european psychotherapy

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Varieties of Psychotherapeutic Experience

Abstract

Meta-analytic studies have concluded that level of psychotherapeutic experience, whether measured in years of professional practice or in terms of level of training, has at most a weak relation to treatment outcome. It is suggested that this is due to the failure to distinguish between different aspects of therapeutic experience. Assuming a less simplistic view on therapeutic experience, we studied the relations among a number of experience indicators in a random national sample of 227 licensed psychotherapists Sweden. On the basis of a cluster analysis of the experience indicators, four kinds of therapist experience were identified. One, seniority, may be considered a core variety of experience in terms of number of post-license years, supervisor training and activity, and training in several varieties of psychotherapy. Another variety of experience that emerged in the analysis, called psychodynamic repute, had psychoanalytic training and long personal therapy as its principal indicators (linked to seniority by way of long private practice). A third experience cluster was long and faithful service, indicated by long experience of psychotherapy in psychiatric practice, inpatient or outpatient, as well as age and number of pre-license years. A fourth, variety was associated with a large accumulated case-load, particularly linked to cognitive-behavioural orientation and practice. It is suggested that, in judging qualification of applicants for training, jobs, or teaching positions, it may be important to differentiate among these kinds of experience.

Introduction

Most people would agree that professional experience is a good thing in general, and when it is not, we prefer to use other names for it, like routine, or burnout. Thus, being experienced as a psychotherapist is generally a quality contributing to one's credibility – possibly also to one's quality. Therefore, it becomes a bit confusing and disturbing when research is reported to the

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effect that therapeutic experience, or clinical experience in general, does not seem to pay off for the clients. A classic example are the findings of Strupp and Hadley (1979) of no outcome differences between professional therapists and relations-skilled university teachers. Although Strupp (1996) himself has de-emphasized it, Dawes (1994), Jacobson (1995), and others, have contended the interpretation that clinical training and experience are irrelevant or that psychotherapy as such is more based on faith than on learning and knowledge.

Several research reviews on the value of experience of psychotherapists have also arrived at negative conclusions (Auerbach & Johnson, 1977; Berman & Norton, 1985; Beutler, Machado & Neufeldt, 1994; Hattie, Sharpley & Rogers, 1984; and for children and adolescents, Weisz, Weiss, Alicke & Klotz, 1987). Stein and Lambert (1984, 1995) appear to have treated the issue in the most systematic and sophisticated manner, in two meta-analyses. In their first meta-analysis, they found the average effect size equal to 0, meaning no difference between more and less experienced therapists. In their second meta-analysis, Stein and Lambert (1995) focussed on training and concluded that "a variety of outcome sources are associated with modest effect sizes favoring more trained therapists" (p. 182). "Modest effect sizes" in this case refer to d values between 0.2 and 0.3, which are conventionally called "small effects" (Cohen, 1988). These results are probably counter-intuitive to most of us. Among others, Rönnestad, Orlinsky, Parks, Davis et al. (1997) have noted that the null findings might have been due to the fact that the allegedly experienced therapists have indeed not been very experienced, which has led to restriction of range and thereby weaker relations between therapist experience and patient outcome. Another – so far unexplored – reason for the unexpected meta-analytic findings may be that experience has been taken as a unitary phenomenon, which it may not be. Stein and Lambert commented, 1995 as well as 1984, that researchers usually had confounded training level, training quality, duration of clinical practice, case-load, and age, and suggested that difficulties in the definition of therapeutic experience had hampered research integration in the area. Even such sophisticated studies as those of Orlinsky, Rönnestad et al. (1999) and Rönnestad et al. equated therapeutic experience with "duration in professional practice [of psychotherapy] (answered in months and years)" (1997, p. 194). It is likely that experience is somewhat more complicated than that. The purpose of this paper was to consider, theoretically and empirically, the various aspects of psychotherapeutic experience? The importance of this issue is highlighted in situations where the qualifications of therapists, therapy students, or applicants for therapy training have to be judged and compared, typically based on various parameters of experience.

