 'fit' in attachment terms between applicants and assessors.

7.2.2 Sample.

The sample of applicants was self-selected from a cohort of applicants to a well-known training organisation in London. The characteristics of the sample were as described previously in Section 6.2.2 of Chapter 6.

The sample of assessors used for this study was that described in Study 2 of Chapter 6 and were those assessors who assessed the sample described in Study 1 of Chapter 6. The demographic characteristics of the sample are described in detail in Section 6.7.2 of Chapter 6.

All subjects volunteered for the study and participated under conditions of informed consent and strict confidentiality.

7.2.3 Measures.

The Adult Attachment Interview (AAI).

The Adult Attachment Interview (Main & Goldwyn, 1985) is a semi-structured interview comprising 25 questions and requiring approximately one hour for completion although the precise length depends upon the length of responses. The interview asks subjects to talk about their childhood experiences and current view on their relationship with each parent at the time. They are asked to recount specific instances and their reactions and those of others when they felt upset, were ill, or were hurt in some way. They are asked about any losses they have had and their current view of the effect this may have had on their current life. Overall, the interview traces the subjects current view of early relationships, how these have developed and changed as they have grown, and the effect that certain incidents are considered to have had or not had. Responses are audio taped, transcribed and subsequently rated on two series of nine point scales assessing the adult's views of past attachment experiences, current state of mind, and current attachment experiences. Both a dichotomous and a tripartite classification can then be made of subjects' attachment status. The dichotomous classification distinguishes overall Secure status from Insecure status. The tripartite classification of Autonomous, Dismissing, Preoccupied have also been shown to have a significant association to the classifications of attachment status of infants (Fonagy et al, 1991). These overall classifications can also be subdivided into a further fifteen subgroups, thereby adopting a 'multi dimensional approach to the subjects' (Steele, 1991). The AAI has proved to have adequate inter-rater reliability and construct validity (Steele, 1991; van IJzendoorn, 1995) and was described in greater detail in Chapter 5³. A copy of the AAI Protocol is presented in Appendix 1.

³ The focus of the AAI is on the meaning of events and relationships rather than the nature of events and historical accuracy. It is for this reason that the rating of AAI interviews is a skill requiring considerable training. For the purposes of this study, the author completed the AAI training institute and subsequently completed the eighteen-month reliability exercise to become a reliable rater of the AAI.

Reflective Functioning (RF).

Reflective functioning was defined as the sum manifestation of the “psychological processes that underlie the capacity to mentalise (Fonagy, Steele, Steele, & Target, 1997). It was operationalised in a process similar to that of the scales of the AAI. Different manifestations of reflected functioning are rated in the response to questions of the AAI that are considered to specifically call for the use of the reflective function, e.g. why do you think your parents behaved towards you in the way they did when you were a child? All ratings occur on a scale ranging from -1 (an active resistance to adopting a reflective stance) to 9 (exceptional RF). An overall rating is then given on the basis of the previous ratings.

7.2.4 Procedure.

The procedure followed was identical to that described in Study 1 (Chapter 6). Both applicants and assessors were contacted by letter informing them of the study. To prevent the study interfering with the application process, applicants were initially informed of the study once they had formally applied to the training body but were only formally recruited to the study once they have completed the application process. Following the application process, all subjects completed the AAI. All subjects were volunteers and non were paid or induced in any way to participate in the study. All information was obtained under strict conditions of confidence and the training body were not provided with the data of any one individual subject.

7.3 Results.

The Attachment Status of Applicants.

On a 2-way classification of attachment status, applicants were distributed as 54% Insecure and 46% Secure. This compared with 42% insecure and 58% secure in the meta-analysis as reported by van IJzendoorn & Bakermans-Kranenburg (1996) and which is regarded as norm for research samples. The distribution of the current

sample did not appear to differ greatly from that reported by van IJzendoorn & Bakermans-Kranenburg (1996) and inspection of this Chi-sq analysis indicated a highly significant [$p < .001$] association between the two populations. This suggested that the sample population did not differ significantly, or corresponded to, the other reported 'normal' subject populations. Similarly, a 3-way classification of attachment indicated that the insecure group divided into applicants who were dismissing with respect to attachment behaviour (38% of the total sample) and those who were preoccupied with regard to attachment behaviour (16% of the total sample). This was once again compared with the distribution reported by van IJzendoorn & Bakermans-Kranenburg (1996) whose meta-analysis indicated a distribution comprising 24% dismissing, 18% preoccupied and 58% secure. Once again a highly significant [$p < .001$] association between the two population suggesting therefore that the sample population corresponded to the 'normal' population.

Analysis of the individual scales of the AAIs from the applicant group indicated that a small number of scales significantly correlated with group demographics. The Loving Father scale weakly but significantly correlated with age [$r = .32$, $df = 1$, $p < .02$], as did Idealisation Mother [$r = .36$, $df = 1$, $p < .01$]. The Neglecting Father scale inversely correlated with age and whilst the correlation was itself weak, the result was highly significant [$r = -.41$, $df = 1$, $p < .003$].

Two applicant AAI scales showed a significant association with gender. Male applicants tended to represent their mothers as less neglecting than female applicants [$t = -2.09$, $df = 1$, $p < .04$]. The mean for male applicants was 1.54 ($sd = 1.0$) whilst that for female applicants was 2.46 ($sd = 1.34$). Additionally, female applicants tended to idealise their fathers more than male applicants [$t = -2.55$, $df = 1$, $p < .01$], the mean score for female applicants being 3.59 ($sd = 1.14$) whilst that for male applicants being 2.40 ($sd = 1.10$).

Applicant representations of mother as neglecting were also seen to inversely correlate with the three category classification of education [$r = -.30$, $df = 1$,

$p < .04$] and a stronger but similar relationship with education was noted for the Neglecting Father scale [$r = -.34$, $df = 1$, $p < .02$].

All of the above significant correlations were therefore controlled for in subsequent analyses comparing successful and unsuccessful applicants on the separate scales of the AAI. The results indicated that only one scale was able to differentiate clearly between the two groups. The rating of Father Involving/Reversing scale for successful applicants was significantly lower [$p < .006$] than that for unsuccessful candidates. No other scale was able to differentiate between the two groups. The results for both Experience Scales and State of Mind Scales are shown in tabular form in Tables 7.1 and 7.2. These results also indicated that the range of scores on each scale was relatively high although a non-parametric analysis of the results using the Mann Whitney U test confirmed the results obtained. The only result to alter slightly was that for the Father Pressure to Achieve Scale which approached significance [$U = 218.5$, $p < .06$].

Table 7.1 The Relationship between Applicants' Experience Scales on the Adult Attachment Interview and Acceptance for Training.

Experience Scales of the Adult Attachment Interview		Whole Sample (sd)	Applicants Accepted for Training (sd)	Applicants Rejected for Training (sd)	Differences (Accepted vs Rejected; df= 1, 48)
Loving	Mother	3.85 (1.25)	3.95 (1.25)	3.71 (1.27)	$t = .65$ ns
	Father*	3.73 (1.19)	3.60 (1.18)	3.92 (1.21)	$F = .90$ ns
Rejecting	Mother	3.82 (1.42)	3.96 (1.51)	3.63 (1.31)	$t = .80$ ns
	Father	3.36 (1.46)	3.38 (1.58)	3.33 (1.32)	$t = .100$ ns
Involving/ Reversing	Mother	1.97 (1.38)	1.76 (1.24)	2.25 (1.53)	$t = -1.25$ ns
	Father	1.93 (1.47)	1.39 (.72)	2.68 (1.87)	$t = -2.99$ $p < .006$
Pressure to Achieve	Mother	1.70 (1.11)	1.69 (1.28)	1.17 (.84)	$t = -.07$ ns
	Father	2.08 (1.75)	1.78 (1.64)	2.49 (1.85)	$t = -1.45$ ns
Neglect	Mother °	2.26 (1.32)	2.12 (.234)	2.45 (.275)	$F = .86$ ns
	Father °	2.64 (1.47)	2.73 (.24)	2.52 (.29)	$F = .32$ ns
Idealising	Mother*	3.19 (1.35)	3.24 (1.24)	3.12 (1.53)	$F = .03$ ns
	Father °	3.33 (1.43)	3.15 (1.58)	3.56 (1.18)	$F = .85$ ns
Involving Anger	Mother	1.87 (1.19)	1.64 (.93)	2.19 (1.43)	$t = -1.63$ ns
	Father	1.75 (.94)	1.56 (.67)	2.01 (1.18)	$t = -1.67$ ns
Derogation	Mother	1.26 (.63)	1.17 (.54)	1.38 (.74)	$t = -1.54$ ns
	Father	1.27 (.73)	1.14 (.45)	1.44 (.99)	$t = -1.43$ ns

Key: * Controlled for Age ° Controlled for Sex ° Controlled for Education

Table 7.2 The Relationship between Applicants' State of Mind Scales on the Adult Attachment Interview and Acceptance for Training.

State of Mind Scales of the Adult Attachment Interview	Whole Sample (sd)	Applicants Accepted for Training (sd)	Applicants Rejected for Training (sd)	Differences (Accepted vs Rejected; df= 1, 48)
Overall Derogation	1.33 (.66)	1.18 (.41)	1.52 (.87)	$t = -1.81$ ns
Insistence of Lack of Recall	3.60 (1.39)	3.39 (1.22)	3.88 (1.58)	$t = -1.21$ ns
Metacognitive Processes	1.29 (.57)	1.36 (.65)	1.19 (.43)	$t = 1.05$ ns
Passivity of Thought Processes	3.46 (1.16)	3.39 (1.07)	3.54 (1.30)	$t = -.45$ ns
Fear of Loss	1.42 (.76)	1.45 (.78)	1.38 (.74)	$t = .33$ ns
Unresolved Loss	2.14 (1.32)	1.98 (1.22)	2.35 (1.46)	$t = .98$ ns
Unresolved Trauma	1.40 (.85)	1.41 (.97)	1.38 (.66)	$t = .12$ ns
Coherence of Transcript	4.51 (1.34)	4.67 (1.26)	4.28 (1.45)	$t = 1.00$ ns
Coherence of Mind	4.65 (1.37)	4.79 (1.31)	4.45 (1.46)	$t = .86$ ns

A discriminant analysis was therefore completed on the applicant AAI scales. This indicated that three scales of applicant AAIs were able to correctly predict the outcome of selection for 76% of applicants. In a three step discriminant analysis, the most predictive scale was that of Father Involving/reversing [Wilks lamda = .808, $F = 11.376$, $df = 1, 48$, $p < .001$]. The second step highlighted Insistence of Lack of Recall [Wilks lamda = .742, $F = 8.154$, $df = 1, 47$, $p < .001$] whilst a third step isolated Father Loving [Wilks lamda = .665, $F = 7.739$, $df = 1, 46$, $p < .0001$]. A fourth step failed to isolate any other scale. The results were then cross validated in which each case was classified by the functions derived from all cases other than that case. This resulted in correct prediction for 70% of the cases. The original and cross validated predicted distribution of cases and is shown in Table 7.3.

Table 7.3 Original and Predicted Outcome of Selection
Based on Discriminant Analysis.

		Predicted Group Membership		Total
		Rejected n (%)	Accepted n (%)	
Original	Rejected	15 (71.4)	6 (28.6)	21 (100)
	Accepted	6 (20.7)	23 (79.3)	29 (100)
Cross-validated	Rejected	14 (66.7)	7 (33.3)	21 (100)
	Accepted	8 (27.6)	21 (72.4)	29 (100)

Analysis of successful application by two and three way classification of attachment is shown in Tables 7.4 and 7.5. The results indicated that overall, two-way analysis of attachment did not predict acceptance for training [$\chi^2 = .911$, $df = 2$, ns] Limited sample size invalidated a 3 x 2 chi square analysis although the Kendall's tau-c statistic was not significant [$\tau_c = .126$, ns] suggesting that there was no significant trend between overall attachment status and selection for training.

Table 7.4 The Association between Two-way Classification of Attachment
and Acceptance for Training.

Attachment Classification	WPF Accept/reject n (%)		Total
	Accepted	Rejected	
Secure	15 (65.2)	8 (34.8)	23 (100)
Insecure	14 (51.8)	13 (48.2)	27 (100)
Total	29 (59.2)	21 (40.8)	50 (100)

$$\chi^2 = .911, ns$$

Table 7.5 The Association between Three-way Classification of Attachment and Acceptance for Training.

Attachment Classification	WPF Accept/reject n (%)		Total
	Accepted	Rejected	
Secure	15 (65.2)	8 (34.8)	23 (100)
Dismissing	10 (52.6%)	9 (47.4%)	19 (100)
Preoccupied	4 (50)	4 (50)	8 (100)
Total	29 (59.2)	21 (40.8)	50 (100)

Kendall's tau-c $\tau_c = .126$, *ns*

Reflective Self Functioning (RF).

Applicants' level of RF did not correlate with any demographic variable. The mean level of Reflective Self Functioning for successful applicants was 3.77 (sd=1.24) whilst that for unsuccessful applicants was 3.4 (sd=1.35). Whilst that for successful applicants may be slightly higher, this difference was not significant ($t_{(1,49)} = -.97$, *ns*).

The Attachment Status of Assessors.

The two-way distribution of assessors indicated that 70.6% of assessors were classified as secure with respect to attachment and 29.4% classified as insecure. On a three-way distribution, this insecure group divided into a dismissing group representing 11.8% of the total sample of assessors and an equivalent preoccupied group, also representing 11.8% of the sample. One assessor was coded in the "cannot classify" category and represented 5.9% of the sample. This distribution

was compared to the figures produced by van IJzendoorn & Bakermans-Kranenburg's (1996) meta-analysis and a high degree of association found [$p < .001$]. Consequently, the assessor group could be considered as 'normal'.

For the assessors, no scale of the AAI correlated significantly with any demographic variable. Mean ratings on each scale of the AAI were then correlated against the probability of acceptance for each assessor. This controlled for the fact that different assessors interviewed and accepted different numbers of applicants.

The results indicated that two assessor AAI scale ratings were significantly correlated with the acceptance of a candidate for training. Assessors' mean rating on Pressure to Achieve Mother was moderately negatively and significantly correlated with selection [$r = -.50$, $p < .04$]. This implied that assessors who represented their own mothers as tending to not pressure them to achieve were more likely to accept candidates than assessors who represented their mothers as more actively pressuring them to achieve. Additionally, the idealisation of fathers was moderately, positively, and significantly correlated with selection [$r = .61$, $p < .01$]. This result suggested that the more highly an assessor idealised his/her father, the more likely was the candidate to be accepted.

All the results are shown in tabular form in Tables 7.6 and 7.7.

Table 7.6 The Relationship between Assessors' Scores on the Experience Scales of the Adult Attachment Interview and Assessors' Acceptance of Applicants for Training.

Experience Scales Adult Attachment Interview		Mean Score (sd)	Pearson Correlation with Assessor's Recommendation for Acceptance	Significance
Loving	Mother	4.18 (1.01)	.04	ns
	Father	4.24 (1.20)	.25	ns
Rejecting	Mother	3.11 (1.36)	.17	ns
	Father	2.44 (.86)	-.13	ns
Involving	Mother	2.09 (1.17)	-.22	ns
	Father	1.26 (.56)	-.01	ns
Pressure to Achieve	Mother	1.18 (.52)	-.50	<i>p</i> < .039
	Father	1.47 (.94)	-.08	ns
Neglect	Mother	1.12 (.33)	-.43	ns
	Father	1.53 (.87)	-.34	ns
Idealisation	Mother	2.50 (1.62)	.31	ns
	Father	2.24 (1.03)	.61	<i>p</i> < .01
Involving Anger	Mother	1.35 (.60)	-.12	ns
	Father	1.18 (.52)	-.21	ns
Derogation	Mother	1.18 (.72)	-.43	ns
	Father	1.06 (.24)	-.43	ns

**Table 7.7 The Relationship between Assessors' Scores on the State of Mind
Scales of the Adult Attachment Interview and Assessors'
Acceptance of Applicants for Training.**

State of Mind Scales of the Adult Attachment Interview	Mean Score (sd)	Pearson Correlation with Assessor's Recommendation for Acceptance	Significance
Overall Derogation	1.18 (.72)	-.43	ns
Insistence of Lack of Recall	3.26 (1.37)	-.05	ns
Metacognitive Processes	2.03 (1.20)	-.04	ns
Passivity of Thought Processes	2.74 (1.3)	-.29	ns
Fear of Loss	1.06 (.24)	.34	ns
Unresolved Loss	1.53 (1.12)	-.20	ns
Unresolved Trauma	1.18 (.52)	-.24	ns
Coherence of Transcript	5.26 (1.14)	.28	ns
Coherence of Mind	5.56 (1.22)	.28	ns

The results raised the possibility that assessors' scores on Mother Pressure to Achieve and Father idealisation acted as suppressor variables with respect to applicants' scores on these same scales. An analysis of covariance was therefore completed on applicant ratings whilst controlling for assessor scores. The results confirmed the previous results that the degree to which applicants' represented their own mothers as pressuring or idealised their fathers were not associated with selection. For applicant Mother Pressure to Achieve the result when controlling for assessors rating was not significant [$F= 0.18$, $df=1$, *ns*] and the same result was obtained for applicant Father Idealisation [$F= 1.29$, $df=1$, *ns*].

Reflective Self Functioning

Assessors RSF scores were noted to inversely correlate with education [$r = -.72$, $p < .001$] and indicated a difference between the genders. The mean rating for women was 5.13 ($sd = .60$) whilst that for men was 4.33 ($sd = .67$). This difference was significant [$t = -2.43$, $df = 1$, $p < .03$]. Controlling for these two variables, assessor RSF did not correlate significantly with the probability of being selected by one particular assessor.

The Fit Between Applicants and Assessors.

The fit between applicant and assessor was examined from three different perspectives. Firstly in terms of the absolute difference between applicant and assessor as a measure of similarity and the directional difference as a percentage of the conjoint value of the variable as a measure of the compensatory fit. Secondly, the correlation between rating profiles as a measure of parallel functioning, and thirdly interaction between overall classifications of attachment.

(i) Similarity and Compensatory Fit.

The concept of similarity was conceptualised as the absolute difference between applicant and assessor. The concept of compensatory fit was conceptualised as the percentage difference between applicant and assessor. The results are presented in tabular form in Tables 7.8 and 7.9. They indicate that the absolute difference between applicant and assessor in two scales of the AAI was significant. The difference between applicant and assessor in the representation of Father Involving/Reversing was significantly smaller with successful applicants than with unsuccessful applicants [$p < .002$]. This also appeared to be the case in the measure of compensatory fit between assessor and applicant with regard Father Involving [$p < .05$]. However, Father Involving was a scale of the AAI which predicted applicant success irrespective of rating of the assessor on this scale. Consequently, applicants' Father Involving rating was introduced as a covariate to control for its

previous significance. The effect of this was to remove the significance of the absolute difference [$F = .41$, $df=1$, *ns*] and that of the percentage difference [$F = 1.31$, $df=1$, *ns*].

The absolute difference in Mother Pressure to Achieve was also noted to be significant [$p < .003$]. The difference between applicant and assessor was much smaller for successful applicants than it was for unsuccessful applicants. Mother pressure to achieve had also been noted as a variable predictive of acceptance in the assessor. Consequently, this was also controlled for but did not remove the significance of the current finding [$F = 9.28$, $df=1$, $p < .004$]. Controlling for assessors' Mother pressure to achieve score did not alter the non-significant finding for complementarity.

Assessors' scores on Father Idealisation were also noted to have been significantly associated with applicants' acceptance for training. Controlling for assessors Father Idealisation did not make any change to the results for similarity [$F = .276$, $df=1$, *ns*] or compensatory fit [$F = .713$, $df=1$, *ns*].

**Table 7.8 Measures of the Fit between Applicants and Assessors on the
Experience Scales of the Adult Attachment Interview.**

Experience Scales of the Adult Attachment Interview		Similarity (Absolute Difference in Scores)			Compensatory Fit (Difference as Percentage of Total)		
		Applicants Accepted for Training (sd)	Applicants Rejected for Training (sd)	Accepted vs Rejected; df= 1, 48)	Applicants Accepted for Training (sd)	Applicants Rejected for Training (sd)	Accepted vs Rejected; df= 1, 48)
Loving	Mother	1.38 (.93)	1.16 (.96)	$F = .69$ ns	-2.73 (21.14)	-9.23 (19.5)	$F = 1.23$ ns
	Father	1.35 (1.01)	1.27 (1.06)	$F = .06$ ns	-5.14 (22.37)	-4.79 (25.64)	$F = .003$ ns
Rejecting	Mother	1.48 (1.30)	1.49 (.93)	$F = .01$ ns	10.73 (28.64)	13.70 (21.72)	$F = .15$ ns
	Father	1.70 (1.24)	1.04 (1.13)	$F = 3.66$ $p < .06$	15.32 (30.22)	10.74 (24.29)	$F = .33$ ns
Involving/ Reversing	Mother	1.08 (1.12)	1.17 (1.04)	$F = .10$ ns	-8.22 (30.08)	3.8 (31.82)	$F = 1.86$ ns
	Father	.49 (.72)	1.68 (1.76)	$F = 10.75$ $p < .002$	4.08 (21.91)	20.97 (37.24)	$F = 4.05$ $p < .05$
Pressure to Achieve	Mother	.60 (.77)	1.73 (1.70)	$F = 9.91$ $p < .003$	11.85 (27.15)	14.10 (31.74)	$F = .07$ ns
	Father	1.32 (1.55)	1.32 (1.48)	$F = 0.00$ ns	-2.85 (67.75)	15.82 (31.58)	$F = 1.37$ ns
Neglect	Mother	1.15 (1.32)	1.39 (1.08)	$F = .438$ ns	22.99 (28.66)	31.68 (20.93)	$F = 1.39$ ns
	Father	1.77 (1.25)	1.44 (1.13)	$F = 1.02$ ns	18.03 (38.03)	20.16 (30.25)	$F = .05$ ns
Idealising	Mother	1.92 (1.38)	1.60 (1.24)	$F = .656$ ns	14.65 (36.46)	13.14 (34.69)	$F = .02$ ns
	Father	1.43 (1.42)	1.71 (1.12)	$F = .581$ ns	13.45 (31.32)	26.54 (25.77)	$F = 2.46$ ns
Involving Anger	Mother	.59 (.71)	1.09 (1.37)	$F = 2.70$ ns	11.25 (21.69)	17.55 (29.52)	$F = .76$ ns
	Father	.60 (.65)	1.03 (1.13)	$F = 2.93$ ns	14.80 (20.19)	19.59 (28.33)	$F = .49$ ns
Derogation	Mother	.24 (.67)	.69 (1.05)	$F = 3.39$ ns	.98 (16.03)	4.72 (28.69)	$F = .35$ ns
	Father	.22 (.46)	.46 (.81)	$F = 1.67$ ns	3.33 (14.97)	8.15 (19.84)	$F = .96$ ns

**Table 7.9 The Match between Applicants and Assessors on the State of Mind
Scales of the Adult Attachment Interview.**

State of Mind Scales of the Adult Attachment Interview	Similarity (Absolute Difference in Scores)			Compensatory Fit (Difference as Percentage of Total)		
	Applicants Accepted for Training (sd)	Applicants Rejected for Training (sd)	Accepted vs Rejected; df= 1, 48	Applicants Accepted for Training (sd)	Applicants Rejected for Training (sd)	Accepted vs Rejected; df= 1, 48
Overall Derogation	.29 (.64)	.54 (.86)	$F = 1.45$ ns	3.47 (17.08)	8.52 (24.03)	$F = .76$ ns
Insistence of Lack of Recall	1.65 (1.43)	1.79 (1.27)	$F = .13$ ns	1.57 (26.4)	7.79 (27.00)	$F = .66$ ns
Metacognitive Processes	.89 (.88)	1.05 (1.04)	$F = .31$ ns	-15.63 (25.98)	18.04 (28.64)	$F = .10$ ns
Passivity of Thought Processes	1.37 (1.15)	1.81 (1.41)	$F = 1.51$ ns	12.22 (24.52)	11.26 (30.75)	$F = .02$ ns
Fear of Loss	.45 (.72)	.30 (.64)	$F = .51$ ns	9.47 (20.29)	8.36 (17.07)	$F = .04$ ns
Unresolved Loss	.83 (.96)	1.58 (1.39)	$F = 4.91$ $p < .03$	9.98 (23.67)	15.89 (39.03)	$F = .44$ ns
Unresolved Trauma	.59 (.96)	.60 (.80)	$F = .001$ ns	8.96 (24.03)	6.73 (26.03)	$F = .10$ ns
Coherence of Transcript	1.52 (.97)	1.14 (1.23)	$F = 1.55$ ns	-5.23 (18.57)	-9.68 (16.85)	$F = .75$ ns
Coherence of Mind	1.33 (1.12)	1.20 (1.31)	$F = .13$ ns	-7.29 (16.59)	-10.00 (17.04)	$F = .32$ ns

Reflective Functioning.

The absolute difference in RF for successful applicants was 1.38 (sd=.96) whilst that for unsuccessful applicants was 1.15 (sd=.98). This was not a significant difference [$F = .691$, df=1, ns].

The percentage difference for successful applicants was - 13.7 (sd=24.9) whilst that for unsuccessful applicants was -1 9.73 (sd=20). This was also non-significant [$F = .728$, df=1, ns].

(ii) Applicant and Assessor Correlation of Experience and State of Mind Scales.

The profile of scores on both Experience and State of Mind scales of the AAI for each applicant were correlated against those of the relevant assessor. The correlation was then transformed to a z-score using the Fisher transformation.

The results indicated that Pearson correlations with regard the Experience scales ranged from the minimum of $r = .26$ to the maximum of $r = .95$. Those for the State of Mind Scales ranged from $r = -.19$ to $r = .96$. The distribution of correlations for both Experience and State of Mind scales are shown in Figures 7.1 and 7.2. For the Experience scales, 30% of cases had a correlation greater than $r = .70$ whilst for State of Mind Scales this figure was 16%. However, comparison of accepted and rejected applicants indicated that high correlations, transformed to z-scores, do not in fact predict an applicants' acceptance to training. With regard the Experience scales, the mean z-score for accepted applicants was .46, (sd=.46) whilst that for rejected applicants was .54 (sd=.51). This difference was not significant [$t = -.65$, $df=1$, *ns*] and confirmed by use of the Mann Whitney U test [$U=271$, *ns*]. With regard the State of Mind scales, the mean z-score for accepted applicants was .78, (sd=.51) whilst that for rejected applicants was .61 (sd=.49). This difference was once again not significant [$t = 1.24$, $df=1$, *ns*] and confirmed by use of the Mann Whitney U test [$U=253$, *ns*].