First, to avoid confusion, it should be understood that psychotherapeutic experience in this particular context refers to the level of professional experience of the therapist, not to his or her individual experiences as a therapist. Second and more specifically, psychotherapeutic experience should be understood to refer to parameters or indicators of the level of professional

experience of the therapist, as distinct from his or her stage of development as a therapist. Whereas a number of models of development as a clinician or a psychotherapist attempt to capture internal processes of adaptation, socialization, or maturation in the therapeutic profession (Hogan, 1964; Skovholt & Rönnestad, 1992a, b; Stoltenberg & Delworth, 1987), therapeutic experience in this paper refers to external variables that may be assumed to influence these processes.

Given these qualifications, at least two components seem to be implied in the concept of therapeutic experience, basically, length of practice and level of training, but various qualifications and interactions of these variables generate multiple variables of each kind. Surely, most would hold a therapist as experienced if she/he has had a long practice in the profession, where experience may be easily measured in terms of number of years. However, these years may have been spent in different settings, in psychiatry, for instance, or in private practice, and these setting are probably rather different in terms of types of patients and types of services. There is a risk, also, that one may neglect the therapist's degree of activity during these years, whatever the setting. Thus, it might be more appropriate to measure experience in terms of case-load, the accumulated number of clients treated. One may also distinguish between different levels of qualification or training. Some studies have accordingly compared students at different stages of training or compared licensed therapists or trained therapists with people without any such training (professionals v. paraprofessionals). Of course, length of experience at different levels of training is a complicating interaction between these two basic dimensions. Another aspect of therapeutic training, which Stein and Lambert suggested is seldom considered in research, is the quality of training. Operationally, they proposed to measure the number of theoretical courses and/or the number of hours of supervision. Formal training as supervisor, if available, may be other parameter of training quality. Also, one might consider the therapist's possible activity as a psychotherapy teacher, as supervisor or in other training capacities. Still another component of experience, really a part of professional training that is considered indispensable in psychodynamic circles, is the therapist's personal therapy, or training analysis, as it is called among psychoanalysts (Macran & Shapiro, 1998). It should be kept in mind, however, that the value and meaning of these various components or indicators of experience may depend on the specific school of psychotherapy. Just as personal therapy might make many behavioural therapists appear less experienced, case-load would necessarily cast doubts about the experience of many psychoanalysts.

In view of this diversity of indicators and their modifications and interactions it is no wonder that consistent findings on the associations between "therapist experience" and patient outcome have not been found. Is it possible that the meta-analytic null findings (Stein & Lambert, 1984, 1995; Beutler, Machado & Neufeldt, 1994) are a consequence of the amalgamation of diverse variables of which some have positive and some negative associations with outcome?

An attempt exploratory to chart the terrain of therapeutic experience in order to discover its dimensions or components seems never to have been undertaken, however.

On the hypothesis that therapeutic experience is multidimensional, the purpose of this study was, therefore, to analyze the associations among various parameters of therapeutic experience in order to identify its specific components or aspects. In the Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPP) we have data to submit the associations between various aspects of psychotherapist experience to a rather fine-grained analysis. The STOPPP consists of a number of data collections on patients in long-term psychotherapy and psychoanalysis and their therapists, as well as on various comparison samples. For this particular study we have used a survey in a random national sample of psychotherapists in Sweden that was undertaken for standardization purposes in the STOPPP.

Method

Respondents

The study is a survey in a random sample of licensed psychotherapists in Sweden. In 1996 a mail questionnaire, Therapeutic Identity (THID), was distributed to 325 psychotherapists throughout Sweden. These were a random sample from the population of all psychotherapists licensed at that time by the National Board of Social Welfare. After four reminders 227 of the therapists had responded (70%). The only systematic difference found between responders and non-responders was that therapists in the higher age categories were under-represented in the former category, claiming to have retired from active work.

The questionnaire

The THID[1] has about 150 questions and/or items, divided in six sections, (a) demographics, academic and professional training (age; gender; graduate education [M.D., psychologist, social worker, etc.]; psychotherapeutic training for licensing purposes; auxiliary psychotherapeutic training more than one year; formal supervisory training; academic training or professional training outside psychology or psychotherapy; membership in professional associations), (b) professional experience (duration of psychotherapy practice before and after licensing; psychotherapy practice in different contexts [outpatient or inpatient psychiatry, private practice, etc.]; accumulated case-load in different categorizations [types of therapy, durations and frequencies, age and diagnostic groups of patients, etc.]; supervision taken and/or given past 12 months, (c) personal therapy or training analysis (rounds; kinds; frequencies; durations). The items

[1] **There is now an English, a German, and a Spanish translation of the original Swedish version. All versions are available through the first author.**

were designed specifically for the project or adopted from the questionnaire used in the Society for Psychotherapy Research (SPR) network (Orlinsky, Ambühl et al., 1999). The most important information culled from these sections is summarized in Table 1. Section (d) is a set of six scales to rate one's allegiance to each of some major schools of psychotherapy. Sections (e) to (f) of the THID has three sets of items to chart the therapists therapeutical orientation (Blomberg & Sandell, in press). Items from sections (d) to (f) were not used in this study.

Results

Table 1 presents percentage distributions of the sample on various background and experience variables taken from sections (a) to (c) in the THID. The majority of the therapists were female, between 50 and 54 years of age, and psychologists. If we consider the training that was the basis for the therapist' license, the vast majority (almost 70%) graduated from one of several training institutes with a psychodynamic orientation, either in a university setting or at extra-university training sites. About 10 of these almost 70% were trained at an institute specializing in psychotherapy with children and adolescents. More than 10% had family therapy training, irrespective of theoretical orientation, and 5% psychoanalytic training at either of the two institutes in Sweden. Not more than 2% had training in behavioural or cognitive-behavioural therapy, and only another 2% cognitive therapy training, and these varieties of training will be collapsed into a CBT training variable in the following analyses. More than 50% had additional training in more specific psychotherapeutic modalities after their licensing, and more than 40% had formal training as supervisors. Almost 30% had an academic or professional training outside psychotherapy or related areas.

Where on-the-job experience is concerned, the average length of experience was as high as 17 years, longer before licensing (10.7) than after (6.6). The mean number of years providing psychotherapy in outpatient psychiatry was almost nine years, in inpatient psychiatry almost three, and in private practice more than five. The average number of patients treated was over 80. More than 50% had taken regular supervision during the past 12 months, and more than 50% had supervised colleagues regularly last year. The average therapist had been in personal therapy more than two rounds, for a total of almost eight years, most frequently in individual psychodynamic psychotherapy.

Fifteen variables were selected to explore the structure of psychotherapeutic experience, and these are indicated by bold-face in Table 1. The selection was intended to cover a broad range of experience-related variables. In view of the different metrics of the variables (and the crude metrics of some of them), correlations among the variables were computed using the PRELIS 2.30 program (Jöreskog & Sörbom, 1994, 1999), which estimates product-moment, polyserial, or polychoric correlations in accordance with the scale levels of the variables. These correlations were then subjected to a cluster analysis of the variables, according to a simple and effi-

Table 1: **Distributions (%, unless otherwise specified) on Selected Background and Experience-Related Variables among Therapists in a Random National Swedish Sample (N = 227)**

Gender	
female	68
male	32
Age	
– 44	14
45-49	23
50-54	39
55-60	16
61+	8
M (SD)	51.4 (6.5)
Basic academic training	
MD	11
psychologist	62
social worker	16
other	11
Psychotherapy training taken as a basis for licensing	
psychoanalytic	5
psychodynamic therapy, university training	19
psychodynamic therapy, extra-university training sites	41
child and adolescent psychotherapy	9
behavioural/cognitive-behavioural therapy	2
cognitive therapy	2
family therapy	12
group therapy	2
unspecified	8
Auxiliary psychotherapy-related training	
(›1 yr course(s) in the psychology or psychotherapy area)	55
Formal training as supervisor	43
Academic training or professional training beside the above	28
No. yrs in psychotherapy practice	
before licensing; *M (SD)*	10.7 (6.5)
after licensing; *M (SD)*	6.6 (4.2)
No. yrs doing psychotherapy in	
outpatient psychiatric practice; *M (SD)*	8.9 (7.8)
inpatient psychiatric practice; *M (SD)*	2.6 (5.1)
private practice; *M (SD)*	5.5 (6.5)