**Figure 7.1 Distribution of Correlations of Applicant
And Assessor AAI Experience Scales.**

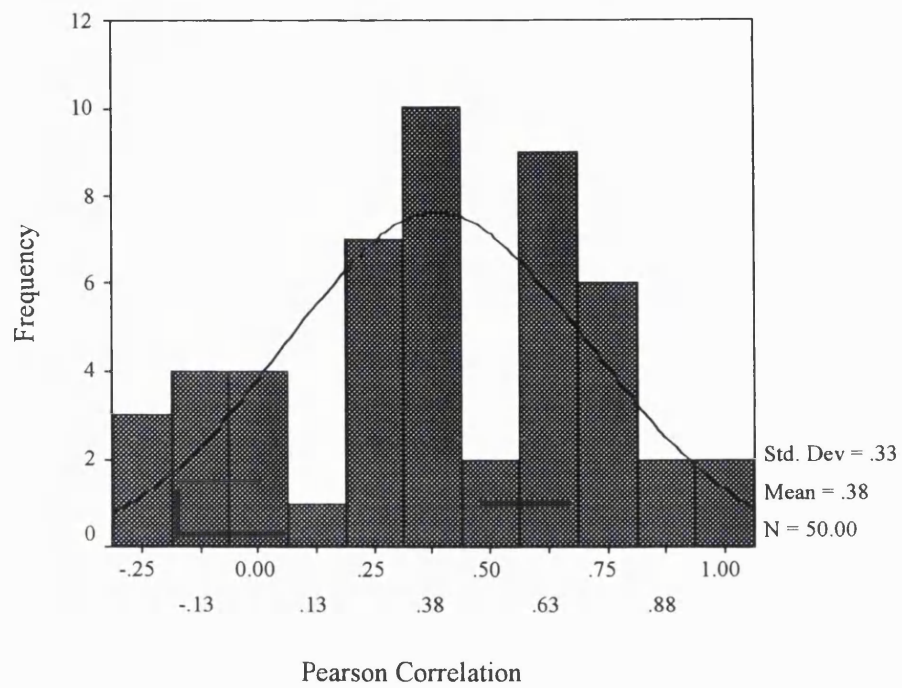
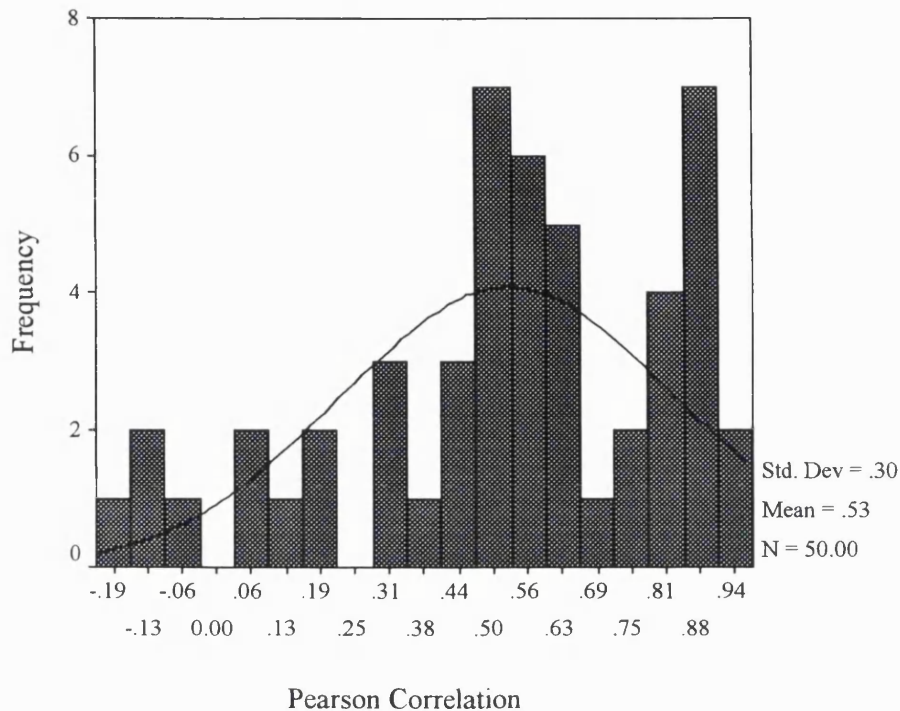


**Figure 7.2 Distribution of Correlations of Applicant
And Assessor AAI State of Mind Scales.**



(iii) The Interaction between Applicant and Assessor Attachment Categories.

Limitations of sample size implied that the only comparison possible was that using a dichotomous classification of attachment status. Consequently analysis of a 2x2x2 contingency table was performed to assess whether there was a significant interaction between assessor and applicant attachment status and acceptance for training. The result was significant [Likelihood ratio $\chi^2 = 4.79$, $df=2$, $p < .03$]. The results are presented in tabular form in Tables 7.10 and 7.11 and indicate the insecure assessors rejected 83% of insecure applicants whilst only 43% of insecure applicants were rejected by secure assessors.

**Table 7.10 The Interaction between Applicant and Assessor
Attachment Categories for Secure Assessors.**

Applicant Attachment Status	Outcome of Application (%)		
	Accepted	Rejected	Totals
Insecure	9 (56.25)	7 (43.75)	16 (100)
Secure	8 (57.14)	6 (42.76)	14 (100)

**Table 7.11 The Interaction between Applicant and Assessor
Attachment Categories for Insecure Assessors.**

Applicant Attachment Status	Outcome of Application (%)		
	Accepted	Rejected	Totals
Insecure	1 (16.67)	5 (83.33)	6 (100)
Secure	6 (75)	2 (25)	8 (100)

7.4 Discussion.

This study explored, in turn, applicant attachment status, assessor attachment status and the interaction between them for associations to selection for training. The results produced a number of interesting findings. Firstly, for both two-way and three-way classification of attachment, both applicants and assessors could be described as arising from normal populations. The distributions of each group was essentially normal when compared to published norms such as that of van IJzendoorn & Bakermans-Kranenburg (1996).

Furthermore, some recognisable and stereotypic results were found such as gender differences involving women having a more idealised representation of their father than men, and men having a representation of their own mothers which was less neglecting than that of women. Furthermore, that RF did inversely correlate with education would substantiate aspects of its definition as arising from the relationship with important caregivers rather than a quality that can be actively 'learnt'. It was also interesting to note that whilst some of the correlations of demographic variables with AAI scales were significant for the applicant sample, this was not the case for the assessors. It would appear that for assessors, possibly linked to greater experience, the attachment representational system operates beyond the influence of external demographic factors.

The results indicated that a categorical measure of attachment of applicants alone did not predict selection. Simply because an applicant had an overall classification of secure did not mean that he/she had a greater probability of successful application. Furthermore, only one scale of the applicants' AAI clearly distinguished between successful and unsuccessful applicants. Unsuccessful applicants had a representation of their father that was significantly more involving and reversing than successful candidates. No state of mind scale, nor level of RF, was able to distinguish between successful and unsuccessful applicants. Whilst no previous study could be found that looked at attachment status and functioning in relation to selection for training, the literature that is available would suggest that greater security would be favoured. It would be correct however to note that all the State of Mind scores bar Fear of Loss, differed in the direction expected were security to be the desired nature of functioning for psychotherapists.

The result may of course be explained by the small sample size or possibly because the training offered is a counselling training as compared with a more rigorous psychotherapy training. However, as shown in Study 2, assessors were very 'tough minded' and their orientation scores did not favour Rogerian principles.

The most important scale by virtue of discriminant analysis was that of Father Involving/reversing followed by Lack of Memory followed by Father Loving. This may of course be indicative of some disruption in the early relationship with father in a mainly female population. The rupture cannot be recalled but is belied by an underlying positive representation of father. Motivation for training may therefore lie in a reparative wish although the current data cannot truly be extended to support or retract this idea. Certainly however the results of the discriminant analysis would support the notion of the “wounded healer” although it would be important to distinguish this from unresolved trauma. Furthermore, that Father Involving/Reversing was the only scale that showed clear significance when considering the applicants alone, may indicate an emphasis in the selection process of selecting against factors that would be detrimental to a therapeutic relationship (Ackerman and Hilsenroth, 2001) rather than selecting for more positively connoted features.

It was also interesting to note that Father Involving/reversing did not predict selection from the perspective of the assessor. Two scales of the assessors’ AAI were significantly correlated with selection. Mother Pressure to Achieve negatively correlated, and Father Idealisation positively correlated with selection. Consequently the less the assessor has representation of mother as pressuring and father as ideal, the more likely the candidate will be accepted. Once more however, state of mind scales were not predictive although once more again, all the correlations were in the direction that would be expected if security was selected for. This was true of all the scales apart from Meta-cognitive processes in which there was a very weak inverse relationship. This may of course be explained by chance but may also reflect on some active work of the assessors to not read too much into the applicant.

The fit between applicant and assessor proved to be the most interesting and may indicate that there were different aspects to the ‘like me’ experience described by selectors (Bird, 1968). Whilst there are some aspects of the attachment system that were significant but unrelated to the interaction between applicant and assessor,

e.g., Father Involving/reversing, others were central to the fit. Even controlling for the assessor's contribution, the similarity between applicant and assessor in Mother Pressure to Achieve was significantly associated with selection. The direction of the difference, whether applicant or assessor represented his/her mother as more or less pressurising, was not related to significance. It is the absolute similarity that is important and therefore reflects the 'Like me' experience. The similarity in Father Rejection also approaches significance and would suggest that accepted candidates had a representation of Fathers-rejecting that was closer to that of the assessor than did unsuccessful candidates. Most significant were the scores for unresolved loss which indicated that smaller differences in the absolute quantum of unresolved loss were associated with selection.

Furthermore, it would be important to note that parallel functioning, as symbolised by high correlation scores between profiles, was also not associated with selection. Remarkably, the results suggested that applicant and assessor could be in perfect harmony, with a high correlation between the scales, but if the actual quantum measures on the scales were not identical, similarity in terms of the profile of scores, would not be a sufficient criteria for selection.

This is once again shown to be the case by the significant statistical interaction effect indicated in the analysis of the by 2x2x2 contingency table of applicant and assessor. Specifically, if both applicant and assessor are classified as insecure, the probability of the applicant being accepted for training was significantly reduced. From the perspective of joint goal-directed behaviour, the insecure-insecure pair may not create sufficient flexibility within the relationship between them to arrive at the joint a consensus that the applicant be accepted for training. For each, the defensive distortions in their respective IWMs are such that they cannot establish sufficient common ground.

Overall therefore, the 'like me' experience does appear to function within the selection interview although it does so in both directions. Absolute similarity on some scales/aspects of the attachment system would appear to enhance the chances

of selection. However, similarity in the sense that of the relative standing of different attachment representations within the individuals IWM, as empirically represented by correlations of the profiles of AAI scales, did not lead to a greater chance of acceptance. Furthermore, from the perspective of overall categories of attachment, the match of insecure assessor and applicant mitigates against acceptance. This particular 'like me' operates in the opposite direction to that described by Bird (1968), but would be in keeping with the types of relationships described by Fisher and Crandell (2000).

It was also interesting to note that the compensatory fit did not seem to be important to selection. This may reflect an aspect of the interview in which it is not considered as a session of psychotherapy, and the "tough minded" assessor leaves the applicant to present him/herself as best they could.

Consequently, the previously qualitative description of 'Like me' (Bird 1968) has received some empirical backing through the results of this study, although can also be viewed as operating against the applicant. It would be important however to note that the sample size for the study was small and replication with a number of cohorts would be required before the results could be given any more weight. Furthermore, whilst the study may suggest that aspects of an individual's attachment representational system plays an important part in their initial selection, the study cannot in any way state that these same attributes were particularly enhancing to progression in training.

CHAPTER 8. THE RELATIONSHIP BETWEEN ATTACHMENT STATUS AND SUCCESS IN TRAINING.

8.0 Introduction.

Studies relating to the training of mental health professionals whether they be psychologists, psychiatrists or psychotherapists, have tended to assess the relevance or quality of training by assessing competence in comparison to lesser trained or untrained workers (Alberts & Edelstein, 1990). This is usually done on the basis of outcome ratings on patients treated by either qualified and experienced or unqualified and inexperienced therapists. The results have been mixed. Ford (1979) conducted a comprehensive review of therapist training studies and concluded pessimistically that the therapist training literature revealed that there was little evidence that training interventions improved trainee's skill levels sufficiently to guarantee that they could deliver therapy effectively. Albert and Edelstein (1990) suggested that Ford was forced into his conclusion because of the limited conceptual complexity in the definition of competence and suggested that a higher degree of definition and measurement was needed before such a conclusion could be reached. Stein and Lambert (1995) subsequently conducted a meta-analysis of therapy outcome studies involving within-study comparison of psychotherapists of different levels of training and experience. They concluded that, based on a variety of outcome measures such as patient rating scales and 'harder' psychometric test results, moderate effect sizes were obtained favouring the more trained therapists. These therapists also tended to suffer fewer patient dropouts than their less experienced counterparts. This result was also in keeping with Consumer Reports (1995), which as Seligman (1995) noted, was based on a huge naturalistic sample and indicated that the outcome for psychotherapy was better with specialist therapists and longer term treatment.

The approach taken in this study was a natural extension of the studies on selection. The previous studies indicated that self-report measures were not particularly useful in assessing candidate performance. On the other hand, they provided some

empirical backing to the qualitative descriptions of the 'like me' experience noted by selectors with regard applicants (1968). Using the AAI the results indicated that absolute similarity on some scales was associated with acceptance but that a paralleling of functioning in terms of the correlations between profiles of scores did not predict acceptance. Most important appeared to be the interaction between applicant and assessor. When each was insecurely classified, the possibility of acceptance was significantly reduced. Overall, and in the context of the results being statistically non significant, one reading of the results suggested that there were a number of indicators leaning towards the selection of applicants securely organised with regard to attachment rather than those insecurely organised. Whilst this was not a statistically significant finding, such an interpretation of the results would concur with the limited literature available indicating that attachment organisation has an important role to play in professional working life e.g., Dozier et al (1994). Consequently, the question arises of whether overall attachment security or some aspects of attachment organisation lead to greater or lesser success in training as they did in selection.

8.1 Methodology.

8.1.1 Design.

This was a cross-sectional study using a mixed design. Group comparison was used to examine the relationship between attachment status and supervisor ratings of the trainee. A correlation design using factor analysis was then used to examine the relationship between the component scales of the measure of attachment and the ratings of trainees made by supervisors.

8.1.2 Sample.

A total of forty psychologists completing the postgraduate training in Clinical Psychology at a London University were recruited for the study. This represented 46% of the total possible available sample.

The sample comprised eight men and thirty-two women with an overall mean age of mean age of 26.77 years ($sd = 4.6$). The mean age of the women was 26.25 years ($sd = 4.7$) whilst that of the men was slightly higher at 28.87 ($sd = 4.0$).

Graduate status was a minimum requirement of entrance to training although some trainees had higher qualifications. Thirty-three trainees (85%) had completed a first-degree prior to clinical the training. A further three (7.5%) had completed a master's degree whilst four (10%) had completed a doctoral degree prior to training.

A total of twenty trainees (50%) had also had over one years relevant experience prior to training, e.g. such as being employed as a psychology graduate, whilst a further 12 (30%) had had only one year of experience prior to beginning training. Four trainees (10%) had had significant amount of experience in terms of having other professions prior to clinical training whilst the remaining four (10%) trainees had had either only ad hoc experience or no experience at all.

Unfortunately the small sample size in the study precluded assessment of ethnicity in any other way than by a white/non-white distinction. Even so, all subjects were white thereby effectively ruling out consideration of ethnicity as a variable.

8.1.3 Measures.

Supervisor Evaluation Ratings on Trainee Clinical Psychologists.

Each trainee undertaking a training in clinical psychology was required to complete a number of mandatory placements and could then complete placements which matched the trainee's particular interest. Mandatory placements comprised Adult Mental Health, Child & Family, and Learning Difficulties. At the end of each placement, supervisors completed an evaluation booklet in which the trainee was rated, using a three point scoring scheme, on a number of scales. These scales and

a description of each is provided in Table 8.1. The original scoring system ranged from '0' (Lacking the desired capacity and needing significant additional assistance) to '2' (Functions at least as described in the scale). The mid-score of '1' represented adequacy and the occasional need for assistance. The form then provided additional space for supervisors to place their comments.

Overall Ratings of Trainees

Overall ratings of trainees were also made using four other scales conceived through using all information available on trainees. These overall scales were devised to reflect the broad different aspects of training and were therefore named accordingly. The scales were Clinical Skills, Academic Skills, Professional Behaviour and an Overall Rating. Each trainee was rated on a 5 point rating scale as described below;

- 5: Excellent in all respects, "sails through"
- 4: Very good: less than 10% of comments negative with only one or two non serious criticisms
- 3: Satisfactory; a spread of mild criticisms was noted.
- 2: Some significant problems; one or two significant problems in one or two placements noted but these were not consistent.
- 1: Consistent significant problems; a compassionate pass.

Table 8.1 Assessment Scales on Trainee Clinical Psychologists.

Scale	Description of Scale
Assessment Skills	Is able to choose the most appropriate formal psychometric test for a client bearing in mind the ethnic, social and other relevant issues, select a method for gathering data, record and summarise it accurately. Or needs more practice and/or help because he/she lacks basic knowledge about the tests to use, the principles of psychometric methods, or is unwilling to learn.
Interview Skills	Is able to establish a therapeutic atmosphere, ask the appropriate range of questions, understand the significance of the client's communications and respond appropriately. Or needs more help/practice e.g. because cannot establish good rapport, is too tense, or uses overly structured or overly loose approach, or is not mindful of different client's needs.
Knowledge of Treatment Methods	Shows sound knowledge of major techniques of therapy. Is aware of theoretical shortcomings or difficulties. Has appropriate knowledge of empirical base for treatment. Or needs more help because e.g. sometimes seems unaware of more than one approach, or how to proceed, or has very little theoretical knowledge and is very 'technique bound'.
Capacity for Formulation	Is able to evaluate the results of interviews or assessment within a sound theoretical, social and cultural framework. Can formulate goals for further assessment or intervention. Or needs more practice or help because is sometimes rather 'woolly', over-inclusive or unclear, sometimes ignores the context or relies on intuition too much.
Manner with Clients	Is able to adapt personal style to the needs of the client; is able to reformulate when necessary and adapt or change therapeutic approach. Or adheres rigidly to one style of communication, one therapeutic modality or one view of formulation.
Persistence with Difficult Clients	Shows interest rather than despair when faced with difficulties. Adopts a constructive, yet realistic approach. Or needs more practice and help because h/she is over-zealous, or work-shy, or by the end of the placement still needs prompting more than once to act on advice.
Written work	Writes reports and letters promptly and well. Minimal correction normally required, shows clarity of thought and expression. Or needs more practice or help because s/he writes too much/little, or uses inappropriate language (e.g. jargon, colloquial language) or ignores the needs of the reader.
Relationship with Colleagues	Maintains professional relationships with other staff; communicates effectively and is respected. Or needs more experience and help because s/he is too shy, over-familiar, arrogant, or under/over involved with staff.
Professional Behaviour	Carries out work reliably, contributes with suggestions, works promptly, independently, responsibly and efficiently. Or needs more practice or more help because s/he evidences e.g. poor timekeeping or cannot manage a responsible workload, is late or cancels appointments, or dresses inappropriately (e.g. cannot fit in with the demands of the environment).
Functioning within the Organisation/context	Understands the work context, attends relevant meetings, contributes and communicates through appropriate channels, tolerates interdisciplinary disagreement Or requires repeated guidance and precise explanation concerning pathways within the working context.
Use of Supervision	Uses supervision flexibly to meet training needs, i.e. to seek reassurance, anxiety reduction, to gain feedback or to learn, as appropriate. Asks for advice and guidance and is receptive to feedback. Or, needs to learn better use of supervision, e.g. has poor response to constructive criticism, does not ask for feedback, seems not to listen to or act on advice.
Accurate Self Appraisal	Is able to be flexible & realistic about his/her capabilities and can communicate these. Or is unrealistic about own capabilities and limitations; seems blind to these.

The Eysenck Personality Scales (EPS).

The Eysenck Personality Scales (Eysenck & Eysenck 1991) were described in Chapter 6, Study 1 and the reader is directed to this study for further information.

The National Adult Reading Test (NART).

The NART (Nelson, 1982) was described in Chapter 6, Study 1 and the reader is directed to this study for further information.

Adult Attachment Interview (AAI).

The AAI was described in full Chapter 5 and the reader is directed to this chapter for further information.

Good Therapist Questionnaire (GTQ).

The GTQ was described in Chapter 6, Study 1 and the reader is directed to this study for a complete description of the measure.

8.1.4 Procedure.

Subjects consenting to participate in the study completed all the measures noted above whilst completing their training. Following the completion of training, all ratings on trainees were collated. For the purpose of this study, these ratings were expanded to a five point scale by introducing the midway of marks '0.5' and '1.5' allocation of which was based upon the written comments made by the supervisor. Separate ratings on each scale were noted for each mandatory placement, i.e. for Adult Mental Health, Child & Family, and Learning Difficulties placements. In cases in which the trainee had more than one supervisor in a placement, the mean of the ratings for that placement were calculated. Mean overall ratings were then

also calculated using all the evaluation forms across all placements, mandatory and specialist.

All other measures were scored as previously described in Section 6.2.3 of Chapter 6.

8.2 Results.

Description of the Sample in terms of Personality, Intellectual Functioning and Attachment Status.

The raw scores for each subject were converted to a z-score using the appropriate age and gender norm as provided by Eysenck & Eysenck (1991). The mean z-scores for the sample of clinical psychologists on Psychoticism scales was 1.86 (sd=1.21) and for the Neuroticism scale was -.07 (sd= .77). The results indicated that whilst clinical psychology trainees may be considered as 'neurotic' as the general public, they did score over one standard deviation above the mean on the Psychoticism scale when compared to the normal population. Eysenck & Eysenck (1991) stated that their use of the term 'Psychoticism' should not be interpreted in psychiatric sense but more in terms of the willingness of the subject to entertain socially unacceptable thoughts and in that sense be "tough minded". Clinical psychology trainees therefore appear to be more tough-minded than the normal population although the high standard deviation suggests that there is considerable variation on this.

The mean z-score for the Extroversion scale was -.13 (sd=.59) whilst that on the Lie Scale was -.40 (sd=.79). In both cases therefore, trainees do not differ greatly from the normal population.

Additionally, on the Addiction Scale the mean z-score was .33 (sd=.75) and on the Criminality Scale the mean z-score was .51 (sd=.90). Consequently, on both scales, trainees were slightly above the mean for the normal population, but did not

appear to be significantly different from the standard population. Consequently, and in view of the fact that each of these scales was derived from the preceding four scales and may have limited relevance to training, they were not included in subsequent analyses.

The results indicated that the mean full scale IQ was 122.05 ($sd=4.90$) whilst that for verbal IQ was 119.35 ($sd=4.6$) and for performance IQ was 120.15 ($sd=4.4$). There was no significant difference between verbal and performance IQs and level of intellectual functioning did not correlate with any demographic variable.

On a 2-way classification of attachment status, 19 trainees (47.5%) were classified as insecure and the remaining 21 (52.5%) as Secure. This compared with 42% insecure and 58% secure in the meta-analysis as reported by van IJzendoorn & Bakermans-Kranenburg (1996). The distribution of the current sample did not appear to differ greatly from that reported by van IJzendoorn & Bakermans-Kranenburg (1996) and inspection of this Chi-sq analysis indicated a highly significant [$p<.001$] association between the two populations. This suggested that the sample population did not differ significantly, or corresponded to, the other reported 'normal' subject populations. Similarly, a 3-way classification indicated that the insecure group divided into 15 trainees (37.5%) who were classified as dismissing with respect to attachment behaviour and the remaining 4 trainees who were preoccupied with regard to attachment behaviour (10%). This once again compared with the distribution reported by van IJzendoorn & Bakermans-Kranenburg (1996) who reported 24% dismissing, 18% preoccupied and 58% secure. As with the two-way classification, Chi Sq analysis of three-way classification indicated an extremely significant association with the distribution reported by van IJzendoorn & Bakermans-Kranenburg and therefore the current sample might be considered as 'normal'.

Training in Clinical Psychology required the trainees to work with a number of very different patient populations. Consequently, separate mean ratings were derived for the trainee's three different mandatory placements of Adult Mental

Health, Child & Family Psychology, and Learning Difficulties. Whilst also completing a period of working with older adults was also mandatory, separate ratings for trainees' work with this population were not used given that the nature of the population and its positioning with regard the other component populations was conceptually unclear. An overall mean rating was also derived by taking the mean of all ratings available on the trainee. This thereby included all specialist placements. In cases where a trainee had more than one supervisor for any placement, the mean ratings across the evaluations was used for that placement.

Distribution of the Sample in terms of Placement Ratings.

The distribution of placement ratings for Adult Mental Health, Learning Difficulty, Child and Family Psychology placements in addition to the mean ratings band is shown in Table 8.2. The mean ratings tend to be all rather high and may reflect the adage that the "trainee was good when he/she came to the placement, and better when they left".

Table 8.2 Distribution of Placement Ratings.

Scale	Adult Mental Health Mean (sd)	Learning Difficulties Mean (sd)	Child & Family Mean (sd)	Mean Ratings Mean (sd)
Assessment Skills	1.50 (.52)	1.85 (.34)	1.71 (.54)	1.71 (.32)
Interview Skills	1.73 (.42)	1.88 (.29)	1.81 (.41)	1.84 (.18)
Knowledge of Treatment Methods	1.76 (.39)	1.93 (.20)	1.84 (.39)	1.88 (.16)
Capacity for Formulation	1.57 (.46)	1.88 (.28)	1.74 (.38)	1.75 (.24)
Manner with Clients	1.85 (.33)	1.88 (.28)	1.88 (.29)	1.87 (.22)
Persistence with Difficult Clients	1.76 (.35)	1.96 (.17)	1.87 (.29)	1.90 (.13)
Written work	1.47 (.49)	1.80 (.46)	1.57 (.46)	1.68 (.32)
Relationship with Colleagues	1.90 (.27)	1.92 (.24)	1.97 (.11)	1.94 (.15)
Professional Behaviour	1.91 (.27)	1.92 (.27)	1.95 (.22)	1.94 (.17)
Functioning within the Organisation/context	1.72 (.43)	1.92 (.27)	1.92 (.24)	1.89 (.22)
Use of Supervision	1.89 (.24)	1.92 (.22)	1.84 (.32)	1.88 (.19)
Accurate Self Appraisal	1.62 (.43)	1.82 (.33)	1.61 (.44)	1.72 (.26)

Analysis with Respect to Supervisor Ratings.

Gender.

Whilst the number of male clinical psychologists was very low, any possible influence of gender was investigated by use of a t-test comparing male and female trainees on each rating scale. The results indicated that gender did not play a significant role in the rating of any trainee on any assessment scale.

Age.

Age significantly correlated with only one assessment scale; Self-Appraisal in Adult Mental Health negatively correlated with age [$r_{(40)} = -.38, p < .04$]. This result is presented in tabular form in Table 8.3.

**Table 8.3 Significant Correlations between Clinical Psychologist Trainee
Demographic variables and Supervision Rating Scales**

Supervisor Rating Scale		Age	Previous Experience
Adult Mental Health Placement	Self Appraisal	-.38 ⁺⁺	
	Knowledge of Treatment		.38**
	Capacity for Formulation		.50***
Child & Family Placement	Assessment Skills		.36*
	Use of Supervision		.43*
Mean Assessment Skills			.37*
Mean Knowledge of Treatment			.41**
Mean Use of Supervision			.54***
Mean Capacity for Accurate Self Appraisal			.32 ⁺

Key: ⁺ $p < .05$, ⁺⁺ $p < .04$, * $p < .02$, ** $p < .01$, *** $p < .004$

Education.

The highest level of education achieved by clinical psychology trainees did not correlate significantly with any assessment scale.

Previous Experience.

The degree of a trainee's previous relevant experience significantly correlated with a number of assessment scales from different placements. Within Adult Mental Health, significant correlation were noted with Knowledge of treatment [$r_{(40)} = .38, p < .01$], and Capacity for Formulation [$r_{(40)} = .50, p < .001$]. Within the assessment of a trainees work with children and families, significant correlations with previous experience were noted with Assessment Skills [$r_{(40)} = .36, p < .02$] and Supervision [$r_{(40)} = .43, p < .02$].

The degree of previous experience also significantly correlated with three summary scales; Mean Assessment Skills [$r_{(40)} = .37, p < .02$], Knowledge of treatment [$r_{(40)} = .41, p < .01$], Use of Supervision [$r_{(40)} = .54, p < .001$], and Capacity for Self Appraisal [$r_{(40)} = .32, p < .05$]. These results are presented in tabular form in Table 8.3.

Experience of Being a Patient.

The results indicated that 22 (54%) of trainees had some experience of being in a therapeutic relationship at some point during training, irrespective of theoretical orientation or modality of treatment. This variable was not aimed at capturing the intensity of therapeutic experience but whether the experience of being a patient was potentially influential to aspects of their functioning as observed/recorded in supervisors' ratings. It did not show any significant association with any other demographic variable.

The results indicated that trainees who were in therapy were rated as having a better relationship with colleagues (mean rating = 1.99, sd = .02) in the Adult Mental Health placement than those trainees who had had no experience (mean rating = 1.79, sd = .38). This difference was significant [$t_{(1,38)} = -2.45, p < .04$]. Additionally, trainees who had had some experience were rated more highly on Written Skills in Child and family Psychology (mean rating = 1.73, sd = .37) than trainees who had had no experience of therapy (mean rating = 1.38, sd = .48). This difference was also significant [$t_{(1,38)} = -2.44, p < .02$]. Experiences of being a patient were not associated with any other differences between trainees in terms of supervisors ratings.

Eysenck Personality Scales.

Interestingly, the Psychoticism scale did not correlate significantly with any of the assessment scales. On the other hand, the Neuroticism scale weakly but

significantly correlated with the Functioning Within the Organisation scale in the Child & Family Placement [$r_{(40)} = -.39, p < .01$]. Its correlation with the Relationships with Colleagues Scale in the same placement neared significance [$r_{(40)} = .31, p < .06$]. Most significant, however, was the correlation of the Neuroticism scale with the Mean Self Appraisal Scale when controlling for Previous Level of Experience [$r_{(37)} = .41, p < .001$].

The Extroversion scale significantly but inversely correlated with the capacity formulate cases in working with Learning Difficulties ($r_{(40)} = -.42, p < .008$) suggesting that the more extrovert the trainee, the less likely he/she would be able to formulate the case. When controlling for age, Extroversion also negatively correlated with the capacity for realistic self appraisal when working in Adult Mental Health [$r_{(27)} = -.46, p < .01$]. When controlling for degree of previous experience, Extroversion positively correlated with the capacity to assess cases in the child and family placement [$r_{(37)} = .32, p < .05$]. A near significant negative correlation was also noted between extroversion and the knowledge of treatment in Adult Mental Health when controlling for the degree of previous experience [$r_{(37)} = -.32, p < .06$].

The Lie scale of the EPS did not correlate significantly with any of the assessment scales. These results are summarised in Table 8.4 below.

**Table 8.4 Significant Correlations Between Clinical Psychologist Trainee
Personality Scales Scores and Supervision Rating Scales**

Supervisor Rating Scale		EPS Extroversion	EPS Neuroticism
Adult Mental Health	Self Appraisal	-.46* ¹	
Child & Family	Assessment Skills	.32 ⁺²	
	Functioning within the organisation.		-.39*
Learning Difficulties	Capacity for formulation	-.42*	
Mean Capacity for Accurate Self Appraisal			.41**

Key: + p < .05, ++ p < .02 * p < .01 ** p < .001 *** p < .004

¹ Controlling for Age ² Controlling for Previous Experience.

Overall therefore, whilst trainees appeared to be quite tough-minded, this trait did not appear to play any part in their assessment during training. The degree of Neuroticism however appeared to be significant to assessment, formulation and self-appraisal in specific contexts once age and previous experience, as suppressor variables, had been controlled for.

EPS scales correlating significantly with particular rating scales were subsequently controlled for in the analysis regarding attachment thereby controlling for the possibility that they acted as suppressor variables.

Intellectual Functioning.

Controlling where necessary for both demographic variables and EPS scales, intellectual functioning was noted to correlate significantly with only one assessment scale. The Mean Capacity to Formulate weakly and negatively correlated with IQ [$r_{(40)} = -.32, p < .05$]. This suggested that the higher intellectual had a slightly detrimental effect upon the trainee's capacity to formulate a case.

Attachment Status.

Consideration of a dichotomous classification of attachment into secure and insecure groups indicated that there was no significant association with any demographic variable. Comparisons of secure and insecure trainees' performance ratings were then conducted whilst controlling for all previously noted covariates.

The results of this analysis are presented in Tables 8.5 to 8.8 and indicated that secure and insecure trainees significantly differed on only five rating scales. In Adult Mental Health secure trainees were evaluated as knowing significantly more about treatments than insecure trainees even when controlling for previous experience [$F_{(1,37)} = 4.55, p < .04$]. Secure trainees were also rated as being able to formulate their cases in Adult Mental Health significantly better than insecure trainees, once again controlling for previous experience. [$F_{(1,37)} = 8.81, p < .005$]. furthermore, when controlling for both age and extroversion, secure trainees were rated as being much better able to realistically appraise themselves than insecure trainees [$F_{(1,37)} = 4.85, p < .04$]. Additionally, secure trainees' overall manner with patients was rated significantly more highly than that of insecure trainees [$t_{(1,38)} = -2.08, p < .05$]. Additionally, secure trainees were rated more highly on Interviewing skills than insecure trainees [$t_{(1,38)} = -2.02, p < .05$]. By contrast, insecure trainees were rated more highly for their teaching abilities [$t_{(1,38)} = -2.08, p < .04$].

Table 8.5 Adult Mental Health Placement: Mean Supervisor Rating Scales by Trainee 2-Way Classification of Attachment Status.

Adult Mental Health Placement			
Evaluation Scale	Insecure Trainees Mean (sd)	Secure Trainees Mean (sd)	Significant Differences (Secure vs Insecure)
Assessment skills	1.39 (.57)	1.60 (.57)	$t = -1.23$ ns
Interview skills	1.67 (.47)	1.78 (.36)	$t = -.86$ ns
Knowledge of Treatment Methods ³	1.62 (.46)	1.88 (.26)	$F_{(1,37)} = 4.55$ $p < .04$
Capacity for Formulation ³	1.36 (.45)	1.77 (.37)	$F_{(1,38)} = 8.81$ $p < .005$
Manner with Clients	1.82 (.37)	1.88 (.30)	$t = -.51$ ns
Persistence with Difficult Clients	1.75 (.38)	1.76 (.33)	$t = -.11$ ns
Written work.	1.39 (.49)	1.54 (.50)	$t = -.97$ ns
Relationship with Colleagues	1.86 (.33)	1.94 (.22)	$t = -.92$ ns
Professional Behaviour	1.89 (.31)	1.94 (.22)	$t = -.64$ ns
Functioning within the Organisation ¹	1.67 (.47)	1.78 (.40)	$t = -.83$ ns
Use of Supervision	1.81 (.32)	1.96 (.18)	$t = -1.63$ ns
Accurate Self Appraisal ¹²	1.44 (.42)	1.76 (.40)	$F_{(1,26)} = 4.85$ $p < .04$

Key: ¹ EPS Extroversion as a covariate. ² Age as a covariate ³ Previous Experience as covariate

Table 8.6 Child & Family Placement: Mean Supervisor Rating Scales by Trainee 2-Way Classification of Attachment Status.

Child & Family Psychology Placement.			
Evaluation Scale	Insecure Trainees Mean (sd)	Secure Trainees Mean (sd)	Significant Differences (Secure vs Insecure)
Assessment skills ^{1 3}	1.56 (.69)	1.84 (.31)	$F_{(1,36)}=1.49$ ns
Interview skills	1.70 (.53)	1.90 (.24)	$t=-1.60$ ns
Knowledge of Treatment Methods	1.80 (.48)	1.87 (.31)	$t=-.46$ ns
Capacity for Formulation	1.71 (.41)	1.77 (.36)	$t=-.52$ ns
Manner with Clients	1.80 (.38)	1.95 (.12)	$t=-1.81$ ns
Persistence with Difficult Clients	1.90 (.25)	1.83 (.32)	$t=.82$ ns
Written work.	1.50 (.53)	1.63 (.38)	$t=-.93$ ns
Relationship with Colleagues	1.95 (.16)	2.00 (.01)	$t=-1.5$ ns
Professional Behaviour	1.89 (.31)	1.99 (.02)	$t=-1.5$ ns
Functioning within the Organisation ²	1.89 (.31)	1.94 (.22)	$F_{(1,38)}=1.21$ ns
Use of Supervision ³	1.85 (.31)	1.83 (.34)	$F_{(1,38)}=.02$ ns
Accurate Self Appraisal	1.56 (.44)	1.66 (.46)	$t=-.65$ ns

Key: ¹ EPS Extroversion as covariate. ² EPS Neuroticism as covariate

³ Previous Experience as a covariate

Table 8.7 Learning Difficulties Placement: Mean Supervisor Rating Scales by Trainee 2-Way Classification of Attachment Status.

Learning Difficulties Placement.			
Evaluation Scale	Insecure Trainees Mean (sd)	Secure Trainees Mean (sd)	Significant Differences (Secure vs Insecure)
Assessment skills	1.89 (.31)	1.82 (.36)	$t = .63$ ns
Interview skills	1.86 (.33)	1.89 (.25)	$t = -.34$ ns
Knowledge of Treatment Methods	1.97 (.11)	1.90 (.25)	$t = 1.13$ ns
Capacity for Formulation ¹	1.88 (.31)	1.89 (.25)	$F_{(1,38)} = .44$ ns
Manner with Clients	1.85 (.36)	1.92 (.18)	$t = -.77$ ns
Persistence with Difficult Clients	1.97 (.11)	1.95 (.22)	$t = .41$ ns
Written work.	1.88 (.36)	1.72 (.53)	$t = 1.14$ ns
Relationship with Colleagues	1.89 (.27)	1.94 (.22)	$t = -.71$ ns
Professional Behaviour	1.94 (.22)	1.89 (.31)	$t = -.64$ ns
Functioning within the Organisation	1.89 (.31)	1.94 (.22)	$t = -.64$ ns
Use of Supervision	1.93 (.24)	1.91 (.20)	$t = -.33$ ns
Accurate Self Appraisal	1.87 (.24)	1.77 (.39)	$t = .79$ ns

Key: ¹ EPS Extroversion as covariate.

**Table 8.8 Mean Supervisor Rating Scales by Trainee 2-Way
Classification of Attachment Status.**

Mean Evaluation Ratings.			
Evaluation Scale	Insecure Trainees Mean (sd)	Secure Trainees Mean (sd)	Significant Differences (Secure vs Insecure)
Assessment skills ³	1.67 (.40)	1.75 (.24)	$F_{(1,38)} = .73$ ns
Interview skills	1.78 (.22)	1.90 (.11)	$t = -2.09$ $p < .04$
Knowledge of Treatment Methods ³	1.84 (.21)	1.91 (.10)	$F_{(1,38)} = 1.36$ ns
Capacity for Formulation ¹	1.68 (.30)	1.82 (.14)	$F_{(1,38)} = 2.91$ ns
Manner with Clients	1.80 (.29)	1.94 (.11)	$t = -2.08$ $p < .05$
Persistence with Difficult Clients	1.90 (.15)	1.88 (.11)	$t = -.02$ ns
Written work.	1.64 (.37)	1.71 (.27)	$t = -.63$ ns
Relationship with Colleagues	1.91 (.18)	1.96 (.11)	$t = -1.07$ ns
Professional Behaviour	1.91 (.24)	1.96 (.08)	$t = -1.03$ ns
Functioning within the Organisation	1.85 (.28)	1.92 (.16)	$t = -.91$ ns
Use of Supervision ³	1.83 (.26)	1.92 (.09)	$F_{(1,38)} = 1.61$ ns
Accurate Self Appraisal ^{2,3}	1.64 (.26)	1.80 (.25)	$F_{(1,36)} = 1.91$ ns

Key: ¹ IQ as a covariate. ² EPS Neuroticism as a covariate ³ Previous Experience as a covariate

A discriminant analysis was subsequently conducted to address which of the rating scales was most closely associated with attachment security. This indicated that only one scale was able to correctly predict attachment security; Problem Formulation in Adult Mental Health [Wilks lambda = .793, $F_{(1,38)} = 9.90$, $p < .003$]. On the basis of this scale, 72.5% of original grouped cases were correctly classified. The results were then cross-validated in which each case is classified by the functions derived from all cases other than that case. This resulted in correct

prediction for also 72.5% of the cases. The original and cross validated predicted distribution of cases and is shown in Table 8.9.

Table 8.9 Original and Predicted Attachment Security
Based on Discriminant Analysis

Original & Cross Validated Count (%)	Predicted Group Membership		Total
	Insecure	Secure	
Insecure	14 (73.7)	5 (26.3)	19 (100)
Secure	5 (23.8)	16 (76.2)	21 (100)

A three-way analysis of attachment was not possible given that only four trainees were classified as Preoccupied. However given the number of trainees who were classified as Dismissing, a further analysis was conducted comparing Secure and Dismissing trainees. Such an analysis part replicated the previous findings in that secure trainees were more highly rated than Dismissing trainees on Capacity to formulate cases in Adult Mental Health. The mean rating for secure trainees was 1.77 (sd = .37) whilst that for Dismissing trainees was 1.35 (sd = .46). When controlling for previous experience, this result was significant [$F_{(1,37)} = 7.39$, $p < .01$]. Secure trainees were also rated more highly than Dismissing trainees on Mean Interviewing Skills. The mean rating for secure trainees was 1.90 (sd = .12) whilst that for Dismissing trainees was 1.75 (sd = .40). This result was significant [$t_{(1,35)} = -2.36$, $p < .02$]. No significant distinction between secure and dismissing trainees was noted on any other rating scale.

A discriminant analysis was also subsequently conducted to address which of the rating scales could best distinguish Secure and Dismissing trainees. As with the two way classification of attachment, this indicated that only one scale was able to correctly predict attachment security; Problem Formulation in Adult Mental Health

[Wilks lamda = .793, $F_{(1,38)} = 8.88$, $p < .005$]. On the basis of this scale, 72.2% of original grouped cases were correctly classified. The results were then cross validated and this resulted in correct prediction for also 72.2% of the cases. In effect, whilst the degree of significance rose, the nature of this result was identical to that obtained through considering a two-way classification of attachment.

A Factor Analytic Approach.

The initial results suggested that a simple overarching relationship between attachment classifications and success in training was an over-simplistic notion. Furthermore, within the initial results lay the suggestion that specific aspects of the attachment system, as reflected by scales of the AAI, are related to different aspects of the training of clinical psychologists. Consequently, and given the number of scales involved, a factor analytic approach was taken in which a factor analysis with varimax rotation of the ratings for each placement was made to establish the principal components of the set of ratings. These factors were subsequently correlated with ratings on AAI scales.

Factor Analysis of Adult Mental Health Ratings.

Factor analysis of the Adult Mental Health ratings produced five factors, which accounted for 73.8% of the total variance. The ratio of items to factors for this analysis was 2.2 : 1. The first factor was termed Use of Guidance given that the two scales which loaded most onto this factor Use of Supervision (.79) and Functioning within the Organisation/Context (.82). The second factor was termed Assessment Skills given that the two scales which most loaded onto this factor were Assessment skills (.84) and Capacity for Formulation (.80). A third scale, Interview Skills also loaded onto this factor but to a much lower degree (.453). The third factor was called Manner given that given that the two scales which most loaded onto this factor were Manner with clients (.87) and Relationship with Colleagues (.72). The scale of professional behaviour also loaded onto this factor but to a much lower degree (.51). The fourth factor was termed Professional

Behaviour and in fact the only scale to load significantly onto this factor was that of Professional behaviour (.65). The final fifth factor was termed Persistence given that the two scales which most loaded onto this factor were Persistence With Difficult Clients (.82) and, to a lesser extent, Knowledge of Treatment Methods (.50). A complete table of the loadings of each evaluation scale onto each factor is provided in Appendix 3.

Factors relating to work in Adult Mental Health were then correlated against trainees' ratings on the AAI. This showed that Supervision correlated positively and significantly with Loving Mother and negatively but significantly correlated with the Derogation scales of the AAI and current Anger at Mother. Most interestingly, Assessment Skills were very significantly correlated to Coherency in the AAI and then Reflective Self Functioning. Consistent with these findings, Assessment Skills were then inversely correlated with the Idealisation scales of the AAI, the Lack of Memory scale and Father Pressure-to-Achieve Scale. The third factor, Manner, also showed a clear association with AAI scales in that it correlated significantly with the Father-loving scale and then inversely correlated with scales in the AAI that would intuitively not be considered to be consistent with a productive professional manner namely, Father-rejecting, Father-neglecting, Mother-neglecting, Overall Derogation. Manner also inversely correlated with unresolved trauma suggesting that the quality of a trainee's overall behaviour with a patient was decreased by the ongoing nature of his or her own trauma. Professional behaviour only correlated with Mother-rejecting but inversely correlated with the Coherence scales of the AAI. Finally Persistence did not correlate with any of the AAI scales. The complete correlation matrix is shown in Table 8.10.

Furthermore, using a two-way classification of attachment, secure trainees were rated as significantly better at Assessment Skills than insecure trainees. Secure trainees had a mean of .31 (sd = .90) whilst insecure trainees had a mean of -.35 (sd = 1.0), this difference being significant [$t_{(1,38)} = -2.22, p < .03$].

**Table 8.10 Correlation Matrix of Factors Derived From Adult Mental Health
Supervisor Evaluation Ratings Versus Scales of the
Adult Attachment Interview.**

Scales of the Adult Attachment Interview	Factors Derived from Adult Mental Health				
	Supervision	Assessment Skills	Manner	Professional Behaviour	Persistence
Mother Loving	.47***	.24	.23	-.03	.01
Father Loving	.11	-.03	.42**	-.09	.01
Mother Rejecting	-.10	-.02	-.14	.28*	.15
Father Rejecting	-.05	.01	-.42**	.12	.08
Mother Involving	-.17	.24	-.16	.10	-.10
Father Involving	-.20	-.05	.06	.10	.09
Mother Pressure	-.06	-.24	.24	.05	.01
Father Pressure	-.24	-.32*	.10	.19	-.08
Mother Neglecting	-.03	.05	-.29*	-.25	-.02
Father Neglecting	-.05	.36*	-.44**	.07	.02
Mother Idealisation	.20	-.41**	.07	.09	-.13
Father Idealisation	.09	-.48***	-.06	.05	-.18
Mother Anger	-.27*	-.01	.16	.24	-.05
Father Anger	-.24	-.09	.17	.06	.16
Mother Derogation	-.51***	.12	-.03	.21	.01
Father Derogation	-.31*	-.01	-.28*	.09	.05
Overall Derogation	-.40**	-.09	-.10	.08	.13
Lack of Memory	.04	-.44**	-.13	.17	-.01
Metacognitive	.03	-.07	.03	-.25	.17
Passivity	.24	-.23	-.14	.21	.09
Fear of Loss	.16	.04	-.15	.12	.22
Unresolved Loss	.12	.09	.03	.02	.25
Unresolved Trauma	.17	-.24	-.35*	.01	.22
Coherence Transcript	.08	.37**	.14	-.31*	.02
Coherence of Mind	.09	.38**	.12	-.34*	-.01
Reflective Self Function	.08	.38*	-.05	-.25	.16

Key: * $p < .05$, ** $p < .01$, *** $p < .001$

Factor Analysis of Child & Family Ratings.

Factor analysis of the Child and Family placement evaluation ratings produced four factors, which accounted for 70.4% of the total variance. The ratio of items to factors for this analysis was 2.75 : 1. The first factor was termed as Relating given that relating with colleagues most highly loaded onto this factor (.935) but was followed by Interviewing skills (.83) and Manner with Clients (.75). The second factor combined Use of Supervision (.81), Persistence with difficult clients (.73)

and, to a lesser extent, Self appraisal (.60). The nature of this scale seemed consistent with to the notion of Supervision and it was so termed. The third factor was termed Knowledge given that two scales loaded onto this factor far more than any other scale. These were Knowledge of treatment (.90) and Capacity to formulate cases (.81). The fourth and final factor was termed Work of Assessment given that the two scales that most loaded onto this factor were Written work (.76) and Assessment Skills (.72). A complete table of the loadings of each evaluation scale onto each factor is provided in Appendix 3.

Correlations between the factors Relating, Knowledge, and Use of Supervision with the scales of the AAI were sparse. Relating did not correlate significantly with any scale of the AAI whilst the Use of Supervision factor inversely correlated to Mother-neglecting only. Knowledge only correlated with Father Derogation. Interestingly the Work of Assessment factor correlated positively with both Mother- and Father-loving and to Reflective Self Function. Consistent with these findings it correlated negatively with Mother-rejecting and Lack of Memory. The complete correlation matrix is shown in Table 8.11.

**Table 8.11 Correlation Matrix of Factors Derived From Child & Family
Psychology Supervisor Evaluation Ratings Versus Scales of the
Adult Attachment Interview.**

Scales of the Adult Attachment Interview	Factors derived from Child & Family Psychology Ratings			
	Relating	Use of Supervision	Knowledge	Work of Assessment
Mother Loving	.22	.02	.08	.34*
Father Loving	.08	.06	-.10	.33*
Mother Rejecting	.09	.22	-.18	-.30*
Father Rejecting	-.16	-.12	.05	-.25
Mother Involving	.11	-.15	.12	-.11
Father Involving	.05	-.03	-.20	-.15
Mother Pressure	.14	.05	.11	.10
Father Pressure	.15	.07	.02	-.23
Mother Neglecting	.03	-.31*	.19	-.13
Father Neglecting	.08	-.18	.24	-.17
Mother Idealisation	-.14	.25	-.14	-.09
Father Idealisation	-.24	.16	-.18	-.19
Mother Anger	.15	-.02	-.08	.01
Father Anger	.15	-.07	-.04	.07
Mother Derogation	-.16	.01	.13	-.07
Father Derogation	-.06	-.09	.27*	-.14
Overall Derogation	-.06	-.02	.21	-.12
Lack of Memory	-.02	.16	-.05	-.29*
Metacognitive	.15	-.20	.25	.20
Passivity	.10	.07	-.11	.06
Fear of Loss	.08	.09	.04	.13
Unresolved Loss	.19	.01	-.12	.11
Unresolved Trauma	-.21	.18	.01	-.08
Coherence Transcript	.20	-.22	.07	.16
Coherence of Mind	.22	-.20	.20	.19
Reflective Self Function	.31	.27	.27	.33*

Key: * $p < .05$, ** $p < .01$, *** $p < .001$

Factor Analysis of Learning Difficulties Placement.

Factor analysis of the Learning Difficulties placement evaluation ratings produced three factors that accounted for 78.5% of the total variance. The ratio of items to factors for this analysis was 3.66 : 1. The first factor was termed Capacity for Clinical Work since it comprised high loadings from four scales; functioning within the organisation (.85), relationships with colleagues (.84), assessment skills (.81)

and manner with clients (.80). The second factor was termed Diagnostic and Written skills given that the four highest loadings were Knowledge of treatment (.87), Written work (.79), Capacity to formulate (.76), and Interview Skills (.74). The third factor was termed Dedication since it comprised of Use of Supervision (.94), Persistence with difficult Clients (.87), Professional behaviour (.75) and, to a lower extent, Accurate self appraisal (.63). A complete table of the loadings of each evaluation scale onto each factor is provided in Appendix 3.

Correlation with the scales of the AAI indicated that the Capacity for Work factor only correlated negatively with three AAI scales; Mother-rejecting, Father-pressure to achieve, and Father idealisation. Diagnostic and Written skills correlated positively with Father-loving and negatively with Father-neglecting and Father-rejecting. Dedication did not correlate with any of the AAI scales. The complete correlation matrix is shown in Table 8.12.

**Table 8.12 Correlation Matrix of Factors Derived From Learning Difficulties
Supervisor Evaluation Ratings Versus Scales of the
Adult Attachment Interview.**

Scales of the Adult Attachment Interview	Factors Derived from Learning Difficulties Placement		
	Capacity for Clinical Work	Diagnostic & Written Skills	Dedication
Mother Loving	.16	.07	.01
Father Loving	.20	.28*	-.10
Mother Rejecting	-.27*	-.14	.19
Father Rejecting	-.13	-.35*	.14
Mother Involving	-.07	-.10	.05
Father Involving	.01	-.02	-.13
Mother Pressure	.15	.13	.03
Father Pressure	-.31*	.25	-.17
Mother Neglecting	.13	-.03	.03
Father Neglecting	-.09	-.42**	.19
Mother Idealisation	-.16	.16	.17
Father Idealisation	-.33*	.13	.04
Mother Anger	-.03	.07	-.06
Father Anger	.17	.07	-.17
Mother Derogation	.03	-.13	.09
Father Derogation	.09	-.13	.11
Overall Derogation	.10	-.07	.09
Lack of Memory	-.23	.04	.20
Metacognitive	.24	-.09	-.05
Passivity	-.02	.03	.09
Fear of Loss	.02	-.01	.10
Unresolved Loss	.17	.11	-.04
Unresolved Trauma	-.12	.01	.05
Coherence Transcript	.10	-.11	-.16
Coherence of Mind	.15	.06	-.09
Reflective Self Function	.18	-.14	-.05

Key: * $p < .05$, ** $p < .01$, *** $p < .001$

Factor Analysis of Mean Ratings.

Factor analysis of the Mean Ratings produced three factors that accounted for 70.3% of the total variance. The ratio of items to factors for this analysis was 3.66 : 1. The majority of overall scales were loaded onto the first factor which itself accounted for 49.6% of the total variance. The evaluation scales loading onto this factor were Professional behaviour (.93), manner with clients (.86), Interview skill

(.78), Persistence (.74), Functioning within the organisation (.73), Relationship with colleagues (.68) and Capacity to formulate cases (.62). This factor was therefore called Professional Clinical Work. The second factor was termed Use of Supervision given that only two scales were highly contributed to this factor, Accurate Self Appraisal (.86) and Use of Supervision (.83). The third factor was termed Teaching given that the two scales that loaded most heavily onto this factor were Teaching (.76) and Knowledge of treatments (.63). A complete table of the loadings of each evaluation scale onto each factor is provided in Appendix 3.

Correlation with the scales of the AAI indicated that Professional Clinical Work only correlated with two scales of the AAI. A positive correlation was noted with Mother-loving and a negative correlation was noted with idealisation father. The Supervision factor correlated negatively with Mother- and Father- Pressure to Achieve, Father idealisation, Mother-Anger and Lack of Memory. However, it correlated positively with the Coherence of Mind Scales and Reflective Self Functioning. The third factor, Teaching, only correlated with one AAI scale; an inverse correlation with Mother-rejecting. The complete correlation matrix is shown in Table 8.13.

It was further noted that, using a two-way classification of attachment, secure trainees were rated as significantly higher at Supervision than insecure trainees. On the Supervision Factor Secure trainees had a mean of .33 (sd = .58) whilst insecure trainees had a mean of -.36 (sd = 1.2), this difference being significant [$t_{(1,38)} = -2.28, p < .04$].

Table 8.13 Correlation Matrix of Factors Derived From Mean Supervisor Evaluation Ratings Versus Scales of the Adult Attachment Interview.

Scales of the Adult Attachment Interview	Factors derived from Mean Ratings		
	Professional Clinical Work	Use of Supervision	Teaching
Mother Loving	.35*	.24	-.05
Father Loving	.18	-.01	.17
Mother Rejecting	-.06	.07	-.37**
Father Rejecting	-.16	.01	-.05
Mother Involving	-.11	.04	.12
Father Involving	-.04	-.19	-.04
Mother Pressure	.18	-.50***	.08
Father Pressure	-.07	-.58***	-.06
Mother Neglecting	-.13	-.01	.24
Father Neglecting	.02	.16	-.20
Mother Idealisation	-.05	-.23	-.07
Father Idealisation	-.29*	-.28	-.10
Mother Anger	.01	-.21	.15
Father Anger	.09	-.28	.95
Mother Derogation	.03	-.14	.02
Father Derogation	-.02	-.09	.17
Overall Derogation	.02	-.14	.15
Lack of Memory	-.10	-.34*	-.16
Metacognitive	.10	.10	.06
Passivity	.01	.17	.01
Fear of Loss	.17	.15	-.19
Unresolved Loss	.20	-.02	.05
Unresolved Trauma	-.21	.28	-.07
Coherence Transcript	.09	.30	-.04
Coherence of Mind	.12	.40**	.02
Reflective Self Function	.05	.45**	.17

Key: * $p < .05$, ** $p < .01$, *** $p < .001$

Second Factor Analysis.

The first factor analysis thereby produced a total of fifteen different factors relating to trainee clinical psychologists. A further factor analysis was conducted to ascertain whether these factors in themselves could be meaningfully reduced further. This second factor analysis produced a total of six factors that accounted for 76.2% of the total variance. The ratio of items to factors for this second

analysis was 2.5 : 1. A complete table of the loadings of each factor onto the second order factors is provided in Appendix 3.

The first factor produced comprised the Diagnostic and Written Skills factor from Learning Disability, the Manner factor from Adult Mental Health and the Use of Supervision from Child & Family Psychology. The emphasis on diagnostic skills led to this factor being thought of as a factor describing the function of Diagnosis/Formulation. The second factor was termed Reporting Skills given the high loadings from Work of Assessment from Child & Family Psychology, Capacity for Clinical Work from Learning Difficulties, and Persistence from Adult Mental Health. The third factor was clearly related to Teaching given the loadings of Teaching from the Mean ratings, and Knowledge from Child & Family Psychology. This factor also comprised a negative loading of Professional Behaviour from Adult Mental Health. The fourth factor was termed Professionalism since it comprised of Relating from Child & Family Psychology and Professional Clinical Work from the mean ratings. The fifth factor was termed Use of Supervision and Guidance given that it comprised Use of Supervision from the Mean Rating and Guidance from Adult Mental Health. The sixth and final factor was termed Assessment Skills given that the only main loading was derived from the Assessment skills factor in Adult Mental Health.

Correlation of these second order factors with the scales of the AAI some interesting results. Diagnosis/Formulation correlated positively with Father-loving and negatively with Father-neglecting and Father-rejecting. Reporting Skills failed to correlate significantly with any of the scales of the AAI and Teaching only correlated negatively with Mother-rejecting. Professionalism correlated negatively with Father-idealisation and also negatively with unresolved Trauma. Use of Supervision and Guidance correlated with a number of AAI scales, most importantly with both Coherence of Mind and Transcript and negatively with both Mother- and Father-Pressure to Achieve, Father Idealisation, and Lack of Memory. It also correlated positively with Father-neglecting. Finally, Assessment skills correlated positively with Mother-loving, and then negatively with all three

Derogation scales, Father Pressure to Achieve and Mother-anger. The complete correlation matrix is shown in Table 8.14.

Table 8.14 Correlation Matrix of Factors Derived From Second Factor Analysis Evaluation Ratings Versus Scales of the Adult Attachment Interview.

Experience Scales of the AAI	Factors derived from Second Factor Analysis					
	Diagnostic & Written Skills	Reporting Skills	Teaching	Professionalism	Use of Supervision & Guidance	Assessment Skills
Mother Loving	.08	.155	.02	.20	.19	.39**
Father Loving	.29*	.20	.16	.06	-.14	.09
Mother Rejecting	.03	.15	-.43**	.05	.20	.08
Father Rejecting	-.36*	-.07	-.14	-.09	.12	-.06
Mother Involving	-.18	-.10	.05	.17	.20	-.19
Father Involving	-.01	-.03	-.06	.05	-.17	-.17
Mother Pressure	.14	.11	.06	.22	-.31*	-.16
Father Pressure	.20	-.25	-.04	.14	-.40**	-.35*
Mother Neglecting	-.25	-.03	.28	.05	.09	-.01
Father Neglecting	-.45**	-.09	-.15	.15	.42**	-.06
Mother Idealisation	.23	-.12	-.16	-.16	-.30*	.16
Father Idealisation	.16	-.25	-.14	-.28*	-.38**	.07
Mother Anger	.07	.01	-.01	.18	-.13	-.31*
Father Anger	.04	.15	.08	.16	-.22	-.25
Mother Derogation	-.07	.08	-.07	.06	.07	-.50**
Father Derogation	-.21	.06	.07	.06	.10	-.31*

Key: * $p < .05$ (1-tailed), ** $p < .01$ (1-tailed).

**Table 8.14 Correlation Matrix of Factors Derived From Second Factor
Analysis Evaluation Ratings Versus Scales of the Adult Attachment Interview
(Continuation).**

State of Mind Scales of the AAI	Factors derived from Second Factor Analysis					
	Diagnostic & Written Skills	Reporting Skills	Teaching	Professionalism	Use of Supervision & Guidance	Assessment Skills
Overall Derogation	-.08	.12	.05	.03	.01	-.40*
Lack of Memory	.05	-.18	-.24	-.07	-.27*	-.02
Metacognitive	-.12	.23	.21	.05	.05	.04
Passivity	-.02	.05	-.14	-.05	-.03	.21
Fear of Loss	.02	.17	-.01	.13	.004	.093
Unresolved Loss	.021	.165	-.001	.13	.01	.09
Unresolved Trauma	-.03	-.01	-.11	-.39**	.07	.20
Coherence Transcript	-.10	.05	.18	.11	.25	.13
Coherence of Mind	-.08	.07	.24	.12	.35*	.14

Key: * $p < .05$ (1-tailed), ** $p < .01$ (1-tailed).

A Second control for Demographic and Personality Factors.

Overall, the correlations between placement ratings with demographic factors, level of intellectual functioning, and personality as measured by the EPS, tended to be quite low and relatively weak. Consequently it was considered not strictly necessary to control for these factors once more following the initial factor analysis. Nevertheless, any impact of controlling once more for these factors would highlight the debate between the nature of attachment functioning and other factors termed personality traits. Consequently, the results of the separate factor analyses were once more correlated against demographic and personality factors and then re-correlated against the scales of the AAI.

Amongst the factors derived from the Adult Mental Health placement ratings, Professional behaviour was noted to correlate with the Extroversion scale of the EPS [$r_{(40)} = .38, p < .02$]. Controlling for Extroversion, the correlation of Professional Behaviour with the scales of the AAI indicated a replicated but increased inverse correlation with both Coherence scales of the AAI. Professional behaviour now correlated more negatively with Coherence of Transcript [$r_{(1,37)} = -.36, p < .03$] and more negatively with Coherence of Mind [$r_{(37)} = -.43, p < .006$]. Furthermore, a significant negative correlation with Metacognition emerged [$r_{(37)} = -.32, p < .04$] although the previous significant correlation with Mother-rejecting was no longer significant.

Amongst the factors derived from the Child and Family Psychology ratings, a significant correlation between Relating and the Neuroticism scale of the EPS was noted [$r_{(40)} = .34, p < .03$]. Controlling for this did not alter the nature of the results initially obtained; no scale of the AAI correlated significantly with this factor. The Use of Supervision factor was noted to correlate significantly with the Psychoticism scale of the EPS [$r_{(40)} = .35, p < .03$]. Controlling for this, no change was noted in the status of any of the correlations initially obtained.

Amongst the factors derived from the Learning Difficulties placement, Diagnostic and Written Skills was noted to negatively correlate with the Extroversion scale of the EPS [$r_{(40)} = -.34, p < .03$]. However, subsequent correlation of this scale against scales of the AAI whilst controlling for Extroversion served to increase the size of the noted correlations with Father Rejecting and Father Neglecting and to increase the significance of each.

Amongst the factors derived from the Mean Ratings, Use of Supervision correlated significantly with both previous experience [$r_{(40)} = .39, p < .01$] and the Neuroticism scale of the EPS [$r_{(40)} = -.33, p < .04$]. Subsequent correlation of this scale against scales of the AAI whilst controlling for Neuroticism and previous experience maintained the previous correlations with Mother and Father pressure to

achieve, but the correlations with Lack of Memory and Coherence of Mind were lost.

Amongst the factors derived from the second factor analysis, Teaching inversely correlated with Extroversion as measured by the EPS [$r_{(40)} = -.32, p < .04$] and professionalism with the Neuroticism scale of the EPS [$r_{(40)} = .36, p < .02$]. Additionally, Use of Supervision correlated significantly with previous experience [$r_{(40)} = .47, p < .003$] as did assessment skills [$r_{(40)} = .34, p < .03$]. Subsequent correlation against the scales of the AAI indicated that whilst the correlation with Father-Idealisation did not occur, that with Trauma increased in strength to [$r_{(40)} = -.43, p < .007$]. The Use of Supervision factor also did no longer correlate with Coherence of Mind or the Idealisation of either mother or father although the correlations with Father neglecting and Father Pressure to Achieve remained. Additionally, a new significant correlation with RF was noted [$r_{(37)} = .33, p < .04$]. The Assessment skills factor retained the correlations noted previously. The correlation between Teaching and Mother Rejecting remained virtually the same although a new significant correlation emerged between Teaching and Lack of Memory [$r_{(37)} = -.31, p < .05$]. Additionally, the correlation between Teaching and RF increased in strength and significance [$r_{(37)} = .34, p < .04$].

Overall Ratings.

In addition to the placement ratings, the author and an independent researcher conducted the overall ratings of trainees on Clinical Skills, Academic Skills, Professional Behaviour, and an Overall rating. Concordance rates on initial ratings were as follows; an 80% concordance of rating of Clinical Skills, a 67.5% rating concordance on Academic Skills, and 85% concordance rating on Professional behaviour and a 72.5% concordance on the overall rating. Discussion following a first rating raised the concordance rate on Academic skills to a healthier 72.5%.

As shown in the correlation matrix in Table 8.15, the scales did correlate very closely with one another. On the basis of these correlations the Clinical Skills and

Professional Behaviour scales were combined thus producing three scales, Academic Skills, Mean Clinical Skills and an Overall Rating.

Table 8.15 Correlation Matrix of Overall Rating Scales.

	Clinical Skills.	Academic Skills.	Professional Behaviour.
Academic Skills.	.506**		
Professional Behaviour.	.702**	.649**	
Overall Rating.	.885**	.609**	.630**

Key: * $p < .01$ (2-tailed).

No one of the scales correlated with any demographic variable and did not correlate at all with any scale of the EPS. However correlation with the scales of the AAI revealed significant correlations between the Overall Rating and the Mean Clinical Rating with Mother loving [$r_{(40)} = .35, p < .03$] and [$r_{(40)} = .39, p < .01$] respectively. Additionally, both these scales also correlated negatively with the Father Pressure to Achieve scale of the AAI; [$r_{(40)} = -.41, p < .01$] and [$r_{(40)} = .40, p < .01$] respectively.

Analysis of these ratings by a 2-way classification of attachment proved highly inconclusive, with secure and insecure trainees not differing significantly on any of the three scales, as shown in Table 8.16.

Table 8.16 Comparison of Secure and Insecure Trainees on Overall Ratings.

Scale	Secure Trainees Mean (sd)	Insecure Trainees Mean (sd)	Difference
Academic Skills	3.73 (.51)	3.79 (.82)	ns
Mean Clinical Skills	3.93 (.31)	3.88 (.66)	ns
Overall Rating	3.76 (.93)	3.75 (.66)	ns

A mean rating for each trainee was subsequently established using the mean of the Overall rating, Mean Clinical skills rating and Academic rating. This Mean Overall rating did not correlate significantly with any scales of the EPS, level of intellectual functioning or demographic variable. There was also no significant difference between secure and insecure trainees on this scale. The Mean Overall rating replicated the correlations with AAI scales, namely a significant positive correlation with Mother Loving [$r_{(40)} = .32, p < .05$] and a negative correlation with Father Pressure to Achieve [$r_{(40)} = -.34, p < .03$] respectively.

Consequently, this scale was then used to devise two groups, one of 'Excellent Trainees' who scored '4' and above, and a group of Satisfactory trainees who scored below '4'. This produced a group of 11 Excellent Trainees and a second group of 29 Satisfactory Trainees.

Such an analysis did show a significant difference between Excellent and Satisfactory trainees on the Criminality scale of the EPS. Excellent trainees had a lower Criminality z-score than did satisfactory trainees; $-.35$ ($sd = .88$) and $.72$ ($sd = .84$) respectively, and this difference was significant [$t_{(1,38)} = 2.52, p < .02$]. They could therefore be considered to have less "criminal tendencies" although this scale was not subsequently used in the analysis given that it is derived from a combination of other EPS scales and has a less than satisfactory definition.

A 2x2 cross-tabulation indicated that there was no significant association between type of trainee and attachment status; Fisher's exact test was not significant. A group comparison between Excellent and Satisfactory trainees on the AAI Ratings indicated that excellent trainees were distinguished from satisfactory trainees on the basis of Mother Loving and Mother Pressure to Achieve scales. The mean Mother Loving rating for Excellent trainees was 5.32 (sd = .90) as opposed to 4.45 (sd = 1.19) for Satisfactory trainees. This difference was significant [$t_{(1,38)} = -2.19$, $p < .04$]. Excellent trainees also had significantly less pressurising mothers, the mean rating for them being 1.0 (sd = 0) whilst that for Satisfactory trainees was 1.67 (1.12). This difference was once again significant [$t_{(1,38)} = 3.23$, $p < .003$].

A discriminant analysis to distinguish between Excellent and Satisfactory trainees using the scales of the EPS failed to indicate any scale as predictive of classification. However, a discriminant analysis using the AAI scales suggested that Excellent and Satisfactory trainees might be distinguished on the basis of Loving Mother Scale and the Unresolved Trauma scale. The most predictive scale was that of Mother Loving [Wilks lambda = .89, $F_{(1,38)} = 4.80$, $p < .04$] with the second step of the analysis highlighting Disorganised with regard to Trauma [Wilks lambda = .75, $F_{(1,37)} = 6.77$, $p < .005$]. Excellent trainees scored more highly on unresolved trauma with a mean of 1.36 (sd = .67) than did Satisfactory trainees who had a mean score of 1.06 (sd = .25). A third step failed to isolate any other scale. The results were then cross-validated in which each case was classified by the functions derived from all cases other than that case. This resulted in correct prediction for 72.5% of the original cases and 70% of the cross-validated cases. The original and cross-validated predicted distribution of cases and is shown in Table 8.17.

Table 8.17 Original and Predicted Membership of Excellent and Satisfactory Trainees Based on Discriminant Analysis of Overall Ratings.

Count		Predicted Group Membership		Total
		Satisfactory	Excellent	
Original Count (%)	Satisfactory	20 (69)	9 (31)	29 (100)
	Excellent	2 (18.2)	9 (81.8)	11 (100)
Cross-validated Count (%)	Satisfactory	20 (69)	9 (31)	29 (100)
	Excellent	3 (27.3)	8 (72.7)	11 (100)

Good Therapist Questionnaire.

The Good Therapist questionnaire was an exploratory measure with high face validity. The reliability of the scales were once more examined using Cronbach alpha. The results suggested that all but the Eclectic Scale were reliable with the Cronbach alpha scores for the scales being as follows; Psychodynamic (alpha = .79), Cognitive (alpha = .67), Behavioural (alpha = .72), Humanistic (alpha = .61), and Eclectic (alpha = .33). Hence only the Eclectic scale was of dubious reliability but was included in the analysis for the sake of completeness.

The distribution of scores for each scale is shown in Table 8.18. All scales were normally distributed.

**Table 8.18 Responses of Secure and Insecure Clinical Psychology Trainees
on the Good Therapist Questionnaire.**

Good Therapist Questionnaire Scale	Whole Sample Mean (sd)	Insecure Trainees Mean (sd)	Secure Trainees Mean (sd)	Differences (Secure vs Insecure)
Psychodynamic Orientation	3.95 (.66)	3.90 (.65)	4.0 (.68)	ns
Cognitive Orientation	4.12 (.57)	4.36 (.58)	3.91 (.49)	$t_{(1,38)} = 2.60$ $p < .01$
Behavioural Orientation	3.95 (.64)	4.17 (.74)	3.75 (.47)	ns
Humanistic Orientation	5.03 (.46)	5.03 (.54)	5.03 (.38)	ns
Eclectic Orientation	5.01 (.45)	4.31 (.90)	4.03 (.35)	ns

A significant association was noted between gender and the Humanistic scale of the GTQ. The mean item score on the Humanistic scale for women was 5.5 (sd=.39) whilst that for men was 4.7 (sd=.55), this difference being significant [$t_{(1,38)} = -2.41$, $p < .02$]. The Behavioural orientation scale showed a significant positive correlation level of education, [$r_{(40)} = .34$, $p < .03$], but all other relationships with demographic variables were not significant. Additionally, both the Humanistic and Eclectic scales correlated significantly, and to the same degree with the Lie scale of the EPS, [$r_{(40)} = .54$, $p < .001$]. No significant correlation was noted with level of intellectual functioning or previous experience of therapy.

Analysis by Two-way Classification of Attachment.

Secure and insecure trainees were compared on their ratings of how they consider a good therapist would behave. The results are shown in Table 8.18 and indicate that insecure trainees tended to believe that a 'good' therapist would behave in manner more in keeping with cognitive models than secure trainees. Secure therapists do not seem to be associated with any particular orientation.

The individual AAI scales were then correlated against the separate scales of the GTQ to examine whether particular dimensions of attachment were related to

particular orientations. Psychodynamic orientation negatively correlated with the Mother-derogation scale [$r_{(40)} = -.32, p < .05$] and no other scale of the AAI. Cognitive orientation correlated with Father rejecting [$r_{(40)} = .38, p < .02$] and then negatively with Fear of Loss [$r_{(40)} = -.31, p < .05$], Coherence of Mind [$r_{(40)} = -.33, p < .04$], and Reflective Self Functioning [$r_{(40)} = -.35, p < .03$]. Behavioural orientation did not correlate with any scale and neither did Humanistic orientation when controlling for both for gender and the EPS Lie scale. Controlling for the EPS Lie scale brought to the fore the correlation of the Eclectic Orientation scale with the derogation scales of the AAI. Eclecticism correlated very highly with Mother-derogation [$r_{(1,37)} = .82, p < .001$], Father-derogation [$r_{(1,37)} = .54, p < .001$], and overall derogation [$r_{(1,37)} = .56, p < .001$]. Additionally it correlated negatively with Mother-loving [$r_{(1,37)} = -.36, p < .03$].

GTQ by Excellent or Satisfactory trainees.

Response to the GTQ were also analysed through a comparison between previously rated Excellent and satisfactory trainees. The distribution of scores is shown in Table 8.19 indicating that the two groups were virtually identical on that measure. From the perspective of the authors' own ratings, the quality of a trainee does not therefore appear to be associated with what they say they believe a good therapist does.

Table 8.19 A Comparison of Excellent and Satisfactory Trainees
Using the Good Therapist Questionnaire.

Good Therapist Questionnaire Scale	Excellent Trainees Mean (sd)	Satisfactory Trainees Mean (sd)	Differences (Excellent vs Satisfactory)
Psychodynamic Orientation	4.02 (.61)	3.90 (.69)	ns
Cognitive Orientation	4.31 (.67)	4.28 (1.1)	ns
Behavioural Orientation	4.00 (.71)	3.92 (.61)	ns
Humanistic Orientation	5.02 (.37)	5.06 (.60)	ns
Eclectic Orientation	4.16 (.82)	4.15 (.29)	ns

8.3 Discussion.

The initial results indicated that clinical psychology trainees were a highly intelligent group who were essentially consistent with the published norms for personality traits whilst being slightly more ‘tough minded’ than the normal population. They were also ‘normal’ with regard the distribution of attachment classifications although there tended to be greater numbers in the dismissing classification than in the normal population. Nevertheless, the distribution found was in keeping with the little literature available directly concerning attachment functioning clinical psychology trainees e.g., Leiper and Casares (2000). No study could be found which focussed upon the role of attachment organisation in the training of clinical psychologists.

An initial analysis of the data conveyed some expected findings. Whilst this was a female dominated population gender and age did not appear to play a strong role in ratings of performance. Previous experience was clearly important and may reflect a number of aspects of the trainees’ functioning such as ease with the clinical environment based on previous experience, or maturity or what may be termed an internal resource available for them to call on. Experience of being a patient was

also potentially important but not well enough explored. A better measure would have been the actual degree of experience in therapy.

Aspects of the initial results were also understandable at face value; increased neuroticism made it more difficult for the trainee to function within the organisation, and the outgoing nature of extroversion as defined by Eysenck and Eysenck (1991) may have made it more difficult to attend to delicate aspects of clinical work such as formulation in learning difficulties. Furthermore, the weak negative correlation between IQ and mean capacity to formulate, suggesting that formulation of a case was not just an intellectual exercise.

The results with respect to the attachment representational system tended to show a tendency towards attachment security being beneficial for performance. Attachment security was associated with higher ratings in areas that require more clinically oriented skills such as overall manner with patients, interviewing skills and self appraisal whilst insecurity was associated with aspects of clinical work that may involve a relationship at one step removed such as teaching. These results were substantiated by the comparison between secure and dismissing trainees. It was unfortunate that both limitations of sample size and distribution of classifications, in there being only a very small number of trainees who were classified as preoccupied, did not allow for a more substantive three way analysis.

The capacity to formulate a case was initially most predictive of attachment security and, when considering the requirements of formulating, this also makes some intuitive sense but is clearly a condensed picture. However, it was also clear that there was no overarching notion that secure trainees are rated more highly than insecure trainees in general and at first inspection, a classificatory approach to attachment functioning indicated that it may not be relevant to working with either child and family or learning disability patient populations. This was confirmed by the factor analytic approach adopted which indicated a number of correlations between different AAI scales and aspects of clinical work although these were sparser for the child and family and learning disability placements.

The results did suggest however, that aspects of the attachment system associated with security were important in some aspects of functioning. In their first placement, trainees who recalled their mothers as loving and whose descriptions of relationships did not contain much derogation were more able to use supervision. Similarly, those trainees with a greater coherency of mind, and reflective self function, which colloquially is linked to the capacity to 'think', and did not idealise relationships or split off aspects of their thoughts were better at assessment skills. The lower the saliency of internal representations of unresolved trauma and the less derogation and neglect of the trainees model of relationships contained, the better was their manner with patients. It was interesting to note that for the first placement, recognised to be highly stressful (Cushway, 1992), professional behaviour was inversely linked to coherency. The more the trainee could make sense of his/her situation, the less they were able to behave in a manner deemed professional. This may be an indication of a response to the working environment or nature of the training with which the trainee is involved.

As stated previously, results with child and family work quite surprising in that the absence of correlations apart from the Work of Assessment in which again aspects of security correlated with higher ratings. Fewer correlations were also found with the learning difficulties placement although those that were found were again understandable in that greater capacity for the clinical work itself was enhanced by the trainee's internal relationships not being dominated by aspects such as rejection, pressure to achieve and idealisation, all of which are highly relevant to that particular patient group, and all of which that patient group must experience quite highly.

The factor analysis of mean ratings supported the notion of clinical work itself being enhanced by an internal loving relationship, and that the use of supervision is enhanced by higher coherence of mind, reflective self functioning and internal working models of relationships which have lower levels of pressure to achieve from the internalised object. This is contrasted with aspects of work such as teaching in which, the absence of viewing the relationship with the other as

dominated by rejection allows for greater rated teaching ability. This is further supported by the comparison of 'Excellent' and 'Satisfactory' trainees, which suggested that excellent trainees had an internal representation of mothers as more loving. The initial factor analysis did appear to emphasise qualities more positively associated with security, such as the representation of relationships as loving. The second factor analysis tended to lay emphasis on the absence of qualities such as rejection, neglect, current anger and unresolved trauma although coherency was still related to use of supervision.

It was interesting to note that the factors of Persistence in Adult Mental Health did not correlate with any scale of the AAI and that this was also true of Dedication in Learning Difficulties. This may be explained by an understanding of persistence as not an essentially new factor and calling upon qualities that have not been accounted for previously. Consequently, in a factor analysis that assumes that factors are orthogonal and therefore independent of each other, persistence and dedication may represent what remains when all other factors have been accounted for and may therefore not correlate with scales of the AAI.

Additionally, the place of trauma in relation to successful training was potentially conflicting. Unresolved trauma was negatively correlated with Use of Supervision in the first factor analysis and to Professionalism in the second factor analysis. This is understandable in that such trauma would be represented as disorganised states (Lyons-Ruth & Jacobvitz, 1999) and would consequently make for vulnerability in managing the myriad of aspects of professional work. On the other hand, the overall ratings of trainees noted that Excellent trainees had a higher score on unresolved trauma than did satisfactory trainees. This is consistent with the literature, which suggests that some degree of trauma is a requirement for psychological work (Kappelle, 1996).

The second factor analysis tended to refine and strengthen the associations identified in the first factor analysis. However, controlling for personality and demographic factors in this second factor analysis, led to some associations

disappearing, e.g. that of the Use of Supervision with Coherence when controlling for previous experience and Neuroticism. Nevertheless, other associations emerged such as that between Use of Supervision and Reflective Functioning.

Whilst the Good Therapist Questionnaire was not a rating of performance, it was included in the current study in an attempt to assess the degree of correlation between the quality of a trainee and the self reported behaviour that the trainee consciously stated would be aimed for. The results indicated that Excellent and Satisfactory trainees could not be distinguished on the basis of how they stated they would behave towards a patient. The results did suggest that insecure trainees tended to favour cognitive models of therapy whilst secure trainees indicated did not appear to have opted for one specific paradigm.

Overall the results suggest four main points. Firstly, and broadly speaking, attachment can be seen to make a contribution to clinically rated performance independent of personality traits that are known to have significant genetic underpinnings/determinants. Secondly, there are some instances where the association with attachment ratings are reduced or disappear when personality factors are controlled for. These instances can be interpreted in two ways. Personality variables, e.g. extroversion, may be viewed as determining both an individual's rating of clinical performance e.g., response to supervision and ratings of their attachment representation system e.g., coherence. Alternatively, neuroticism influences attachment that in its turn determines performance in clinical supervision. Thirdly, some associations emerge when these personality traits are controlled for. This indicates that the personality variable had suppressed an underlying association with attachment. Therefore there could be two underlying determinants of the clinical variable, for example, either the trainee is extroverted and therefore more accessible by the supervisor or the trainee has underlying reflective capacity. The current study would not be able to tease out these two factors and it is most probable that attachment alongside personality both influence clinical performance. Fourthly, the results would suggest that whilst attachment security as a whole would be favourable to the trainee, such classification does not

guarantee successful training. A more accurate description would be that different aspects of the attachment representational system appear better or less suited to different aspects of working as a clinical psychologist. This finding would be very much in keeping with the identified importance of the individual therapist (Lambert & Okiishi, 1997).

This study was certainly exploratory in nature and the results must be considered as such, and especially so given that it is the first study of its kind. Unfortunately, the sample size was small, precluding a 3-way analysis of attachment classification and the number of statistical procedures very large. Consequently, a number of these results may have occurred by chance and this would be even more influential when the majority of correlations have tended to be moderate at best. Furthermore, the ratio of items to factors in all the factor analyses completed was low, ranging from 2.2 to 3.66. No factor analysis reached the ideal ratio of 4:1 (Prof Jon Allen, Personal Communication) and consequently the nature of the factors themselves must be viewed as exploratory. It should also be noted that the ratings of performance were used with no knowledge of the nature or attachment functioning of the supervisor/rater. No account could therefore be made for this factor. Future replications would perhaps be focussed on particular placements in which both supervisor and trainee completed identical measures allowing for examination of the 'fit' between them.

CHAPTER 9. THE RELATIONSHIP BETWEEN ATTACHMENT STATUS, CAREER CHOICE AND DIFFICULTIES IN CLINICAL WORK: A PILOT PROSPECTIVE STUDY.

9.0 Introduction.

There have been very few empirical studies linking therapists' attachment organisation aspects of professional working life even though there is an increasing qualitative literature on the area e.g., Slade (1999). Dozier, Cue and Barnett (1994) suggested that security in the therapist increased their sensitivity towards the dependency needs of their patients, made them less vulnerable to strong countertransference reactions, and more able to respond to their patients at greater psychological depth rather than at the surface manifest need. Tyrrell et al (1999) reported that patient and case manager attachment states of mind interacted in predicting the working alliance and client functioning.

In a unique study of its kind, Leiper and Casares (2000) reported a cross-sectional study in which they used questionnaire measures of attachment to examine the association between security of attachment organisation and aspects of professional working life in a sample of 196 clinical psychologists. They reported that psychologists who were secure with regard attachment organisation experienced less difficulty in their work than insecurely organised colleagues and located their difficulties less within themselves or their working environment. Furthermore, psychologists classified as secure felt more supported at their place of work, and felt that their working lives interfered less with their personal lives. Interestingly, there was no significant difference in terms of preferred therapeutic approach although fewer insecure psychologists had experienced personal therapy.

The findings presented in Chapter 8 suggested that aspects of the attachment system were associated with performance whilst training and that security of attachment tended to be associated with stronger clinical skills. Simultaneously, higher degrees

of trauma were noted in the most highly rated trainees and the results indicated that personality variables were also associated with some aspects of performance.

No studies could be found in which attachment status whilst training was prospectively linked to the aspects of professional life noted by Leiper and Casares (2000). Furthermore, measures of personality functioning were not included in Leiper and Casares' study and the results obtained thus far would suggest that this was an important omission. Consequently, the current study looked at the association between attachment organisation whilst completing a clinical psychology training and subsequent aspects of professional life such as satisfaction and experienced difficulties in clinical work. In doing so, it also included examination of the same association with personality variables.

9.1 Methodology.

9.1.1 Design.

This prospective study used a mixed design to assess whether aspects of a clinical psychologists' attachment functioning during training predicted aspects of the professional work following qualification.

9.1.2 Sample.

Each subject comprising the sample described in Chapter 8 was re-contacted post qualification. Four subjects failed to respond to being contacted and a further four had not worked at all as clinical psychologists once they had qualified. Of these, three had immediately had families and the third pursued a business career unassociated with clinical work. One subject was not traceable and one subject had died. This left a total sample of 31, a response rate of 77.5%.

The sample comprised five men and twenty-six women and the mean age was 33.48 years (sd= 4.5). The mean length of time since qualification was 6.36 years (sd = 1.23).

The vast majority of subjects (87.1%) had completed a first degree prior to clinical training and no other academic qualification. Two subjects (6.5%) had completed a master's degree prior to training and a further two subjects (6.5%) had completed a Doctorate prior to training. Twelve subjects (39.7%) had had one year or less relevant experience prior to training and the remaining nineteen subjects (60.3%) had had over one years relevant experience prior to training.

9.1.3 Measures and Procedure.

The questionnaire used within this study was based upon that used by Leiper and Casares (2000). It comprised of three sections;

(i) Work orientation. This section consisted of questions on speciality, primary role, therapeutic model most often used, preferred mode of working (e.g., with the individual or with the family or staff) and preferred way of working (e.g., alone or with another therapist). Each question was categorical and required the respondent to choose one response.

(ii) Current therapeutic work. This comprised two parts assessing the degree of reward the psychologist felt with respect to the level of disturbance in patients, and the subjectively experienced current difficulties in clinical work.

Participants were asked to rate on a scale of 1-5 (1= not at all rewarding to 5=extremely rewarding) how rewarding they found it to work with clients who were mildly, moderately and severely disturbed. This question was adapted from the Common Core Questionnaire used in an international study on the development of psychotherapists (Orlinsky et al, 1999).

Current difficulties in therapeutic practice were measured using a scale also taken from the Common Core Questionnaire (Orlinsky et al, 1999). It consisted of 21 questions relating to current difficulties in therapeutic practice. Subjects were required to rate the frequency with which they experienced each difficulty on a six point likert (0= never, 5= very often). A total difficulty score was obtained by the summing of all ratings. Additionally, three subscales scores were calculated with regard three different sources of difficulty, the patient, the therapist, and external circumstances. Difficulties within the patient focussed on the therapist's experience on feeling alienated from his/her patient, or frustrated in their endeavours. Difficulties with the therapist had an experiential focus on feelings of being not equal to the therapeutic challenge. Difficulties in external circumstances focussed on moral, ethical and/or existential dilemmas. These scales had very high face validity and were reliable with reported Chronbach alpha's ranging between .67 and .77. Intercorrelations between the scales ranged between .55 and .58 suggesting that the scales were related to each other but also independent of each other (Davis, 1995). Furthermore, the degree of reward in working with different levels of disturbance were also taken from the Common Core Questionnaire and asked the subject to rate on a six point scale the degree to which they received satisfaction from working with mildly, moderately and severely disturbed patients. A short definition of degree of disturbance was provided for each statement.

Aspects such as the amount of overtime completed by psychologists, degree of perceived support at work, the extent to which work interfered with personal life, and degree of self-perceived competency and satisfaction were all measured using individual five point scales. A copy of the complete questionnaire is available in Appendix 1.

Available data on subjects included the Eysenck Personality Scales, National Adult Reading Test, and Adult Attachment Interview, which were completed by this sample as described in detail in Chapter 8.

9.2 Results.

Experience of Therapy.

Eighteen subjects (58.1%) had entered formal psychotherapy and of the remaining thirteen subjects, only one stated that he/she had never considered having psychotherapy. Of those who had entered psychotherapy, twelve described this as Psychodynamic in orientation, one each as Cognitive, Humanistic, and Jungian, and three described the therapy as eclectic or 'integrative'. The mean number of hours spent in psychotherapy was 180.7 although the range was considerable from the minimum being 8 hours to the maximum being 1144 hours.

Whether the psychologist had experienced any form of psychotherapy did not appear to be associated with any other measure including categorical attachment status. A Chi Sq analysis between having had therapy and a two-way classification of attachment did not reach statistical significance. Furthermore there was no difference between these two groups on any individual scale of the AAI. Additionally, using the Mann Whitney U test, no association was noted between attachment classification and the number of hours in therapy.

The number of hours in therapy did however correlate significantly with the neuroticism scale of the EPS. Controlling for this in subsequent analyses did not alter the previous result although, a significant correlation was noted with the Mother Rejecting scale of the AAI [$r_{(31)} = .45, p < .01$] and with the Mother Neglecting Scale [$r_{(31)} = .84, p < .001$].

Main Area of Work and Primary Role.

Eleven subjects (35.5%) reported working in Adult Mental Health, fourteen subjects (45.2%) reported working in Child and Family services reported and two subjects (6.5%) reported working in each of Learning Disabilities, Older Adult services, and Forensic. Twenty-six subjects (83.9%) reported that they worked as

clinical practitioners and twenty-eight subjects (90.3%) reported that they worked with their preferred client group. Of the remaining three subjects, two stated their preference for work in Adult Mental Health and one for Forensic.

A recoding of subject patient population into two groups based upon whether the patient population was principally adult or principally child based, showed no association with a dichotomous classification of attachment [Fisher's Exact Test, $\chi^2_{(31)} = .33, ns$] and these two groups showed no significant difference the EPS scales or the majority of the AAI scales except for the unresolved trauma scale. Those psychologists working in child based services had a mean score of unresolved trauma of 1.25 (sd = .55) whilst those working in adult based services reported a mean score of 1.0 (sd = 0). This difference approached significance [$t_{(1,29)} = -2.03, p < .06$].

Theoretical Approach Used, View of Psychological Functioning and Mode of Work.

A spread of theoretical approaches was noted. Eight subjects (25.8%) reported using a cognitive approach whilst four subjects (12.9%) each reported using a psychodynamic and systemic approach respectively. Five subjects (16.1%) reported using a behavioural approach and ten subjects (32.2%) reported using an eclectic approach. Analysis of the approaches used required the collapsing of categories together given the small sample size. This was completed on the basis of the degree to which an orientation recognised the presence of a dynamic unconscious. Consequently, psychodynamic and humanistic approaches were grouped together and all other approaches grouped together. The subsequent comparison of secure and insecure psychologists revealed no significant result.

When asked to note their predominant view of psychological functioning, subjects responses differed to reported approaches used. Ten subjects (32.3%) noted having a psychodynamic view whilst nine subjects (29%) had a systemic view. Four subjects (12.9%) had a behavioural view, two subjects (6.5%) a cognitive view and

six subjects (19.4%) noted their predominant view as eclectic. In only ten cases (32.3%) was a subject's predominant view concordant with the theoretical approach they most often used. A similar collapsing of categories as described above produced ten subjects who favoured a psychodynamic approach and twenty-one subjects who did not. No significant association between attachment classification and view of psychological functioning was found. However, in considering the individual scales of the AAI, psychologists who had higher scores on unresolved loss when training, tended to favour a non-psychodynamic orientation in their professional work. The mean unresolved loss score for these psychologists was 1.62 (sd=1.02) whilst that of psychologists favouring a psychodynamic approach was 1.05 (sd=.15). This difference was significant [$t_{(1,29)} = -2.49, p < .02$] and confirmed through use of the Mann Whitney U test given the small sample size involved.

Fifteen subjects (48.4%) reported that their preferred mode of work was with individual patients whilst another fifteen subjects (48.4%) reported preferring working in a group modality whether this be with the family or a patient group. The one remaining psychologist reported preferring to work through staff. No significant association between preferred mode of work and any of the measures used was noted.

Seventeen subjects (54.8%) reported that their preferred way of working was alone. Of the remaining fourteen subjects, eleven (35.5%) preferred working with one other therapist and the remaining three (9.7%) preferred a combination of these two modes. No significant association between preferred mode of work and any of the measures used was noted.

Level of difficulty experienced.

The mean level of difficulty reported in the therapist was 10.57 (sd= 3.25) and that in the patient was 12.31 (sd= 3.87). The mean level of difficulty attributed to the environment was 9.71 (sd =3.63). The results were compared to the mean level of

difficulty reported by Orlinsky et al (1999) and were not significant on any of the three scales. The current subjects were therefore consistent in terms of their level of difficulty with Orlinsky et al's larger sample.

Level of difficulty in the external environment was noted to correlate positively with the Psychoticism scale of the EPS [$r_{(31)} = .51, p < .003$]. This was therefore controlled for in subsequent analysis. A repeated measures indicated that there was a significant difference between the mean levels of difficulty [$F_{(1,28)} = 10.50, p < .003$] but that attachment status as measured between secure and insecure was not significant [$F_{(1,28)} = .67, ns$].

Controlling for EPS Psychoticism, level of external difficulty inversely correlated with the Lack of Memory scale in the AAI [$r_{(31)} = -.36, p < .05$]. Reported difficulty that was located in the patient was also noted to inversely correlate with the Lack of Memory scale [$r_{(31)} = -.46, p < .01$] and Total difficulty also correlated with the same AAI scale [$r_{(31)} = -.46, p < .01$].

Degree of Overtime Reported.

The majority of psychologists, twenty-one subjects (67.7%) reported that they completed less than 5 hours overtime per week. Eight subjects (25.8%) reported that they completed between five and ten hours of overtime per week whilst two subjects (6.5%) reported completing between 10 and twenty hours per week.

Overtime completed did not correlate with any measure other than two scales of the AAI. A significant correlation was noted with the Fear of Loss scale [$r_{(31)} = .41, p < .02$] and with the Trauma scale [$r_{(31)} = .365, p < .04$].

Reward and Satisfaction at Work

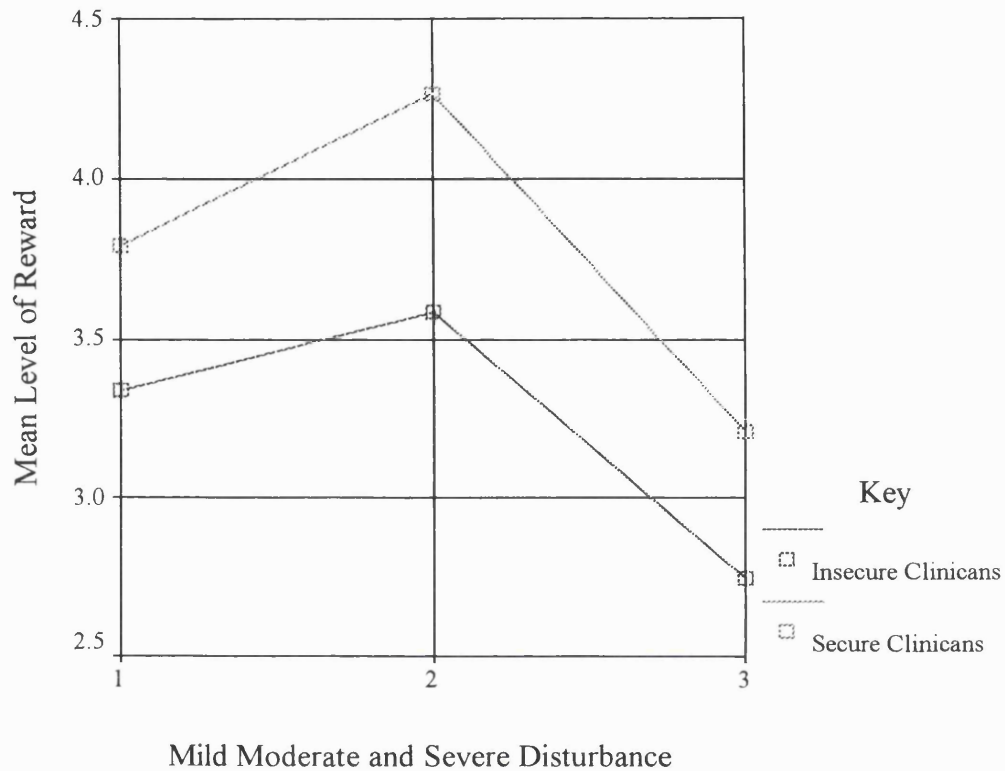
The majority of psychologists (83.9%) reported that they viewed their primary role as that of a clinical practitioner. One subject reported himself to be a consultant and the remaining four viewed themselves as managers.

The degree of reward experienced by psychologists in the work place with respect their patients was assessed as a function of their perception of the level of disturbance of the patients for whom they carried some clinical responsibility. The level of self reported reward in working with either mildly, moderately or severely disturbed patients did not correlate with any demographic variable.

A repeated measures ANOVA was used to compare secure and insecure psychologists on level of reward. The results indicated that whilst greatest satisfaction was experienced with moderately disturbed patients, at all levels of disturbance, secure psychologists experienced a greater level of reward than insecure psychologists [$F_{(1,29)} = 4.75, p < .04$].

This result is illustrated graphically in Figure 9.1.

Figure 9.1. Mean level of Reward for Psychologist by Level of Patient Disturbance for Secure and Insecure Clinical Psychologists.



Correlation with the AAI scales indicated only two significant correlations. Level of reward in working with the moderately disturbed inversely correlated with Current Anger with Mother [$r_{(31)} = -.39, p < .03$] and reward in working with the severely disturbed correlated with the Fear of Loss scale [$r_{(31)} = .43, p < .02$].

Psychologist ratings of perceived level of support in the work place did not correlate with any demographic variable or measure of personality trait. The mean level of support reported by insecure psychologists was 4.08 (sd = 1.08) whilst that by secure psychologists was slightly lower at 3.68 (sd = .94). This difference was not significant.

Self ratings of support within the working environment only showed an inverse correlation with the Rejecting father scale of the AAI [$r_{(31)} = -.38, p < .04$].

The extent to which the subject's professional work was rated as interfering with their personal life was correlated with the Psychoticism scale of the EPS [$r_{(31)} = .55, p < .01$]. The mean for secure psychologists was 2.58 (sd = 1.26) whilst that for insecure psychologists was 2.0 (sd = .60). This difference was not significant [$F_{(1, 28)} = .86, ns$]. This scale did not correlate significantly with any scale of the AAI.

Psychologists rating of overall satisfaction at work inversely correlated with the Psychoticism scale of the EPS [$r_{(31)} = -.41, p < .02$]. The mean for secure psychologists was 3.84 (sd = .89) whilst that for insecure psychologists was 3.67 (sd = .98). This difference was also not significant [$F_{(1, 28)} = 1.31, ns$].

Self reported Overall competency did not correlate with any other measure. Secure and Insecure psychologists had virtually identical ratings and there was no significant difference between them. The mean for secure psychologists was 3.68 (sd = .49) whilst that for insecure psychologists was 3.66 (sd = .44). This scale did not correlate significantly with any scale of the AAI.

9.3 Discussion.

This study was considered a natural development from the assessment of the relationship between attachment status and success in training. Taking a prospective approach, the current study examined the relationship between attachment status measured at training and subsequent aspects of the psychologists professional life. This was possible given the strong data on the AAI's reliability (van IJzendoorn, 1997) and predictive validity (Pederson, 1998). No other study using the AAI as a predictor variable for clinical psychologists' self-rated performance at work could be located and this study was therefore undertaken as a pilot study. The results would be best considered as indicative of potentially fruitful areas for future studies.

The results indicated that both attachment classifications and separate scales of the AAI were able to predict aspects of trainees' future experience of professional work but were not the only predictive factor. Attachment classification did not predict whether the trainee would have therapy, the orientation of therapy, or the amount of therapy. However, in this predominantly female population, psychologists who represented their mother as rejecting and neglecting whilst they were training were highly likely to have entered therapy by the sixth year of their professional lives. Attachment classification per se did not predict which patient population would be chosen although the degree of unresolved trauma within the psychologist may be linked with a choice between adult focussed or child based services.

The current data identified the degree of unresolved loss as measured whilst training was subsequently associated with a possible tendency against a psychodynamic orientation in working practice. This was the exact opposite of the data presented by Leiper and Casares (2000). This difference may be accounted for in two ways. Firstly, Leiper and Casares asked a different question, one relating to early loss experienced, which is therefore by definition consciously known. Secondly, the measures used to measure attachment. Leiper and Casares used only self-report measures e.g. the Adult Reciprocal Attachment Questionnaire (West & Sheldon-Keller, 1994) in which the subject completes questionnaire items related to attachment. It is a measure in which the subject's responses are assumed to be face valid and the final classification consistent with conscious response. The analysis of the AAI however, focuses upon the manner of the response and its relationship to the content, rather than focussing on content alone. It is a significantly more substantial measure, which does not rely on the subject to be consciously aware of the unresolved nature of their loss or even the loss itself. Consequently, and almost by definition, the nature of unresolved loss cannot be consciously reported and would not be picked up by the measures used by Leiper and Casares. That unresolved loss appears to predict against a psychodynamic view was perfectly in keeping with the results suggesting that the greatest overtime was completed by those psychologists with the highest fear of losing their psychic objects and were also unresolved with regard some aspect of their experience. The picture that

emerges is that of psychologists who have higher scores on scales of the AAI usually associated with insecurity, tend to work harder than their more secure colleagues, not necessarily through dedication but because they have to work harder to maintain their own sense of felt security. This was also fully consistent with by the finding that those psychologists with higher Lack of Memory scales scores on the AAI also experienced greater levels of difficulty at work. Consequently, whilst attachment classification per se do not appear to predict levels of reported difficulty, psychologists who had higher scores on scales associated with insecurity whilst training were also found to those that had to work longer in their professional lives. There is some research evidence which suggests that, from a more clinical perspective, insecure therapists appear to be more vulnerable to becoming involved in enactments with their patients (Fonagy, 2002).

The results obtained were also consistent with those obtained in studying the role of attachment and personality factors in successful training (Chapter 8). Both neuroticism and psychoticism, when conceptualised as personality traits (Eysenck & Eysenck, 1991) and measured whilst the psychologist was in training were seen to be associated with the amount of therapy the psychologist had and the degree of difficulty experienced at work. Such a finding does make intuitive sense if psychoticism is considered as a measure of tough mindedness and rigidity as Eysenck and Eysenck (1991) suggested. The more tough minded individual would experience far greater difficulty in adapting to the changing nature of the workplace. Similarly, neuroticism conceptualised as high degrees of worry and anxiety, would inevitably spend more time in therapy. The results would therefore once again suggest that both personality factors and attachment organisation have their independent contributions and that there could be two underlying determinants of the trainee's future experience as a professional psychologist. The current study would not be able to tease out these two factors and it is most probable that attachment alongside personality both influence clinical performance.

Interestingly however, attachment organisation appeared to independently predict the level of reward experienced by the psychologist across all levels of patient

disturbance. Secure trainee psychologists reported, six years post qualification, significantly higher levels of reward in working with patients than did trainees who were rated as insecure when training. This was particularly interesting given that attachment security per se was not associated with overall higher degrees of success in training but would be consistent with Fonagy's (2002) proposition that secure functioning supports the development of competence and enable the psychologist to mentalise his/her contact with patients and therefore be less at risk of becoming involved in enactments.

Finally, it should be reiterated that this was a pilot study given the small number of subjects within the sample. Its results did suggest that once again individuals whose attachment organisation characterised by security are more likely to be able to enjoy their work to a higher degree and not have to complete excessive amounts of overtime. This study would therefore suggest the value of repeating the study with a larger sample and at a more frequent follow-up rate so as to chart the nature and influence of attachment organisation on professional lives.

CHAPTER 10. GENERAL DISCUSSION, CONCLUSIONS, AND FUTURE DIRECTONS.

10.0 Introduction.

The current thesis explored the selection and training of psychological therapists through the lens of attachment theory and its links with other psychoanalytic theories. The thesis discovered some significant findings, which will be discussed in reference to the hypotheses stated in Chapter 5 and the themes identified in relation to the selection of therapists namely, a list of criterion, the balance of normality and psychopathology, and the degree of similarity between applicant and assessor, the 'like me' phenomenon. The potential of the measurement of attachment organisation as a model of functioning to be used in the selection process is then discussed. The chapter is subsequently brought a close with a discussion of the limitations of the studies and concludes with suggestions for future studies.

Overall, the results echoed both the findings and conclusions of much of the existing literature and in relations to Hypotheses 1 and 3. A range of demographic and psychometric measures were used which paralleled Fisk's (1977) taxonomy of therapist variables. Results using these measures all but singularly failed to differentiate between successful and unsuccessful applicants and to a lesser extent, the degree of success in training. The results obtained using these measures were however fully consistent with the previous findings on selection of therapists (Bird, 1968) and strongly echoed the conclusion of over forty years ago,

"At present we question whether it is possible with any certainty to say more than the following; that a person who seems analysable, says he wants to be an analyst, and has accomplished in life enough so far to give promise that he can carry out what he intends to do or wants to be, should be acceptable" (The Study Commission on the evaluation of applicants for Psychoanalytic Training, 1969).

In doing so, the results were further evidence of what has been described as the 'fault line' (Fonagy, 2000) between clinical practice and empirical research.

However, the psychometric measures employed did lend further support to the increasing recognition of the variability and therefore importance of the individual psychotherapist that has been previously identified (Lambert & Oshikii, 1997). Both in terms of the range of cognitive styles, theoretical orientations, and degree of symptomatology, it cannot be argued that therapists are a uniform group. More specifically, the results indicated that experienced therapists and newly selected therapists reported a range of symptomatology that was in cases clinically significant and, by virtue of the questions asked, chronic in nature. This therefore lent further support to the research noting that therapists are mistakenly viewed as having baseline good health (Sherman, 1996) and may be in some respects regarded as 'wounded healers' (Holmes, 1991).

The present studies were original in that to date, no study has examined selection for training from an attachment perspective or attempted to examine the fit between applicant and assessor. The exploration of the relationship between attachment functioning and potentially 'good' therapists was then extended to consider the relationship between attachment organisation and success in clinical training. The natural extension of this study was to examine whether attachment organisation was a predictor variable with regard future aspects of professional lives. Whilst a few recent studies had used cross-sectional designs to examine the link between attachment organisation and professional work, no prospective studies in this area could be located. The discussion of the results is considered through reference to the broad themes identified in the history of the selection process; the notion of criteria, the need for normality versus psychopathology, and the 'like me' phenomenon.

10.1 The Criterion Approach to Selection.

The notion of specific criteria upon which selection may be made relates to Hypothesis 1 as stated in Section 5.8. The scales of the Adult Attachment Interview (AAI; Main et al, 1985) may form a number of criteria by which selection or the definition of a good therapist may occur. For example, Heinman's (1954) absence of denial may correspond to lack of memory, capacity to maintain relationships may correspond to the loving, rejecting and derogating scales whilst 'psychological flair' may correspond to Reflective Functioning. Other authors also describe qualities that may correspond with secure functioning such as Eisendorfer's (1959) capacity for articulate communication may correspond to measures of coherence.

From the perspective of regarding attachment organisation and classification as a combination of a list of criterion, i.e. the scales of the AAI, the overall conclusion has to be one of mixed results. Only one scale (Father Loving) predicted selection although two different scales were related to assessors' choice of candidates. Consequently, in considering assessors as representing experienced, and by virtue of their role in being selectors, successful therapists, different criteria appear to be important. For assessors, representations of their mothers which were not pressuring to achieve, and representations of their fathers which were idealised appeared to be definitive of their biases towards choice of candidates. Consequently, the scales that were associated with selection were different to those that correlated with the biases of experienced therapists.

Within the milieu of the clinical setting, aspects of the attachment organisation were differentially associated with different aspects of professional work. A representation of mother as loving and not pressuring to achieve were all linked to an increased capacity to use supervision. Coherence of mind and reflective function were associated with assessment skills when working with adults but not when working with children or those with a learning difficulty. Analysis of mean ratings, spanning the whole of training indicated that use of supervision was more strongly associated with the degree of coherence and reflective functioning and not

associated with the representation of parents. Additionally, supervisor rated capacity to teach was only negatively correlated with a representation of mother as rejecting. So that, for the therapist as teacher, the quality of teaching does not appear to depend on the representation of relationships as loving, nor on reflective functioning or even coherence, but simply on the absence of representations of relationships as dominated by rejection. Furthermore, the degree of unresolved trauma was associated with excellence in trainees and unresolved trauma and loss appeared predictive of how hard the therapist has to work and choice of patient population.

Consequently, the results do in part meet some criteria stated in the literature such as Kohut's (1968) notion of curiosity being driven by love rather than by the wish to destroy or belittle. These same factors are considered to maximise the therapeutic alliance (Ackerman & Hilsenroth, 2001) and may echo Rothenberg's (1987) division of empathy into self and object representation, intrapsychic operations, and cognition. Simultaneously, they provide some support for Knight's (1953) near insistence on some degree of psychopathology as a requirement for successful therapists. However, even given the ease with which attachment theory can be translated into observations and hypotheses regarding object relations, there does not appear to be an overarching picture. Therefore there is only limited support for Hypotheses 2 and 3. Different aspects of the attachment representational system, whilst having similarities with qualitatively described desired qualities, appear to map selectively onto different aspects of clinical work and do so at different times with different patient populations, and there was no true consistency between applicant and assessor.

Whilst the current findings produced many associations that were intuitively correct and matched the literature, isolating scales of the AAI to use as fixed criteria would not be recommended. This notion of specific criteria is possible but would have to be tightly associated with highly defined working roles to a degree that becomes unfeasible and probably incorrect in terms of the flexibility required in the consultation room.

10.2 Normality and Psychopathology.

The degree of the applicant's normality as a basis for selection may be made relates to Hypothesis 2 as stated in Section 5.8. The degree of normality or psychopathology within the person of the therapist has been considered an important factor from the clinical perspective although views differ as to the necessity for health (e.g., Freud, 1937) and for some degree of neurosis or more severe psychopathology (Knight, 1953). The same issue has subsequently become transformed into a matter of social concern vis-à-vis the standing of the psychotherapeutic professions (Bird, 1968; Kapelle, 1996). The psychological health of psychotherapists has been an assumed baseline in much psychotherapeutic research (Guy & Liaboe, 1986) although there is increasing empirical evidence that the individuals who seek to make a career in the psychotherapeutic field have suffered significant psychological difficulties in their lives (Deutsch, 1985), or that the nature of the work itself can be iatrogenic (Rabin et al, 1999; Sherman, 1996). The results obtained from the current studies would be consistent with both the views arising from the clinical literature and could provide superior research baselines.

The results indicated that subjects, whether applicants, assessors, or clinical psychologists, did have either significant acute or chronic levels of difficulties. This finding is in keeping with both clinical literature (Greenacre 1960), and empirical literature (Wiggins & Giles, 1984). It was in addition consistent with recent findings, which indicated that 60% of trauma therapists had a history of trauma and up to one third of therapists report a history of childhood sexual abuse (Fonagy, 2002).

On the whole, the results point towards the value of normality as represented by attachment security and therefore give limited support to Hypotheses 1 and 2. In terms of selection, there were some indications of a tendency towards security with all differences between accepted and rejected candidates being in the expected direction if security was the criteria for selection. Furthermore, there was broad

consistency across populations that secure therapists are those who are selected and then perform better than insecure therapists. Prospectively, attachment security was associated with greater sense of reward across all levels of patient disturbance, and secure therapists experienced their working lives as intruding less into their personal lives and had to complete less overtime.

These findings were fully consistent with Slade's (1999) qualitative description and with Fonagy's (2002) suggestion that a secure attachment history supports the development of competence and in the interactive moment with a patient, supports the capacity to act appropriately, i.e., work towards mentalisation. The clinical situation was described as one in which developmental competence in childhood was a function of both attachment and arousal which both affected overall capacities to mentalise. These same factors subsequently affect current performance and mentalisation and the clinical situation is one of the interaction of mentalising functions, each participant attempting to make sense of their experience whilst in the presence of the other and the therapist attempting to use his/her experience to make sense of that of the patient. These results therefore also echo much earlier findings of 'personality integration' in the therapist being associated with lower rates of premature termination (Anchor, 1971) but are able to substantiate their findings with theoretically linked definitions of classifications rather than having to use face valid but unclear terms.

On the other hand, the results also highlight a place for psychopathology. Unresolved trauma was higher in 'excellent' trainees and this would be consistent with Knight's (1953) view of psychic disturbance enabling the creative spirit required in psychotherapeutic work. In support of this lies the statistic that just under 30% of assessors were classified as insecure, and one was classified as predominantly disorganised. Furthermore, the motivating force behind successful training appeared to be a wish to repair a damaged and loved object; father in a predominantly female subject population. Unresolved loss was also noted to influence therapists' choice of orientation and unresolved trauma the choice of patient population. This aspect of the data therefore supports Holmes' (1991)

metaphor of the 'wounded healer', borrowed from the Greek myth of Chiron, in which the wounded healer is employed as a metaphor for the duality that exists in all individuals. In Holmes' (1991) view, the therapist's acknowledgement of his/her psychopathology therefore constitutes a major source of cure for the patient.

The findings therefore appear to empirically support the qualitative literature in tending to favour normality but do not do so globally, that is to say, selection purely on the basis of attachment security may miss some aspects of the individual which could contribute to the therapist development and career choice. Overall therefore, the results obtained would empirically support the literature but are not able to significantly advance the debate itself.

10.3 Similarity and the 'Like Me' Phenomenon.

The notion of similarity of 'fit' between applicant and assessor as a basis upon which selection may be made relates to Hypothesis 3 as stated in Section 5.8. In its purely qualitative form, the 'like me' experience is positively connoted under the quasi-logical argument that if the assessor can identify with and see themselves in the applicant, then the applicant will be able to progress through the training and qualify because the assessor has done the same. This experience has been described as the remnant of the search for instruments by which to select candidates for training in the absence of any formal measures (Bird, 1968). The empirical evidence produced was in part agreement with the like me phenomenon although not in terms of its positive connotation. The results therefore generally supported Hypothesis 1 but the nature of this support was not expected.

There were instances when the absolute similarity between assessor and applicant was associated with acceptance. The Mother Pressure to Achieve scale of the AAI was an example of this and important in that it was the precise quantum rather than directionality of the measure that was associated with acceptance. If both applicant and assessor had representations of their respective mothers that were identically pressuring to achieve, this would increase the applicant's probability of being

accepted. That applicant or assessor had the higher rating was not important, acceptance was dictated by the absolute difference. This would be consistent with the 'like me' phenomenon.

However, there were also instances when the profile of scores on both attachment and style questionnaires such as the Opinions about Psychological Problems (OPP; Barker et al, 1983, Pistrang & Barker, 1992) were in very high correlation. This differs from absolute similarity in that it may represent a situation of identical parallel functioning where there is scope for processes of identification. Consequently this could also be considered part of the 'like me' phenomenon. These instances universally were not associated with acceptance. Consequently, the correlations of profiles of scores may suggest a situation more akin to Kantrowitz's (1995) notion of similarity being a situation in which both assessor and applicant reflect each other's difficulties and consequently cannot work together in achieving a goal.

Kantrowitz's (1995) notion of similarity was further supported by the analysis of global categories of attachment. The data indicated that if both applicant and assessor were classified as insecure, the probability of acceptance was far reduced. This finding had striking similarity to Fisher and Crandell's (2001) description of insecure couple functioning. With successful application representing the goal towards which applicant and assessor are both working, the rigidity of patterns of relating in insecure-insecure pairings would imply that they cannot attune to each other and inevitably do not meet their goal.

The importance of this finding further lays in the fact that it stands independent of the attachment status of either applicant or assessor, but is the interaction between them that is the most important aspect. From this perspective, it is consistent not only with the psychoanalytic model, but also meets important research criteria. As Berzins (1977) stated,

“Regardless of the characteristics of therapists and patients considered separately, the interaction of these characteristics proves decisive for the process of outcomes of psychotherapy” (p222).

10.4 The Utility of Attachment Organisation as a Research Variable.

The selection of therapists has been hampered by the absence of both an appropriate psychometric tool based in a model of functioning that is not antithetical to psychoanalysis. The difficulty in selection has been one of prediction an activity to which psychoanalysis is not particularly well suited. From this perspective, attachment theory and the development of the AAI do have a contribution to make. The results obtained suggest that aspects of an individual's attachment representational system correlate with aspects of their professional lives and that these correlations can be meaningfully interpreted from an object relations perspective. Attachment classifications do seem to provide better conceptualisations of therapist style than were previously available given that they are reliable and may be less situationally dependent as were other measures (e.g., Hardy & Shapiro, 1985).

However, the results also suggested that there were aspects of individuals' functioning that were not available to interpretation through an attachment perspective. Factor analysis of clinical ratings indicated factors interpreted as persistence and dedication that did not relate in any way to the scales of the AAI. Whilst it is true that the factors were created orthogonally thus reducing the scales available for later factors, it may also be the case that the current analysis cannot account for these factors. This may be consistent with the findings that aspects of personality traits known to have a genetic loading also played a significant role in performance. This was particularly true of neuroticism. Furthermore, when personality traits were statistically controlled for, additional associations between performance and attachment organisations emerged. It was unclear whether any one personality trait influenced attachment functioning or vice versa and the current conclusion must be one of each having a determining role with regard overall

performance. The results also indicated that experienced therapists were very 'tough minded', scoring in some cases over two standard deviations above the mean on the Psychoticism scale of the Eysenck Personality Scales. Whilst this scale did not appear to strongly influence ratings of competency, it is noteworthy. Consequently, whilst attachment functioning appears to map onto different aspects of clinical work so too does personality. For this reason, it would be erroneous to ignore this latter variable.

10.5 Limitations of the Current Studies.

There is no doubt that the three most fundamental limitations of the reported studies concern the small sample sizes, the number of statistical procedures completed, and the need for replication. Several additional limitations are noteworthy.

Undoubtedly the studies on selection (Chapter 6, Studies 1 to 3 and Chapter 7) would have benefited greatly from much larger sample sizes, generated possibly by repeating the study over two cohorts of applicants or using more than one training organisation. The former possibility would have also meant that each assessor saw a greater number of applicants so that the statistical analysis would have been much more robust and not rely on each assessor interviewing a small number of applicants. A future study could address this by ensuring that each applicant is interviewed by more than one assessor and attachment measures are obtained for all involved. Subjects in the current studies participated following completion of the application procedure. Ethical considerations prevented measures on applicants being taken prior to the application process itself. In the current studies applicants knew the outcome of their application prior to their completion of the measures in the study. Whilst there is little to suggest this had an adverse effect on the data, a superior design would have had subjects complete the measures in-between their completing the application process and before they knew the result of their application. Furthermore, the ideal completion of some measures such as the Interview Report Form would have occurred very shortly following their actual interview note a few weeks later. Furthermore, whilst assessors were initially

interviewed regarding their views on candidate selection, and the Indicators of Acceptance Questionnaire thus devised, it would have been useful to create a more conceptually linked questionnaire which would have allowed the interview responses to be analysed with greater linkage to theory and therefore higher construct validity.

The studies concerning the training of therapists (Chapter 8) also had a number of limitations, which future studies could correct for. Firstly the sample was small and arose from different year groups in the training programme. Future studies would aim to follow whole year groups rather than a self-selected group from the student body. Furthermore, the current study had not obtained any data on students who had not participated in the study. Whilst the previous studies (Chapters 6 and 7) had managed to obtain data on non-participants and were then able to establish some ground upon which to generalise the results, the later studies only had data on the sample generated. A limitation therefore is that there were no placement rating data on the non-participant sample against which a comparison would have enabled a perspective on generalisation to be taken. Consequently the possibility remained that the sample generated differed from the general population on a variable unknown to the researcher. Whilst the measures used had strong reliability and related to aspects of functioning not expected to change, a superior design would have at least two points of measurement pre-training and shortly before qualification. The nature of the data on the clinical psychology trainees also had its limitations. Whilst the study has considered the importance of the fit between patient and therapist, the fit between trainee and supervisor would be of equal importance and warrants future investigation. The studies did not include any measures of the supervisors who completed the ratings and therefore could not account for any particular biases that may have been present. Whilst asking all supervisors to complete AAIs would be highly unrealistic, use of questionnaire measures of attachment would have provided data on the particular pairing involved or the possible fit between supervisor and trainee. The present study has to treat the ratings provided as utterly objective whereas this may not necessarily be the case. Additionally, whilst a measure of whether the trainee had had experience of being a

patient was taken, the study was limited in that there was no measure of the total amount, timing, or orientation of therapy the trainee had been involved in. It would have been advantageous to have such a measure. Furthermore whilst ratings were available for the compulsory placements, ratings for the specialist placements were not used given that the sample size and variety of specialist placements would make the data far too diverse and therefore not statistically viable. Ratings on specialist placement would have been useful to include given that these were placements that the trainee chose and the relationship between attachment organisation and performance on placement may have been much more acute. Furthermore, the study was further limited in that only one independent rater was used to rate trainees overall performance and a superior design would have included at least two raters.

Whilst the need to replicate the studies has been mentioned often, this need is further exacerbated by the fact that whilst sample sizes were small, the number of statistical tests used was vast. Even attempting to account of this through the use of procedures such as Bonferroni corrections on all Univariate analyses, it is highly likely that some of the significant results obtained are false positives. This only strengthens the case for replication.

10.6 Implications of Findings for Training and Selection.

The results obtained from these studies carried a number of implications for the training and selection of psychological therapists.

The findings were consistent with the available literature that self report measures were not predictive of acceptance. Consequently, any such measures used by the T.O. may be abandoned and use of such measures in the future may be abandoned. Whilst the Adult Attachment Interview may be the only measure at this time that may provide information useful to the task of selecting, it remains doubtful whether it is a feasible tool to use given the time required for its completion and rating. Similarly, the results indicated that the choice of candidates was predominantly

made on the basis of the personal interview and not on the basis of any other interview. For the T.O. and potentially for other training bodies, this implied that all procedures, other than the personal interview, may be abandoned. However, the results also indicated the reality of the risk of suitable candidates being turned away if they happened to be interviewed by an assessor who would be classified as insecure with regard to attachment. Consequently, the results would suggest that application procedures should include at least two individual interviews with different selectors so as to guard against the possibility of rejecting a suitable candidate.

The wide range of opinion amongst selectors with regard factors important in selection would suggest the need for a greater degree of debate and discussion amongst the group of selectors with regard factors they consider important in applicants.

The results also suggested that different aspects of clinicians functioning, in attachment terms, were differently suited to different aspects of professional work e.g. clinical or academic teaching, and to different patient groups. Clinicians classified as more dismissing for example, appeared to be better suited to teaching, whilst those classified as more coherent were potentially better able to engage in different aspects of clinical work itself. The results further suggested that much more attention be given to the match between clinician and supervisor, the relationship between them potentially having an influence upon the rating and experience of training.

The results also had potential implications for the retention of clinicians. Those classified as secure with respect to attachment appeared to be much happier in their work generally than those classified as insecure. This may imply that insecure clinicians may be more prone to 'burn out' than their secure colleagues given that they seem to have to work much harder and experience a lower level of satisfaction in their work.

Finally, the results suggested that the population of people who come into training tend to be white and approaching middle age. This may not reflect the patient population but would imply that the service provided may be perceived as not available to other sections of the population. Similarly, future studies may also focus upon the 'local' culture of the Training Organisation and attempt to arrive at a definition of this that would lend itself to empirical measures.

10.7 Future Directions.

Attachment theory and measures have been shown to be potentially highly relevant to the process of therapist selection and training. However, there is an overriding need to increasingly define the mapping of the different aspects of attachment organisation with an increasing definition of the clinical skills required to be a good therapist.

The literature available has stressed the importance of the individual therapist and the results of this thesis have not disconfirmed this finding. Future studies would be therefore be required to adopt research designs that take account of this and take measures of the therapist as well as the patient. Simultaneously, the selection and development of psychotherapists remains a neglected area and attachment measures provide some direction in providing reliable and valid but theoretically driven instruments. Consequently, future studies would be better placed to nest individual case studies of therapists working with particular patients, within a longitudinal framework for the development of these same therapists. Over time, this may provide increasingly sharp definitions of the clinical skills developed as 'experience' is gained and serve to make the whole process of selection less 'amateurish' (Bird, 1968).

10.8 Conclusions.

This thesis investigated the role of personality and attachment organisation in the selection and training of psychological therapists from a psychoanalytic perspective.

In doing so it provided empirical support for the qualitative conclusions identified in the literature but also expanded the dimensions of these conclusions so that they may be considered as both predicting success and failure in application. The present thesis represents the only known application of attachment theory to the question of therapist selection and one in which the fit between therapist and assessor and was addressed. In doing so and in its attention to the relationship between attachment organisation and training, it hopefully paves the way for future studies in this neglected area.

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NATIONAL ADULT READING TEST

Name of Patient..... Assessed By.....	Dept. Ref. No..... Date.....
Number of Errors	Full Scale IQ
Verbal IQ	Peformance IQ

CHORD	SUPERFLUOUS
ACHE	SIMILE
DEPOT	BANAL
AISLE	QUADRUPEd
BOUQUET	CELLIST
PSALM	FACADE
CAPON	ZEALOT
DENY	DRACHM
NAUSEA	AEON
DEBT	PLACEBO
COURTEOUS	ABSTEMIOUS
RAREFY	DETENTE
EQUIVOCAL	IDYLL
NAIVE	PUERPERAL
CATACOMB	AVER
GAOLED	GAUCHE
THYME	TOPIARY
HEIR	LEVIATHAN
RADIX	BEATIFY
ASSIGNATE	PRELATE
HIATUS	SIDEREAL
SUBTLE	DEMESNE
PROCREATE	SYNCOPE
GIST	LABILE
GOUGE	CAMPANILE

Age.....Sex.....

INSTRUCTIONS Please answer each question by putting a circle around the "YES" or the "NO" following the question. There are no right or wrong answers, and no trick questions. Work quickly and do not think too long about the exact meaning of the questions.

PLEASE REMEMBER TO ANSWER EACH QUESTION

1.	Do you have many different hobbies?.....	YES	NO
2.	Do you stop to think things over before doing anything?.....	YES	NO
3.	Does your mood often go up and down?.....	YES	NO
4.	Have you ever taken the praise for something you knew someone else had done?.....	YES	NO
5.	Do you take much notice of what people think?.....	YES	NO
6.	Are you a talkative person?.....	YES	NO
7.	Would being in debt worry you?.....	YES	NO
8.	Do you ever feel 'just miserable' for no reason?.....	YES	NO
9.	Do you ever give money to charities?.....	YES	NO
10.	Were you ever greedy by helping yourself to more than your share of anything?.....	YES	NO
11.	Are you rather lively?.....	YES	NO
12.	Would it upset you a lot to see a child or animal suffer?.....	YES	NO
13.	Do you often worry about things you should not have done or said?	YES	NO
14.	Do you dislike people who don't know how to behave themselves?....	YES	NO
15.	If you say you will do something, do you always keep your promise no matter how inconvenient it might be?.....	YES	NO
16.	Can you usually let yourself go and enjoy yourself at a lively party?....	YES	NO
17.	Are you an irritable person?.....	YES	NO
18.	Should people always respect the law?.....	YES	NO
19.	Have you ever blamed someone for doing something you knew was really your fault?.....	YES	NO
20.	Do you enjoy meeting new people?.....	YES	NO
21.	Are good manners very important?.....	YES	NO
22.	Are your feelings easily hurt?.....	YES	NO
23.	Are all your habits good and desirable ones?.....	YES	NO
24.	Do you tend to keep in the background on social occasions?.....	YES	NO
25.	Would you take drugs which may have strange or dangerous effects?	YES	NO
26.	Do you often feel 'fed-up'?.....	YES	NO
27.	Have you ever taken anything (even a pin or a button) that belonged to someone else?.....	YES	NO
28.	Do you like going out a lot?.....	YES	NO
29.	Do you prefer to go your own way rather than act by the rules?.....	YES	NO
30.	Do you enjoy hurting people you love?.....	YES	NO

31.	Are you often troubled about feelings of guilt?.....	YES	NO
32.	Do you sometimes talk about things you know nothing about?...	YES	NO
33.	Do you prefer reading to meeting people?.....	YES	NO
34.	Do you have enemies who want to harm you?.....	YES	NO
35.	Would you call yourself a nervous person?.....	YES	NO
36.	Do you have many friends?.....	YES	NO
37.	Do you enjoy practical jokes that can sometimes really hurt people?	YES	NO
38.	Are you a worrier?.....	YES	NO
39.	As a child did you do as you were told immediately and without grumbling?.....	YES	NO
40.	Would you call yourself happy-go-lucky?.....	YES	NO
41.	Do good manners and cleanliness matter much to you?.....	YES	NO
42.	Have you often gone against your parents' wishes?.....	YES	NO
43.	Do you worry about awful things that might happen?.....	YES	NO
44.	Have you ever broken or lost something belonging to someone else?.	YES	NO
45.	Do you usually take the initiative in making new friends?.....	YES	NO
46.	Would you call yourself tense or 'highly-strung'?.....	YES	NO
47.	Are you mostly quiet when you are with other people?.....	YES	NO
48.	Do you think marriage is old-fashioned and should be done away with?	YES	NO
49.	Do you sometimes boast a little?.....	YES	NO
50.	Are you more easy-going about right and wrong than most people?.....	YES	NO
51.	Can you easily get some life into a rather dull party?.....	YES	NO
52.	Do you worry about your health?.....	YES	NO
53.	Have you ever said anything bad or nasty about anyone?.....	YES	NO
54.	Do you enjoy co-operating with others?.....	YES	NO
55.	Do you like telling jokes and funny stories to your friends?.....	YES	NO
56.	Do most things taste the same to you?.....	YES	NO
57.	As a child were you ever cheeky to your parents?.....	YES	NO
58.	Do you like mixing with people?.....	YES	NO
59.	Does it worry you if you know there are mistakes in your work?...	YES	NO
60.	Do you suffer from sleeplessness?.....	YES	NO
61.	Have people said that you sometimes act too rashly?.....	YES	NO
62.	Do you always wash before a meal?.....	YES	NO
63.	Do you nearly always have a 'ready answer' when people talk to you?	YES	NO
64.	Do you like to arrive at appointments in plenty of time?.....	YES	NO
65.	Have you often felt listless and tired for no reason?.....	YES	NO
66.	Have you ever cheated at a game?.....	YES	NO
67.	Do you like doing things in which you have to act quickly?.....	YES	NO
68.	Is (your was) your mother a good woman?.....	YES	NO
69.	Do you often make decisions on the spur of the moment?.....	YES	NO
70.	Do you often feel life is very dull?.....	YES	NO
71.	Have you ever taken advantage of someone?.....	YES	NO
72.	Do you often take on more activities than you have time for?....	YES	NO
73.	Are there several people who keep trying to avoid you?.....	YES	NO
74.	Do you worry a lot about your looks?.....	YES	NO
75.	Do you think people spend too much time safeguarding their future with savings and insurances?.....	YES	NO
76.	Have you ever wished that you were dead?.....	YES	NO

77.	Would you dodge paying taxes if you were sure you could never be found out?.....	YES	NO
78.	Can you get a party going?.....	YES	NO
79.	Do you try not to be rude to people?.....	YES	NO
80.	Do you worry too long after an embarrassing experience?.....	YES	NO
81.	Do you generally 'look before you leap'?.....	YES	NO
82.	Have you ever insisted on having your own way?.....	YES	NO
83.	Do you suffer from 'nerves'?.....	YES	NO
84.	Do you often feel lonely?.....	YES	NO
85.	Can you on the whole trust people to tell the truth?.....	YES	NO
86.	Do you always practice what you preach?.....	YES	NO
87.	Are you easily hurt when people find fault with you or the work you do?.....	YES	NO
88.	Is it better to follow society's rules than go your own way?...	YES	NO
89.	Have you ever been late for an appointment or work?.....	YES	NO
90.	Do you like plenty of bustle and excitement around you?.....	YES	NO
91.	Would you like other people to be afraid of you?.....	YES	NO
92.	Are you sometimes bubbling over with energy and sometimes very sluggish?.....	YES	NO
93.	Do you sometimes put off until tomorrow what ought to be done today?	YES	NO
94.	Do other people think of you as being very lively?.....	YES	NO
95.	Do people tell you a lot of lies?.....	YES	NO
96.	Do you believe one has special duties to one's family?.....	YES	NO
97.	Are you touchy about some things?.....	YES	NO
98.	Are you always willing to admit it when you have made a mistake?	YES	NO
99.	Would you feel very sorry for an animal caught in a trap?.....	YES	NO
100.	When your temper rises, do you find it difficult to control?.....	YES	NO
101.	Do you lock up your house carefully at night?.....	YES	NO
102.	Do you believe insurance schemes are a good idea?.....	YES	NO
103.	Do people who drive carefully annoy you?.....	YES	NO
104.	When you catch a train, do you often arrive at the last minute?.....	YES	NO
105.	Do your friendships break up easily without it being your fault?.....	YES	NO
106.	Do you sometimes like teasing animals?.....	YES	NO

PLEASE CHECK TO SEE THAT YOU HAVE ANSWERED ALL THE QUESTIONS

OPINIONS ABOUT PSYCHOLOGICAL PROBLEMS

This questionnaire has two parts. The first asks about how you view the causes of your problems; the second asks how you think these problems can be helped.

Causes of Psychological Problems

People have different views about what causes psychological problems. The following questions ask for your opinion of your own problems. There are no right or wrong answers: your own opinion is what counts. Please indicate how much you agree or disagree with each statement by using the following scale. Circle one number for each statement.

Disagree Strongly	Disagree Moderately	Disagree Mildly	Agree Mildly	Agree Moderately	Agree Strongly
-3	-2	-1	+1	+2	+3

My problems are caused by:

1.	Feelings that are buried out of sight	-3	-2	-1	+1	+2	+3
2.	Illogical beliefs	-3	-2	-1	+1	+2	+3
3.	Other people not accepting me for who I am	-3	-2	-1	+1	+2	+3
4.	Becoming too anxious in certain situations	-3	-2	-1	+1	+2	+3
5.	A disorder of the brain or nervous system	-3	-2	-1	+1	+2	+3
6.	Worrying too much about what other people think of me	-3	-2	-1	+1	+2	+3
7.	Exaggerating the importance of things that may happen	-3	-2	-1	+1	+2	+3
8.	Unemployment or an unsatisfactory job	-3	-2	-1	+1	+2	+3
9.	Events that happened in childhood	-3	-2	-1	+1	+2	+3
10.	Having learnt bad habits over the years	-3	-2	-1	+1	+2	+3
11.	An inherited physical cause	-3	-2	-1	+1	+2	+3
12.	Repeating old patterns in relationships with other people	-3	-2	-1	+1	+2	+3

MEASURES/OPP

		Disagree Strongly -3	Disagree Moderately -2	Disagree Mildly -1	Agree Mildly +1	Agree Moderately +2	Agree Strongly +3	
13.	Hiding feelings from friends or family	-3	-2	-1	+1	+2	+3	
14.	Lack of money	-3	-2	-1	+1	+2	+3	
15.	Running away from responsibilities	-3	-2	-1	+1	+2	+3	
16.	Repressing basic human impulses	-3	-2	-1	+1	+2	+3	
17.	Thinking about myself too much	-3	-2	-1	+1	+2	+3	
18.	Having learnt the wrong reactions to certain situations	-3	-2	-1	+1	+2	+3	
19.	Unsatisfactory means of transport	-3	-2	-1	+1	+2	+3	
20.	Not paying attention to my feelings	-3	-2	-1	+1	+2	+3	
21.	Making harsh judgements of myself	-3	-2	-1	+1	+2	+3	
22.	A lack of will power	-3	-2	-1	+1	+2	+3	
23.	Not accepting myself for who I am	-3	-2	-1	+1	+2	+3	
24.	Conflicting feelings about my parents when I was young	-3	-2	-1	+1	+2	+3	
25.	Dissatisfaction with the community I live in	-3	-2	-1	+1	+2	+3	
26.	Not having a realistic view of the good and the bad things that have happened	-3	-2	-1	+1	+2	+3	
27.	Conflicts in my unconscious mind	-3	-2	-1	+1	+2	+3	
28.	Illness, such as colds or flu	-3	-2	-1	+1	+2	+3	
29.	The state of the economy	-3	-2	-1	+1	+2	+3	
30.	Unrealistic thinking	-3	-2	-1	+1	+2	+3	
31.	Rewards or punishments received in the past	-3	-2	-1	+1	+2	+3	

		Disagree Strongly -3	Disagree Moderately -2	Disagree Mildly -1	Agree Mildly +1	Agree Moderately +2	Agree Strongly +3	
32.	A conscience that won't let me alone				-3	-2	-1	+1 +2 +3
33.	Not liking myself				-3	-2	-1	+1 +2 +3
34.	Having unrealistic expectations				-3	-2	-1	+1 +2 +3
35.	Something going wrong with my body				-3	-2	-1	+1 +2 +3
36.	Not understanding what I really feel inside				-3	-2	-1	+1 +2 +3
37.	Laziness				-3	-2	-1	+1 +2 +3
38.	Not having learnt the right ways to cope with certain situations				-3	-2	-1	+1 +2 +3
39.	Not being true to myself				-3	-2	-1	+1 +2 +3
40.	Other people being unreasonable				-3	-2	-1	+1 +2 +3
41.	Putting myself down for no reason				-3	-2	-1	+1 +2 +3
42.	Poor housing				-3	-2	-1	+1 +2 +3
43.	The wrong balance of chemicals in my body				-3	-2	-1	+1 +2 +3
44.	Bad luck or fate				-3	-2	-1	+1 +2 +3
45.	Having learnt wrong ways of doing things from someone else				-3	-2	-1	+1 +2 +3
46.	Unsatisfactory relationships with other people				-3	-2	-1	+1 +2 +3
47.	It's impossible to explain the cause of my problems				-3	-2	-1	+1 +2 +3

If you think there are other important causes not listed below, please add them here:

Help for Psychological Problems

People have different views about what may help psychological problems. The following questions ask for your opinion of how your own problems could be helped. There are no right or wrong answers: your own opinion is what counts. Please indicate how much you agree or disagree with each statement by using the following scale. Circle one number for each statement.

Disagree Strongly	Disagree Moderately	Disagree Mildly	Agree Mildly	Agree Moderately	Agree Strongly
-3	-2	-1	+1	+2	+3

A good way to help my problems would be:

1.	Taking the attitude that I should count my blessings, rather than looking on the dark side of things	-3	-2	-1	+1	+2	+3
2.	Having an expert show me how to think in a more logical way	-3	-2	-1	+1	+2	+3
3.	Getting tablets to regulate my mood	-3	-2	-1	+1	+2	+3
4.	Learning to pay attention to my feelings	-3	-2	-1	+1	+2	+3
5.	Discussing the problems with someone in an honest, person-to-person way	-3	-2	-1	+1	+2	+3
6.	Understanding the childhood origins of the problems	-3	-2	-1	+1	+2	+3
7.	Having an expert teach me better ways of reacting to certain situations	-3	-2	-1	+1	+2	+3
8.	Getting medication	-3	-2	-1	+1	+2	+3
9.	Better housing	-3	-2	-1	+1	+2	+3
10.	Having an expert point out the meaning of my dreams and fantasies	-3	-2	-1	+1	+2	+3
11.	An improvement in the economy	-3	-2	-1	+1	+2	+3
12.	Examining, with an expert, what situations make the problems better or worse	-3	-2	-1	+1	+2	+3

		Disagree Strongly -3	Disagree Moderately -2	Disagree Mildly -1	Agree Mildly +1	Agree Moderately +2	Agree Strongly +3	
13.	Talking to an expert about my relationship with my parents when I was young	-3	-2	-1	+1	+2	+3	
14.	Having someone listen to my feelings without giving advice	-3	-2	-1	+1	+2	+3	
15.	Worrying less about what other people think of me	-3	-2	-1	+1	+2	+3	
16.	Learning to live with the problems, rather than trying to change them	-3	-2	-1	+1	+2	+3	
17.	Being shown by an expert how to change my outlook on the problems	-3	-2	-1	+1	+2	+3	
18.	Learning to accept myself for who I am	-3	-2	-1	+1	+2	+3	
19.	Taking my mind off myself	-3	-2	-1	+1	+2	+3	
20.	Having medical treatment to put the chemicals of my body back into balance	-3	-2	-1	+1	+2	+3	
21.	A better community to live in	-3	-2	-1	+1	+2	+3	
22.	Learning the skills needed in difficult situations	-3	-2	-1	+1	+2	+3	
23.	Putting my bad feelings aside, so I can feel more cheerful	-3	-2	-1	+1	+2	+3	
24.	Tackling the problems in a planned, step-by-step way	-3	-2	-1	+1	+2	+3	
25.	Learning to think more realistically	-3	-2	-1	+1	+2	+3	
26.	Having other people change, rather than changing myself	-3	-2	-1	+1	+2	+3	
27.	Having an expert teach me specific ways to change my behaviour	-3	-2	-1	+1	+2	+3	
28.	Discovering what I really feel inside	-3	-2	-1	+1	+2	+3	

MEASURES/OPP

		Disagree Strongly -3	Disagree Moderately -2	Disagree Mildly -1	Agree Mildly +1	Agree Moderately +2	Agree Strongly +3	
29.	Deciding to keep a "stiff upper lip"	-3	-2	-1	+1	+2	+3	
30.	Talking about my feelings to someone I trust	-3	-2	-1	+1	+2	+3	
31.	Learning to think differently about the problems	-3	-2	-1	+1	+2	+3	
32.	Having an expert analyze my unconscious reasons for doing things	-3	-2	-1	+1	+2	+3	
33.	Keeping busy, so as not to think about the problems	-3	-2	-1	+1	+2	+3	
34.	Hearing from other people that I am doing well or trying hard	-3	-2	-1	+1	+2	+3	
35.	Getting a satisfactory job	-3	-2	-1	+1	+2	+3	
36.	Learning to judge myself less harshly	-3	-2	-1	+1	+2	+3	
37.	Talking to someone who listens closely to what I'm really saying	-3	-2	-1	+1	+2	+3	
38.	Realizing how I repeat old patterns in relationships with other people	-3	-2	-1	+1	+2	+3	
39.	Deciding to 'grin and bear it'	-3	-2	-1	+1	+2	+3	
40.	Getting tablets	-3	-2	-1	+1	+2	+3	
41.	Getting physically fit and healthy	-3	-2	-1	+1	+2	+3	
42.	Having an expert point out that how I think about myself can sometimes be wrong	-3	-2	-1	+1	+2	+3	
43.	Better means of transport	-3	-2	-1	+1	+2	+3	
44.	Coming to understand feelings or impulses that I'm not aware of	-3	-2	-1	+1	+2	+3	
45.	Having more money	-3	-2	-1	+1	+2	+3	

MEASURES/OPP

		Disagree Strongly -3	Disagree Moderately -2	Disagree Mildly -1	Agree Mildly +1	Agree Moderately +2	Agree Strongly +3			
46.	Using will power to overcome the problems				-3	-2	-1	+1	+2	+3
47.	There's nothing that can be done to help my problems				-3	-2	-1	+1	+2	+3

If you think there are other ways in which your problems could be helped, please add them here:

Therapists have different views about what may be helpful in therapy. Please indicate how much you agree or disagree with the following statements by using the scale below. Write down one number beside each statement in the space provided.

	Disagree Strongly 1	Disagree Moderately 2	Disagree Mildly 3	Agree Mildly 4	Agree Moderately 5	Agree Strongly 6
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						

	Disagree Strongly 1	Disagree Moderately 2	Disagree Mildly 3	Agree Mildly 4	Agree Moderately 5	Agree Strongly 6
22.						
23.						
24.						
25.						
26.						
27.						
28.						
29.						
30.						
31.						
32.						
33.						
34.						
35.						
36.						
37.						
38.						
39.						
40.						
41.						
42.						

THANK YOU FOR YOUR HELP

Bronx Municipal Hospital Center
P-M Scale

Name (Please print) _____

Forty five statements are listed below. Each statement is followed by four phrases:

strongly agree
mostly agree
mostly disagree
strongly disagree

Please place a check (✓) next to the phrase which best describes how you feel about each.

	<u>Strongly Agree</u>	<u>Mostly Agree</u>	<u>Mostly Disagree</u>	<u>Strongly Disagree</u>
1. I would be willing to talk about my personal problems if I thought it might help me or a member of my family.	_____	_____	_____	_____
2. I am always curious about the reasons people behave as they do.	_____	_____	_____	_____
3. I think that most people who are mentally ill have something physically wrong with their brain.	_____	_____	_____	_____
4. When I have a problem, if I talk about it with a friend, I feel a lot better.	_____	_____	_____	_____
5. Often I don't know what I'm feeling.	_____	_____	_____	_____
6. I am willing to change old habits to try a new way of doing things.	_____	_____	_____	_____
7. There are certain problems which I could not discuss outside my immediate family.	_____	_____	_____	_____
8. I often find myself thinking about what made me act in a certain way.	_____	_____	_____	_____
9. Emotional problems can sometimes make you physically sick.	_____	_____	_____	_____
10. When you have problems, talking about them with other people just make them worse.	_____	_____	_____	_____
11. Usually, if I feel an emotion, I can identify it.	_____	_____	_____	_____

	<u>Strongly Agree</u>	<u>Mostly Agree</u>	<u>Mostly Disagree</u>	<u>Strongly Disagree</u>
2. If a friend gave me advice about how to do something better, I'd try it out.	_____	_____	_____	_____
3. I am annoyed by someone, whether he is a doctor or not, who wants to know about my personal problems.	_____	_____	_____	_____
4. I find that once I develop a habit, that it is hard to change, even if I know there is another way of doing things that might be better.	_____	_____	_____	_____
15. I think that people who are mentally ill often have problems which began in their childhood.	_____	_____	_____	_____
16. Letting off steam by talking to someone about your problems often makes you feel a lot better.	_____	_____	_____	_____
17. People sometimes say that I act as if I'm having a certain emotion (anger for example) when I am unaware of it.	_____	_____	_____	_____
18. I get annoyed when people give me advice about changing the way I do things.	_____	_____	_____	_____
19. It would not be difficult for me to talk about personal problems with people such as doctors and clergymen.	_____	_____	_____	_____
20. If a good friend of mine suddenly started to insult me, my first reaction might be to try to understand why he was so angry.	_____	_____	_____	_____
21. I think that when a person has crazy thoughts, it is often because he is very anxious and upset.	_____	_____	_____	_____
22. I've never found that talking to other people about my worries helps much.	_____	_____	_____	_____
23. Often, even though I know that I'm having an emotion, I don't know what it is.	_____	_____	_____	_____
24. I like to do things the way I've done them in the past. I don't like to try to change my behavior much.	_____	_____	_____	_____
25. There are some things in my life that I would not discuss with anyone.	_____	_____	_____	_____

	<u>Strongly Agree</u>	<u>Mostly Agree</u>	<u>Mostly Disagree</u>	<u>Strongly Disagree</u>
6. Understanding the reasons you have deep down for acting in certain ways is important.	_____	_____	_____	_____
7. At work, if someone suggested a different way of doing a job that might be better, I'd give it a try.	_____	_____	_____	_____
8. I've found that when I talk about my problems to someone else, I come up with ways to solve them that I hadn't thought of before.	_____	_____	_____	_____
9. I am sensitive to the changes in my own feelings.	_____	_____	_____	_____
10. When I learn a new way of doing something, I like to try it out to see if it would work better than what I had been doing before.	_____	_____	_____	_____
11. It is important to be open and honest when you talk about your troubles with someone you trust.	_____	_____	_____	_____
12. I really enjoy trying to figure other people out.	_____	_____	_____	_____
13. I think that most people with mental problems have probably received some kind of injury to their head.	_____	_____	_____	_____
14. Talking about your worries to another person helps you to understand your problems better.	_____	_____	_____	_____
15. I'm usually in touch with my feelings.	_____	_____	_____	_____
16. I like to try new things, even if it involves taking risks.	_____	_____	_____	_____
17. It would be very difficult for me to discuss upsetting or embarrassing aspects of my personal life with people even if I trust them.	_____	_____	_____	_____
18. If I suddenly lost my temper with someone, without knowing exactly why, my first impulse would be to forget about it.	_____	_____	_____	_____

	<u>Strongly Agree</u>	<u>Mostly Agree</u>	<u>Mostly Disagree</u>	<u>Strongly Disagree</u>
39. I think that what a person's environment (family, etc.) is like has little to do with whether he develops mental problems.	_____	_____	_____	_____
40. When you have troubles, talking about them to someone else just makes you more confused.	_____	_____	_____	_____
41. I frequently don't want to delve too deeply into what I'm feeling.	_____	_____	_____	_____
42. I don't like doing things if there is a chance that they won't work out.	_____	_____	_____	_____
43. I think that no matter how hard you try, you'll never really understand what makes people tick.	_____	_____	_____	_____
44. I think that what goes on deep down in a person's mind is important in determining whether he will have a mental illness.	_____	_____	_____	_____
45. Fear of embarrassment or failure doesn't stop me from trying something new.	_____	_____	_____	_____

CONFIDENTIAL

Interview Session Report

Introduction

You are being asked to take part in a study of what happens during individual interviews. The questions in this measure are designed to make your description of your interview simple and quick.

There will be many people participating in this project. The personal reactions of individuals are not being studied. Rather, the study seeks to determine the average kind of events that take place during individual interviews.

Because your honest responses are so important, your answers will be kept confidential. Every resource has been used to guarantee complete anonymity for the participants in this study. However, we do need a method of keeping all of the reports from each person together. Consequently, we are asking you to put your initials and the date at the bottom of this cover sheet. This sheet will be removed and destroyed as soon as an appropriate code number has been entered on the other sheets.

The knowledge gained from this research will deepen our understanding of the psychotherapeutic interview process. We want to thank you for your contribution to this effort.

Initials: _____

Today's Date: _____

Ref: _____

BE SURE TO ANSWER EACH QUESTION

1. How do you feel about the individual interview session which you have completed?
(Please tick the statement which best applies).

- ☐ 1. This was a really good interview
- ☐ 2. This was a pretty good interview
- ☐ 3. This was a fair interview
- ☐ 4. This was a pretty poor interview
- ☐ 5. This was a really poor interview

Session Content Area Themes

What did you talk about during this interview (tick as many answers below as apply to this session).

During this interview, I talked about:

- ☐ 2. Social activities and relationships, friends and acquaintances
- ☐ 3. Work supervisors, associates on the job (or at school)
- ☐ 4. Recreations, hobbies, interests
- ☐ 5. Domestic and household responsibilities, concerns and activities (finances, children)
- ☐ 6. Relationship with spouse, boyfriend or girlfriend
- ☐ 7. Current relations with parents, brothers or sisters
- ☐ 8. Childhood experiences with family members, and feelings about them
- ☐ 9. Childhood experiences in school with friends and with other kids
- ☐ 10. Feelings and attitudes toward myself
- ☐ 11. Body functions, health, physical symptoms
- ☐ 12. Inadequacies, fears or successes in getting along personally and socially
- ☐ 13. Sexual feelings and experiences
- ☐ 14. Angry and aggressive feelings and experiences
- ☐ 15. Feelings about being close to or needing someone
- ☐ 16. Dreams, fantasies
- ☐ 17. Plans, hope and goals for the future
- ☐ 18. Strange or unusual ideas, feelings or experiences
- ☐ 19. Therapy, the therapist, being a patient, other.....

Purpose of the Interview Session

What did you want or hope to get out of this interview session?

Behaviour in Interview Session

How did you act towards your therapist during this session? (try to tick only one set of words for each item; but, if the way you acted changed during this session, check as many sets of words as are necessary).

Item 1 - During this interview session, I was mainly:

- ☐ 40. taking the lead; having my own ideas; bringing up things to talk about.
- ☐ 41. following; receptive; waiting for direction from my interviewer.
- ☐ 42. working together; joining in; co-operating.
- ☐ 43. distant; reserved; holding back.

Item 2 - During this interview session, I was mainly:

- ☐ 44. determined; not giving in; firm.
- ☐ 45. agreeing; going along with; changing my mind.
- ☐ 46. able to compromise; sharing; "give and take".
- ☐ 47. independent; uninfluenced; making up my own mind.

Item 3 - During this interview session, I was mainly:

- ☐ 48. friendly; warm; respectful.
- ☐ 49. critical; negative; sarcastic.
- ☐ 50. respectful but critical; both positive and negative; "mixed feelings".
- ☐ 51. neutral; impartial; neither positive nor negative.

Item 4 - During this interview session, I was mainly:

- ☐ 52. excited; emotional; actively involved.
- ☐ 53. feeling deeply; moved but controlled; stirred up but quiet.
- ☐ 54. talkative; businesslike; active but not stirred up.
- ☐ 55. quiet; inactive; unemotional.

Feelings in Interview Session

How did you feel during this interview? (tick as many as apply)

_____ 1.	tense	_____ 16.	satisfied	_____ 31.	suspicious
_____ 2.	anxious	_____ 17.	cheerful	_____ 32.	hurt
_____ 3.	worried	_____ 18.	optimistic	_____ 33.	rejected
_____ 4.	calm	_____ 19.	shy	_____ 34.	trusting
_____ 5.	relaxed	_____ 20.	embarrassed	_____ 35.	secure
_____ 6.	relieved	_____ 21.	guilty	_____ 36.	accepted
_____ 7.	inadequate	_____ 22.	confident	_____ 37.	tired
_____ 8.	inferior	_____ 23.	playful	_____ 38.	dull
_____ 9.	helpless	_____ 24.	likeable	_____ 39.	bored
_____ 10.	effective	_____ 25.	bored	_____ 40.	alert
_____ 11.	superior	_____ 26.	irritable	_____ 41.	hungry
_____ 12.	triumphant	_____ 27.	angry	_____ 42.	thirsty
_____ 13.	frustrated	_____ 28.	interested	_____ 43.	sexually aroused
_____ 14.	sad	_____ 29.	sympathetic	_____ 44.	need to relieve bladder
_____ 15.	discouraged	_____ 30.	tender	_____ 45.	need to relieve bowels
				_____	OTHER

Development of Interview Session

Think of the individual interview session which you have completed. Read each of the following questions, and circle the number of the answer which best describes the way you felt about this session. Be sure to answer each question.

46. To what extent were you looking forward to coming to this interview?
1. I was very much looking forward to coming to the interview; could hardly wait to get here.
 2. I was somewhat looking forward to coming to this interview; was glad to get here.
 3. I was not anticipating this interview one way or the other; it was scheduled and I didn't think much about it.
 4. I felt somewhat unwilling to come to this interview; I thought about not coming this time.
 5. I felt I didn't want to come to this interview; I had to make myself come here.
47. How freely were you able to talk with your interviewer during this session?
1. I had a great deal of difficulty talking to my interviewer; it was very hard for me to express myself.
 2. I had considerable difficulty talking with my interviewer, but I was able to discuss some things with him/her.
 3. I had occasional difficulty in talking to my interviewer, but for the most part I was able to express myself freely.
 4. I didn't have any difficulty in talking with my interviewer during the session.

48. How clearly did you know what you wanted to talk about during this interview?
1. I knew clearly what I wanted to talk about during this interview.
 2. I knew pretty much what I wanted to talk about during this interview, but sometimes I lost track.
 3. I had some difficulty this interview in finding the things I wanted to talk about; at times I didn't have any thoughts or know what to say.
 4. I had a great deal of difficulty in knowing what to talk about; either my mind was blank or the things I thought of didn't seem right.
49. How well did your interviewer seem to understand how you were feeling and what was really on your mind during this session?
1. My interviewer seemed to understand very well how I was feeling and what was on my mind during this session.
 2. My interviewer understood pretty well how I was feeling and what was on my mind, but there were some things that I couldn't seem to get across to him/her.
 3. I didn't think that my interviewer understood too well how I was feeling and what was on my mind during this interview.
 4. My interviewer seemed to misunderstand how I was feeling and what was on my mind during this session.
50. Do you feel that what your interviewer said and did this session was helpful to you?
1. The things that my interviewer said and did this session were very helpful to me.
 2. The things my interviewer said and did this session were pretty helpful to me.
 3. The things my interviewer said and did this session were somewhat helpful to me.
 4. The things my interviewer said and did this session were only slightly helpful or not at all helpful to me.
 5. I feel that the things my interviewer said and did this session may have made me worse off than I was.
51. Do you feel that the interview shed any light on your dealing with any issues/difficulties for which you are in therapy?
1. I made a considerable amount of progress in dealing with my problems during this session.
 2. I made some progress in this session in dealing with my problems.
 3. I really didn't get anywhere in this session in dealing with my problems.
 4. In some ways my problems got worse during this session.

52. How well do you feel that you are getting along, emotionally and psychologically, at this time.

1. I am getting along pretty well; much the way I would like to.
2. I am getting along pretty well; have my ups and downs.
3. I am getting along fairly well;; manage to keep going with some effort.
4. I am getting along fairly poorly; life gets pretty rough for me at times.
5. I am getting along quite poorly; I feel that I can barely manage to deal with things.

Satisfaction in Interview Session

What do you feel that you got out of this session? (For each item, circle one of the following numbers:-

- 1 Very Much
- 2 Moderately
- 3 Slightly or not at all)

During this session, I feel that I got:

53. Relief from the tension I was under	1	2	3
54. Better insight and self-understanding	1	2	3
55. Reassurance and encouragement about how I'm doing	1	2	3
56. Better ability to feel my feelings, to be what I really am	1	2	3
57. Ideas for new or better ways of dealing with people	1	2	3
58. A sense of having an honest person-to-person relationship with my interviewer, of working together	1	2	3
59. Help in being able to talk about what was troubling me and really important	1	2	3
60. A better ability to tell which of the things I felt and thought were real and which were mostly in my mind	1	2	3
61. Better self-control over my moods and actions	1	2	3

Other: _____

62. To what extent would you be prepared to have another individual interview?

1. I would look forward to another interview very much.
2. I would look forward to another interview pretty much; will be ready for it when it comes.
3. I would not look forward to another interview one way or another; if it is scheduled and so far as I know I'll be there.
4. I would definitely not look forward to another interview; I'm not so sure I would want to come.

Behaviour in Interview Session

How did your interviewer act toward you during this session? (Try to tick only one set of words for each item; but if there were changes in the way your interviewer acted, tick as many sets of words as are necessary).

I During this interview, my interviewer was mainly:

1. leading: directing: bring things up to talk about
2. attentive: waiting for me to lead: following
3. joining in: working together: co-operating
4. distant: reserved: holding back

II During this interview, my interviewer was mainly:

5. insistent: demanding: firm
6. agreeing: going along with: doing what I wanted
7. democratic: open minded: willing to compromise
8. independent: uninfluenced: making up his own mind

III During this interview, my interviewer was mainly:

9. friendly: helpful: on my side
10. critical: negative: sarcastic
11. strict but fair: helpful but critical
12. neutral: impartial: impersonal

IV During this interview, my interviewer was mainly:

13. intense: enthusiastic: excited
14. moved but controlled: stirred: involved
15. businesslike: active but uninvolved: brisk
16. uninvolved: quiet: inactive.

REF _____ **THE SYMPTOM CHECKLIST 90 - REVISED** **CONFIDENTIAL**
Date: _____

Instructions

Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, please fill in one of the numbered spaces to the right that best describes how much that problem has bothered or distressed you in general using the scale shown below. Although it may seem that there are many items, the questionnaire is quite quickly completed. Mark only one numbered space for each problem and do not skip any items. Please read the example below before beginning.

Scale	0	=	Not at all
	1	=	A little bit
	2	=	Moderately
	3	=	Quite a bit
	4	=	Extremely

Example

How much were you bothered by

1. Backaches	0	1	2	3	4

HOW MUCH WERE YOU BOTHERED BY

1. Headaches	0	1	2	3	4
2. Nervousness of shakiness inside	0	1	2	3	4
3. Unwanted thoughts, words or ideas that won't leave your mind	0	1	2	3	4
4. Faintness or dizziness	0	1	2	3	4
5. Loss of sexual interest or pleasure	0	1	2	3	4
6. Feeling critical of others	0	1	2	3	4
7. The idea that someone else can control your thoughts	0	1	2	3	4
8. Feeling others are to blame for most of your troubles	0	1	2	3	4
9. Trouble remembering things	0	1	2	3	4

Scale	0	=	Not at all
	1	=	A little bit
	2	=	Moderately
	3	=	Quite a bit
	4	=	Extremely

10.	Worried about sloppiness or carelessness	0	1	2	3	4
11.	Feeling easily annoyed or irritated	0	1	2	3	4
12.	Pains in heart or chest	0	1	2	3	4
13.	Feeling afraid in open spaces or on the streets	0	1	2	3	4
14.	Feeling low in energy or slowed down	0	1	2	3	4
15.	Thoughts of ending your life	0	1	2	3	4
16.	Hearing voices that other people do not hear	0	1	2	3	4
17.	Trembling	0	1	2	3	4
18.	Feeling that most people cannot be trusted	0	1	2	3	4
19.	Poor appetite	0	1	2	3	4
20.	Crying easily	0	1	2	3	4
21.	Feeling shy or uneasy with the opposite sex	0	1	2	3	4
22.	Feelings of being trapped or caught	0	1	2	3	4
23.	Suddenly scared for no reason	0	1	2	3	4
24.	Temper outbursts that you could not control	0	1	2	3	4
25.	Feeling afraid to go out of your house alone	0	1	2	3	4
26.	Blaming yourself for things	0	1	2	3	4
27.	Pains in lower back	0	1	2	3	4
28.	Feeling blocked in getting things done	0	1	2	3	4
29.	Feeling lonely	0	1	2	3	4
30.	Feeling blue	0	1	2	3	4

Scale	0	=	Not at all
	1	=	A little bit
	2	=	Moderately
	3	=	Quite a bit
	4	=	Extremely

31.	Worrying too much about things	0	1	2	3	4
32.	Feeling no interest in things	0	1	2	3	4
33.	Feeling fearful	0	1	2	3	4
34.	Your feelings being easily hurt	0	1	2	3	4
35.	Other people being aware of your private thoughts	0	1	2	3	4
36.	Feeling others do not understand you or are unsympathetic	0	1	2	3	4
37.	Feeling that people are unfriendly or dislike you	0	1	2	3	4
38.	Having to do things very slowly to ensure correctness	0	1	2	3	4
39.	Heart pounding or racing	0	1	2	3	4
40.	Nausea or upset stomach	0	1	2	3	4
41.	Feeling inferior to others	0	1	2	3	4
42.	Soreness of your muscles	0	1	2	3	4
43.	Feeling that you are watched or talked about by others	0	1	2	3	4
44.	Trouble falling asleep	0	1	2	3	4
45.	Having to check and double check what you do	0	1	2	3	4
46.	Difficulty making decisions	0	1	2	3	4
47.	Feeling afraid to travel on buses, the underground or trains	0	1	2	3	4
48.	Trouble getting your breath	0	1	2	3	4
49.	Hot or cold spells	0	1	2	3	4

Scale	0	=	Not at all
	1	=	A little bit
	2	=	Moderately
	3	=	Quite a bit
	4	=	Extremely

50.	Having to avoid certain things, places or activities because they frighten you	0	1	2	3	4
51.	Your mind going blank	0	1	2	3	4
52.	Numbness or tingling in parts of your body	0	1	2	3	4
53.	A lump in your throat	0	1	2	3	4
54.	Feeling hopeless about the future	0	1	2	3	4
55.	Trouble concentrating	0	1	2	3	4
56.	Feeling weak in parts of your body	0	1	2	3	4
57.	Feeling tense or keyed up	0	1	2	3	4
58.	Heavy feelings in your arms or legs	0	1	2	3	4
59.	Thoughts of death or dying	0	1	2	3	4
60.	Overeating	0	1	2	3	4
61.	Feeling uneasy when people are watching or talking about you	0	1	2	3	4
62.	Having thoughts that are not your own	0	1	2	3	4
63.	Having urges to beat, injure or harm someone	0	1	2	3	4
64.	Awakening in the early morning	0	1	2	3	4
65.	Having to repeat the same actions such as counting, washing	0	1	2	3	4
66.	Sleep that is restless or disturbed	0	1	2	3	4
67.	Having urges to break or smash things	0	1	2	3	4
68.	Having ideas or beliefs that others do not share	0	1	2	3	4
69.	Feeling very self-conscious with others	0	1	2	3	4

Scale	0	=	Not at all
	1	=	A little bit
	2	=	Moderately
	3	=	Quite a bit
	4	=	Extremely

70.	Feeling uneasy in crowds such as shopping or the cinema	0	1	2	3	4
71.	Feeling everything is an effort	0	1	2	3	4
72.	Spells of terror or panic	0	1	2	3	4
73.	Feeling uncomfortable about eating or drinking in public	0	1	2	3	4
74.	Getting into frequent arguments	0	1	2	3	4
75.	Feeling nervous when you are left alone	0	1	2	3	4
76.	Others not giving you proper credit for your achievements	0	1	2	3	4
77.	Feeling lonely even when you are with other people	0	1	2	3	4
78.	Feeling so restless you can't sit still	0	1	2	3	4
79.	Feeling of worthlessness	0	1	2	3	4
80.	Feeling that familiar things are strange or unreal	0	1	2	3	4
81.	Shouting or throwing things	0	1	2	3	4
82.	Feeling afraid you will faint in public	0	1	2	3	4
83.	Feeling that people will take advantage of you if you let them	0	1	2	3	4
84.	Having thoughts about sex that bother you a lot	0	1	2	3	4
85.	The idea that you should be punished for your sins	0	1	2	3	4
86.	Feeling pushed to get things done	0	1	2	3	4
87.	The idea that something serious is wrong with your body	0	1	2	3	4

Scale	0	=	Not at all
	1	=	A little bit
	2	=	Moderately
	3	=	Quite a bit
	4	=	Extremely

88.	Never feeling close to another person	0	1	2	3	4
89.	Feelings of guilt	0	1	2	3	4
90.	The idea that something is wrong with your mind	0	1	2	3	4

CONFIDENTIAL

The Beck Depression Inventory.

Below are groups of statements headed A, B, C etc. Begin by reading all the statements in Group A, and then tick the statement that best describes how you feel at present. Then go on through the other groups in exactly the same way. On completion, please check that you have selected only one statement in each group, and that every group has been covered. If you feel you would like to make any further comments either about the way you have felt over the past few months or how you feel answering the questions please feel free to do so after each question.

- A
- I do not feel sad
 - I feel blue or sad
 - I am blue or sad all the time and I can't snap out of it
 - I am so sad or unhappy that it is very painful
 - I am so sad or unhappy that I can't stand it

Comments.....

- B
- I am not particularly pessimistic or discouraged about the future
 - I feel discouraged about the future
 - I feel I have nothing to look forward to
 - I feel that I won't ever get over my troubles
 - I feel that the future is hopeless and that things cannot improve

Comments.....

- C
- I do not feel like a failure
 - I feel I have accomplished very little that is worthwhile or that means anything
 - As I look back on my life all I can see is a lot of failure
 - I feel I am a complete failure as a person (parent, husband, wife)

Comments.....

- D
- I am not particularly dissatisfied
 - I feel bored most of the time
 - I don't enjoy things the way I used to
 - I don't get satisfaction out of anything anymore
 - I am dissatisfied with everything

Comments.....

- E
- I don't feel particularly guilty
 - I feel bad and unworthy a good part of the time
 - I feel guilty
 - I feel bad or unworthy practically all the time
 - I feel as though I am very bad or worthless

Comments.....

- F
- I don't feel I am being punished
 - I have a feeling that something bad may happen to me
 - I feel I am being punished or will be punished
 - I want to be punished

Comments.....

- G
- I don't feel disappointed in myself
 - I am disappointed in myself
 - I don't like myself
 - I am disgusted with myself
 - I hate myself

Comments.....

- H
- I don't feel I am any worse than anybody else
 - I am very critical of myself for my weaknesses or mistakes
 - I blame myself for everything that goes wrong
 - I feel I have many bad faults

Comments.....

- I
- I don't have any thoughts of harming myself
 - I have thoughts of harming myself but would not carry them out
 - I feel I would be better off dead
 - I have definite plans about committing suicide
 - I feel my family would be better off if I were dead
 - I would kill myself if I could

Comments.....

- J
- I don't cry any more than usual
 - I cry more now than I used to
 - I cry all the time now. I can't stop it
 - I used to be able to cry but now I can't cry at all even though I want to

Comments.....

- K
- I am no more irritated now than I ever am
 - I get annoyed or irritated more easily than I used to
 - I feel irritated all the time
 - I don't get irritated at all by the things that used to irritate me

Comments.....

- L
- I have not lost interest in other people
 - I am less interested in other people now than I used to be
 - I have lost most of my interest in other people and have little feeling for them
 - I have lost all my interest in other people and don't care about them at all

Comments.....

- M
- I make decisions almost as well as ever
 - I am less sure of myself now and try to put off making decisions
 - I can't make decisions anymore without help
 - I can't make any decisions at all anymore

Comments.....

- N
- I don't feel I look any worse than I used to
 - I am worried that I am looking old or unattractive
 - I feel that there are permanent changes in my appearance and they make me look unattractive
 - I feel that I am ugly or repulsive looking

Comments.....

- O
- I can work about as well as before
 - It takes extra effort to get started at doing something
 - I don't work as well as I used to
 - I have to push myself very hard to do anything
 - I can't do any work at all

Comments.....

- P
- I can sleep as well as usual
 - I wake up more tired in the morning than I used to
 - I wake up 1-2 hours earlier than I used to and find it hard to get back to sleep
 - I wake up early every day and can't get more than 5 hours sleep

Comments.....

- Q
- I don't get any more tired than usual
 - I get tired more easily than I used to
 - I get tired from doing anything
 - I get too tired to do anything

Comments.....

- R
- My appetite is no worse than usual
 - My appetite is not as good as it used to be
 - My appetite is much worse now
 - I have no appetite at all anymore

- S
- I have not lost much weight, if any, lately
 - I have lost more than 5 pounds
 - I have lost more than 10 pounds
 - I have lost more than 15 pounds

Comments.....

- T
- I am no more concerned about my health than usual
 - I am concerned about aches and pains or upset stomach or constipation or other unpleasant feelings in my body
 - I am so concerned with how I feel or what I feel that it's hard to think
 - I am completely absorbed in what I feel

Comments.....

- U
- I have not noticed any changes in my interest in sex
 - I am less interested in sex than I used to be
 - I am much less interested in sex now
 - I have lost interest in sex completely

Comments.....

WPF APPLICANT DATA SHEET

Name:

Sex:

DoB:

Route Applied for:

Academic Qualifications:

Main Occ:

Marital Status:

Counselling Exp:

Personal Therapy:

WPF Sheet

	Strong	Average	Weak
Practical Counselling type Exp			
Counselling Skills Course exp			
Personal therapy			
Funding			
Academic Ability			

Case Discussion Group Result

Personal Interview Result

Interviewed By:

Outcome:

Provisional Result

SD.

VM.

JS.

Overall Outcome:

Letter Sent (Date):

Therapist Orientation Questionnaire.
(Adapted from Hamilton 1990).

Please rate the extent to which these orientations/frameworks have influenced your technique. Please make sure that you mark each category, even if the influence has been negligible. Place an X in the appropriate box and return the form to me in the enclosed stamped addressed envelope as soon as possible.

Influence on Technique	Not at all	Very little	To some extent	To a considerable extent	To a very great extent
Orientation					
Jung Classical (Adler Henderson, Stevens)					
Melanie Klein					
Anna Freud					
S. Freud Drive Theory					
Topographic Model					
Structural Model					
Ego Psychology					
Mahler et al.					
American Object Relations Theory: (Jacobson, Loewald, Kernberg etc)					
Jung Strong Developmental: (Fordham, Lambert, Zinkin)					
British Object Relations theory other than Klein: (Winnicott, Balint, Fairbairn, Bowlby etc)					
Post Klein/Bion					
Jung Classical-Developmental (Edinger, Schwartz, Whitmont)					
Sullivan/ Interpersonalist					
Franz Alexander					
Jung Classical-Archetypal (Guggenbuhl, Shorter, R. Stein)					
Kohut					
Self-psychology/Post Kohut					
Lacan					
French analysis other than Lacan					
Contemporary developmental theory: Stern, Emde, attachment theorists.					
Gill					
Schafer/action language					
Jung Strongly Archetypal (Hillman, Lopez-Pedroza, Corbin)					
Hermeneuticists/Spence et al					
Other (please specify):					

The Individual Selection Interview Questionnaire.

This questionnaire asks you to rate the importance of some of the possible items that may arise when you interview an applicant for training.

Question 1

In the table below are a number of aspects of an individual's presentation. Please rate each item as to its importance with regard to being accepted for training using the scale below and record your response in the Rating Column:

-2	-1	0	+1	+2
Strong indicator for rejection.		Neutral		Strong indicator for acceptance

Domain	Item	Rating (Question 1)	Ranking (Question 2)
Family History	1. Supportive & Loving Parents		
	2. Absence of chronic conflict between parents.		
	3. Absence of serious psychological difficulties within family or individuals.		
	4. Positive first memories.		
	5. Stable Socio-Economic Status.		
	6. History of abuse of whatever sort within family.		
Educational History	7. Normal Developmental milestones		
	8. Well remembered transitional objects		
	9. Good educational experience Primary School		
	10. Good educational experience Secondary School		
	11. Good educational experience University		
	12. Troubled adolescence i.e. conflict with parents		
Employment	13. Stable relationships at work		
	14. Success in career of choice		
	15. Satisfying Hobbies/leisure activities.		
Relationships	16. Satisfactory Sexual relationships		
	17. Marriage		
	18. Homosexuality		
	19. Extra-marital relationships		
	20. Clear & coherent sexual identity		
	21. Worked through experience of sexual abuse		
Health	22. Presence of past Psychosomatic Illness		
	23. Presence of past Psychotic Episode		
	24. Presence of current Medical Illness		
	25. Presence of current Medical illness with identified psychological component		
	26. Previous experience of therapy irrespective of quality of experience		
	27. Good experience of previous psychotherapy		

Current State	28. High quality of current relationship		
	29. Gaps present in personal history provided		
	30. Stable sexual relationship		
	31. Good relationship with own children		
	32. Capacity for empathy/introspection		
	33. Presence of significant neurotic symptoms e.g. major work problems		
	34. High level of Intellectual Functioning (IQ)		
	35. Good current relationship with parents		
	36. Good current relationship with siblings		
Behaviour with Interviewer.	37. A high degree, in terms of quantity or intensity, of motivation to train.		
	38. A high degree of understanding as to the underlying reasons for wishing to train.		
	39. Evidence of the capacity to freely express him/herself in the consultation.		
	40. Evidence of the capacity to describe the thoughts and feelings which really seemed to concern the applicant during the consultation.		
	41. Feeling a rapport or empathically 'in touch' with what the applicant was experiencing during the consultation		
	42. Feeling you understood the meaning of what the applicant said during the consultation (in whatever conceptual terms you find most useful).		
	43. Evidence that the applicant was able to use the interview to understand aspects of his/her experience.		
Other	44.		

Question 2

There are 44 items in the above table. Could you now rank them in order of importance using the number '1' for the most important and '44 ' for the least important. Could you write your responses in the Ranking Column of the above table.

Question 3

In your experience, to what extent do the following areas routinely arise in your consultations to applicants for training. Please use the following scale writing your response in the Rating Column:

-2 -1 0 +1 +2
Hardly ever Neutral Nearly always
arises.

Area of Discussion	Rating (Question 3)	Ranking (Question 4)
1. Social activities and relationships, friends and acquaintances		
2. Work, supervisors, associates at work		
3. Recreations, hobbies, interests		
4. Domestic and household responsibilities, concerns and activities (finances, children)		
5. Relationship with spouse, boyfriend or girlfriend.		
6. Current relations with parents, brothers or sisters.		
7. Childhood experiences with family members, and feelings about them.		
8. Childhood experiences in school with friends and with other kids.		
9. Feelings and attitudes toward self.		
10. Body functions, health, physical symptoms.		
11. Inadequacies, fears or successes in getting along personally and socially.		
12. Sexual feelings and experiences.		
13. Angry and aggressive feelings and experiences.		
14. Feelings about being close to or needing someone.		
15. Dreams, fantasies.		
16. Plans, hope and goals for the future.		
17. Strange or unusual ideas, feelings or experiences.		
18. Therapy, the therapist, being a patient or therapist.		
19. Other:		

Question 4

There are 19 items in the above table. Could you now rank them in order of importance using the number '1' for the most important and '19 ' for the least important. Could you write your responses in the Ranking Column of the above table.

**Please make sure you have answered every item and thank you
for completing this questionnaire.**

The Adult Attachment Interview
(George, Main & Kaplan 1985)

1. Could you start by helping me to get oriented to your early family situation, and where you lived and so on? If you start out with where you were born, whether you moved around much, what your family did at various times for a living?
2. I'd like you to try to describe your relationship with your parents as a young child ... if you could start from as far back as you can remember?
3. Now I'd like to ask you to choose five adjectives that reflect your childhood relationship with your mother. I know this may take a bit of time, so go ahead and think for a minute ... then I'd like to ask you why you chose them.
4. Now I'd like you to choose five adjectives that reflect your childhood relationship with your father. I'm going to ask you again why you chose them.
5. To which parent did you feel the closest and why? Why isn't there this feeling with the other parent?
6. When you were upset as a child, what would you do?
7. What is the first time you remember being separated from your parents? How did you or they respond? Are there any other separations that stand out in your mind?
8. Did you ever feel rejected as a young child? Of course, looking back on it now, you may realise it was not really rejection, but what I'm trying to ask about here is whether you remember ever having felt rejected in childhood.
9. Were your parents ever threatening with you in any way, maybe for discipline, or maybe just jokingly?
10. How do you think these experiences with your parents have affected your adult personality? Are there any aspects to your early experiences that you feel were a set-back in your development?
11. Why do you think your parents behaved as they did during your childhood?
12. Were there any other adults with whom you were close, like parents, as a child? Or any other adults who were especially important to you, even though not parental?
13. Did you experience the loss of a parent or other close loved one (sibling, or close family member) while you were a young child?
 - 13(a) Did you lose any other important persons during your childhood?
 - 13(b) Have you lost any other close persons in adult years?

14. Have there been many changes in your relationship with your parents (or remaining parent) since childhood? I mean from childhood through until the present?
15. What is your relationship with your parents like for you now as an adult?
16. How do you respond now in terms of feelings when you separate from your child?
17. If you had three wishes for your child twenty years from now, what would they be? I'm partly thinking of the kind of future you would like to see for your child. I'll give you a minute to think about this one.
18. Is there any particular thing which you feel you learned above all from your own childhood experiences? What would you hope your child might have learned from his/her experiences of being parented?

CLINICAL PLACEMENT RATING FORM

Name of Trainee: _____

Name of Supervisor: _____

Type of Placement: (Learning Difficulties, Child, etc) _____

Starting Date: _____ Completion Date: _____ No. of Days: _____

Has the contract been fulfilled? YES/NO (Please circle one)

Placement Rating: PASS/FAIL

Signature of Supervisor: _____ Signature of Trainee: _____

General Comments of Supervisor:

General Comments of Trainee:

CLINICAL FEEDBACK FORM

3)

INSTRUCTIONS

You are asked to complete this form;

- a) to give feedback to the trainees
- b) to assist you in making the overall placement rating.

Please tick the description which best fits and please use the space available for comments. Give examples where you can to explain your feedback. Please indicate wherever an item is not relevant to your placement, and please use the space provided to add items which may be more relevant to your placement.

-
- 1) SKILLS OF ASSESSMENT e.g. Is able to choose the most appropriate formal psychometric test, or select a method for gathering data, record and summarise it accurately.

- a) Needs more tuition e.g. lacks basic skills or knowledge
- b) Functions satisfactorily but e.g. occasionally misses information
- ☒ c) Functions as general description given above.

Comments:

-
- 2) INTERVIEWING SKILLS - Is able to establish a therapeutic atmosphere, ask the appropriate full range of questions, understand the significance of the client's communications and respond appropriately.

- ☒ a) Functions as above
- b) Satisfactorily but occasionally, e.g. misses information
- c) Needs more tuition or experience, e.g. manner too stiff or over familiar

Comments:

3) KNOWLEDGE OF TREATMENT METHODS - Shows sound knowledge of major techniques of therapy. Is aware of theoretical shortcomings or difficulties.

- a) Has sometimes seemed unaware, e.g of more than one approach, or how to proceed.
- ✓ b) Is competent and functions as general descriptions given above.
- c) Has very little theoretical knowledge.

Comments:

4) FORMULATION OF PROBLEMS - Is able to evaluate the results of interviews or assessment within a sound theoretical framework. Can formulate goals for further assessment or intervention.

- a) Is sometimes 'woolly' overinclusive or unclear
- ✓ b) Functions as general description given above
- c) Seldom is able to formulate without help.

Comments:

5) MANNER WITH CLIENTS OR RELATIVES - Is able to establish a therapeutic alliance or rapport, understand client's communications, respond in an appropriately therapeutic manner. Handles difficulties constructively.

- ✓ a) Functions as above
- b) Is sometimes e.g unempathic, too distant, over familiar
- c) Needs specific training in psychotherapy/communication skills

Comments:

- 6) PERSISTENCE WITH DIFFICULT PROBLEMS OF PATIENTS - Show interest rather than e.g despair. Adopts a constructive, realistic approach.

9.

- ☒ a) Functions as above
- b) Sometimes requires prompting or 'holding back'
- c) Is inappropriately and consistently e.g over zealous or work shy.

Comments:

-
7. WRITTEN WORK - Writes reports and letters promptly and well. No correction normally required, show clarity of thought and expression.

- a) Needs extra tuition e.g in report writing
- b) Sometimes needs assistance
- ☒ c) Functions as in general description given above

Comments:

-
8. RELATIONSHIP WITH COLLEAGUES - Gets on well with other staff
Communicates effectively and well.

- a) Is a bit shy, or over familiar
- ☒ b) Functions as general description given above
- c) Cannot function without supervision

Comments:

9. PROFESSIONAL BEHAVIOUR - Carries out work reliably, contributes with suggestions, work promptly, independently, responsibly and efficiently.

- a) Consistently evidences e.g poor timekeeping or cannot manage a reasonable workload.
- b) Is occasionally late or cancels appointments
- ✓ c) Is competent, functions as in general description given above.

Comments:

10. FUNCTIONING WITHIN THE ORGANISATION/UNIT/CLINIC ETC - Understands the work context, attend relevant meetings, contributes and communicates through appropriate channels, tolerates interdisciplinary disagreement.

- a) Remain e.g underinvolved, appears to disregard context
- b) Occasionally misses meetings or doesn't contribute
- ✓ c) Functions as in general description given above

Comments:

11. TRAINING AND TEACHING OTHERS - Understands the aims of teaching, presents material clearly and effectively. Can adapt to teaching different groups.

- a) Is competent, functions as above
- b) Needs more practice
- c) Needs particular teaching to acquire these skills.

Comments:

CLINICAL PRACTICE QUESTIONNAIRE

REF _____

Background information:

1. Your age: 20-30 ()
 31-40 ()
 41-50 ()
 51-60 ()
2. Sex: M () F ()
3. Please indicate the year that you qualified:
4. What is your current grade as a Psychologist?
5. Have you had/are you having personal therapy? Yes () No ()
6. If yes, please answer the following:
 - a. What was/is the model/orientation?
 - b. How many hours have you had approximately in total?
7. If you have not had personal therapy, please indicate on the following scale to what extent you have considered it:

NOT AT ALL

1

2

3

4

VERY SERIOUSLY

5

Interest at Work.

8. What is the main area of your clinical work?
Please tick one only or specify degree of split in joint posts, e.g. 3 sessions adult, 3 sessions learning disability
 - a. Adult Mental Health ()
 - b. Children/Young people ()
 - c. Learning Disabilities ()
 - d. Older Adult ()
 - e. Forensic ()
 - f. Other (please specify) ()
9. Is this the client group that you would ideally prefer to work with?

YES () NO ()
10. If NO, please indicate what would be your preferred specialty (as listed above):
a. () b. () c. () d. () e. () f. ()

11 Please indicate how you primarily see your role (tick only one).

- Clinical practitioner ()
- Academic ()
- Researcher ()
- Consultant ()
- Supervisor ()
- Manager ()
- Other (please specify) ()

12. Please indicate the **one** approach to therapy that you most often use in your work:

- a. Analytic/Psychodynamic ()
- b. Behavioural ()
- c. Cognitive ()
- d. Humanistic ()
- e. Systemic ()
- f. Eclectic/integrationist ()
- g. Other (specify) ()

13. Which single approach from Question 12 most closely resembles your view of human psychological functioning? (Please indicate a,b,c,d,e,f,g) :

- a. () b. () c. () d. () e. () f. () g. ().....

14. Which of the following is your preferred mode of working (please tick only one):

With the individual ()	Through carers/staff ()
With the family ()	With service systems ()
With groups ()	

15. Which way do you prefer to work: (tick **only** one)

- Alone ()
- With another therapist ()

Current therapeutic work:

16. Please indicate on the scale below how **rewarding** you find it to work with patients with the following levels of disturbance:

[1 = not at all rewarding, 5 = extremely rewarding]

a	MILDLY DISTURBED: <i>Some</i> difficulty in social, occupational or school functioning. Distressed, but generally able to manage.	0 1 2 3 4 5
b	MODERATELY DISTURBED: Moderate impairment in social, occupational or school functioning	0 1 2 3 4 5
c	SERIOUSLY DISTURBED: Serious impairment or inability to function in several or most areas.	0 1 2 3 4 5

17. Difficulties in Therapeutic Practice. (This question has been taken from an international Study of the development of Psychotherapists.)

Currently, how often do you feel...? [0=Never.....5=Very often]

a	Lacking in confidence that you can have a beneficial effect on a patient have a beneficial effect on a patient.	0 1 2 3 4 5
b	Afraid that you are doing more harm than good in treating a patient	0 1 2 3 4 5
c	Unsure how best to deal effectively with a patient.	0 1 2 3 4 5
d	In danger of losing control of the therapeutic situation to a patient.	0 1 2 3 4 5
e	Unable to have much real empathy for a patient's experiences.	0 1 2 3 4 5
f	Uneasy that your personal values make it difficult to maintain an appropriate attitude towards a patient.	0 1 2 3 4 5
g	Distressed by your powerlessness to affect a patient's tragic life situation.	0 1 2 3 4 5
h	Troubled by moral or ethical issues that have arisen in your work with a patient.	0 1 2 3 4 5
I	Unable to generate sufficient momentum to move therapy with a patient in a constructive direction.	0 1 2 3 4 5
J	Irritated with a patient who is actively blocking your efforts.	0 1 2 3 4 5
k	Demoralised by your inability to find ways to help a patient.	0 1 2 3 4 5
l	Guilty about having mishandled a critical situation with a patient in.	0 1 2 3 4 5
m	Unable to comprehend the essence of a patient's problems.	0 1 2 3 4 5
o	Unable to find something to like or respect in a patient.	0 1 2 3 4 5

p	Disturbed that circumstances in your personal life are interfering in your work with a patient.	0	1	2	3	4	5
q	Angered by factors in a patient's life that make a beneficial outcome impossible.	0	1	2	3	4	5
r	Conflicted about how to reconcile obligations to a patient and equivalent obligations to others.	0	1	2	3	4	5
s	Bogged down with a patient in a relationship that seems to go nowhere.	0	1	2	3	4	5
t	Frustrated with a patient for wasting your time.	0	1	2	3	4	5
u	Something else that is difficult for you [please specify]:	0	1	2	3	4	5

18. Please could you think of the client that you found most **rewarding** to work with over the last year. Please indicate:

a. Problem referred for:

b. Age: and c. Gender:

d. Other relevant information:

Could you explain briefly what it was about this client and your relationship with them that you found **rewarding**:

19. Please could you think of the client that you found most **difficult** to work with over the last year. Please indicate

a. Problem referred for:

b. Age: and c. Gender:

d. Other information:

Could you briefly explain what it was about this client and your relationship with them that you found difficult:

Work satisfaction:

20. How much over-time do you think that you do in an average week:

< 5 Hrs () 5-10 Hrs () 10-20 Hrs () > 20 Hrs ()

21. How supported do you feel in your main work setting? (i.e. do you get adequate and supportive supervision, can you discuss cases with colleagues, does the department/team ethos or philosophy match your own, etc.)

NOT AT ALL

VERY MUCH SO

1

2

3

4

5

22. To what extent do you feel that your work life interferes with your personal life?

NOT AT ALL

VERY SERIOUSLY

1

2

3

4

5

23. Overall how satisfied are you with your job?

NOT AT ALL

VERY MUCH SO

1

2

3

4

5

24. Overall how competent do you feel yourself to be at your job?

NOT AT ALL

EXTREMELY

1

2

3

4

5

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE
THIS IS THE END.



UNIVERSITY COLLEGE LONDON

Psychoanalysis Unit

SUB-DEPARTMENT OF CLINICAL HEALTH PSYCHOLOGY
GOWER STREET • LONDON WC1E 6BT

CONFIDENTIAL

HEALTHY VOLUNTEER CONSENT FORM.

**A Study Of The Relationship Between Current Views Of Self (Attachment Status)
And
The Experience Of The Application Procedure To The Westminster Pastoral
Foundation For Training Leading To The Diploma In Psychodynamic Counselling**

NAME OF PARTICIPANT:

CONTACT ADDRESS:

Have you read the information sheet about this study? YES|NO

Have you had the opportunity to ask questions and discuss this study? YES|NO

Have you received satisfactory answers to all your questions? YES|NO

Have you received enough information about this study? YES|NO

Do you understand that you are free to withdraw from this study...

*at any time YES|NO

*without giving a reason for withdrawing YES|NO

Do you agree to take part in the study? YES|NO

Signature of participant

Dated

Signature of investigator

Dated

Freud Memorial Professor & Co-Director: Peter Fonagy 0171-380 7896 • E-mail: p.fonagy@ucl.ac.uk
Professor Emeritus & Co-Director: Joseph Sandler 0171-286 3937 • E-mail: 100450.1357@compuserve.com
Senior Lecturer & MSc Course Organiser: Mary Target 0171-391 1257 • E-mail: mary.target@ucl.ac.uk
Sub-Department Administrator: Julia Curl 0171-380 7896 • E-mail: j.curl@ucl.ac.uk
Conference Organiser: Paula Barkay 0171-286 3937 • E-mail: 100450.1357@compuserve.com
MSc and General Enquiries: Helen Cork 0171-380 7899 • E-mail: h.cork@ucl.ac.uk
Fax: 0171-916 1989

APPENDIX 2: ADDITIONAL DATA

- Table 1. Factor Analysis of Adult Mental Health Evaluation Rating;
Loadings of Evaluation scales on Factors.
- Table 2. Factor Analysis of Learning Difficulties Evaluation Rating;
Loadings of Evaluation scales on Factors.
- Table 3. Factor Analysis of Child and Family Evaluation Rating;
Loadings of Evaluation scales on Factors.
- Table 4. Factor Analysis of Mean Evaluation Rating; Loadings of
Evaluation scales on Factors.

**Table 1: Factor Analysis of Adult Mental Health Evaluation Rating;
Loadings of Evaluation scales on Factors.**

Placement Evaluation Scale	Adult Mental Health Factors				
	Professional Work	Assessment Skills	Manner	Professional Behaviour	Persistence
Assessment skills		.84			
Interview skills					
Knowledge of Treatment Methods					.50
Capacity for Formulation		.79			
Manner with Clients			.87		
Persistence with Difficult Clients					.82
Written work.	.65				
Relationship with Colleagues			.72		
Professional Behaviour			.51	.65	
Functioning within the Organisation	.82				
Use of Supervision	.79				
Accurate Self Appraisal					

**Table 2: Factor Analysis of Learning Difficulties Evaluation Rating;
Loadings of Evaluation scales on Factors.**

Placement Evaluation Scale	Factors Derived from Learning Difficulties Placement		
	Capacity for Clinical Work	Diagnostic & Written Skills	Dedication
Assessment Skills	.80		
Interview Skills		.74	
Knowledge of Treatment Method		.88	
Capacity for Formulation		.76	
Manner with Clients	.80		
Persistence with Difficult Clients			.87
Written Work		.79	
Relationship with Colleagues	.84		
Professional Behaviour	.58		
Functioning within the Organisation	.85		
Use of Supervision			.93
Accurate Self Appraisal		.55	.63

**Table 3: Factor Analysis of Child and Family Evaluation Rating;
Loadings of Evaluation scales on Factors.**

Placement Evaluation Scale	Factors derived from Child & Family Psychology Ratings.			
	Relating	Use of Supervision	Knowledge	Reporting Skills
Assessment Skills				.72
Interview Skills	.83			
Knowledge of Treatment Method			.90	
Capacity for Formulation			.81	
Manner with Clients	.75			
Persistence with Difficult Clients		.74		
Written Work				.76
Relationship with Colleagues	.92			
Professional Behaviour				.55
Functioning within the Organisation				
Use of Supervision		.81		
Accurate Self Appraisal		.60		

Table 4: Factor Analysis of Mean Evaluation Rating; Loadings of Evaluation scales on Factors.

Placement Evaluation Scale	Factors derived from Mean Ratings		
	Professional Clinical Work	Use of Supervision	Teaching
Assessment Skills		.55	.57
Interview Skills	.80		
Knowledge of Treatment Method			.63
Capacity for Formulation	.62		
Manner with Clients	.86		
Persistence with Difficult Clients	.74		
Written Work	.78		
Relationship with Colleagues	.68		
Professional Behaviour	.93		
Functioning within the Organisation	.73		
Use of Supervision		.83	
Accurate Self Appraisal		.86	