Accumulated no. patients in individual psychotherapy ("case-load")	
1-9	
10-24	7
25-49	15
50-99	21
100-199	25
200+	21
M (SD)	82.9 (125.8)
Been in supervision last 12 mos.	
regularly	54
occasionally, as needed	27
not at all	19
Has supervised colleagues last 12 mos.	
regularly	53
occasionally, on request	27
not at all	20
Number of personal therapies; *M (SD)*	2.3 (1.0)
Total duration (in years) of personal therapy; *M (SD)*	7.9 (3.6)
Total number of sessions of personal therapy (dose); *M (SD)*	566.7 (454.7)
Main kind of training therapy (in terms of duration)	
psychoanalysis	21
individual psychotherapy, generally psychodynamic	61
group therapy	11
behavioural/CBT/cognitive	1
unspecified	6

Note. **Boldface** indicates that the variable has been included in the subsequent cluster analyses.

cient, although little known, manual procedure suggested by Kamen (1970). The clustering technique is based only on the ordinal information about the correlations, again making the original metrics of the variables less important. The procedure is to determine, for each variable, its closest connection to another variable (or variables, in case of ties), according to some measure of association, in the present case, the correlations. Only positive associations are considered; thus, the clustering disregards the contrast implied by negative associations. The strongest connection of each variable is then considered a link to the other variable, and the link is graphically indicated by an arrow. In case of ties, two or more links/arrows are entered, and mutual links are indicated by two-headed arrows. In order to obtain a more nuanced structure, these strongest links may be complemented by all other links representing correlations hig-

her than, say, .30. Such links may indicate between-clusters connections. In all its simplicity, Kamen's method often produces a robust solution that agrees remarkably well with those of more technically advanced multivariate methods, like component analysis of factor analysis. Because of missing values – 40 of the cases had one observation missing, seven had two and four had three – two correlation matrices were computed, one with missing observations (effective sample size = 176) and one with the missing observations imputed (effective sample size = 227). The cluster analysis solutions were very similar and the few differences will be commented upon. The correlation matrix based on the imputed data is displayed in Table 2, and the corresponding cluster solution is presented in Figure 1. In this figure, the strongest link of each variable is indicated as an arrow, whereas all other links stronger than .3 are indicated by lines without arrowheads. The thickness of each line indicates the approximate strength of the link.

Table 2: **PRELIS-Computed Correlations among Experience-Related Variables (after Imputation of Missing Values) in a Random National Sample of Swedish Therapists (N = 227)**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Age														
2. Psychoanalytic training	-.22													
3. Cognitive/cognitive-behavioural training	-.10	-.76												
4. Auxiliary therapy training	.23	-.27	-.05											
5. Academic training	.08	-.18	-.04	-.10										
6. Supervisor training	.21	.20	-.06	.16	-.12									
7. Pre-license therapy	**.35**	-.09	.14	.16	-.04	.00								
8. Post-license therapy	.33	.19	.02	**.31**	-.01	**.67**	-.18							
9. Case-load	.04	.05	**.41**	.26	-.08	*.33*	.20	.21						
10. Outpatient psychiatry	.13	-.10	.05	.13	-.22	**.28**	**.28**	.24	.21					
11. Inpatient psychiatry	.14	-.16	.14	.22	-.06	.11	**.23**	.09	.02	.14				
12. Private practice	.22	**.45**	-.14	.29	**.09**	.22	.01	*.37*	.16	-.24	-.09			
13. Been in supervision	-.12	-.00	-.37	.03	-.13	-.19	-.11	-.17	-.04	-.06	.00	-.13		
14. Supervised colleagues	-.02	.06	.04	.18	-.18	**.64**	.08	*.33*	*.32*	.21	.07	.17	**.17**	
15. Length of personal therapy	.05	**.50**	-.32	.19	.00	.14	-.02	.18	.15	.06	-.03	.16	**.17**	.17
Means														

Note. **Boldface** figures indicate strongest correlation for each variable. *Italics* identify correlations ›.30.

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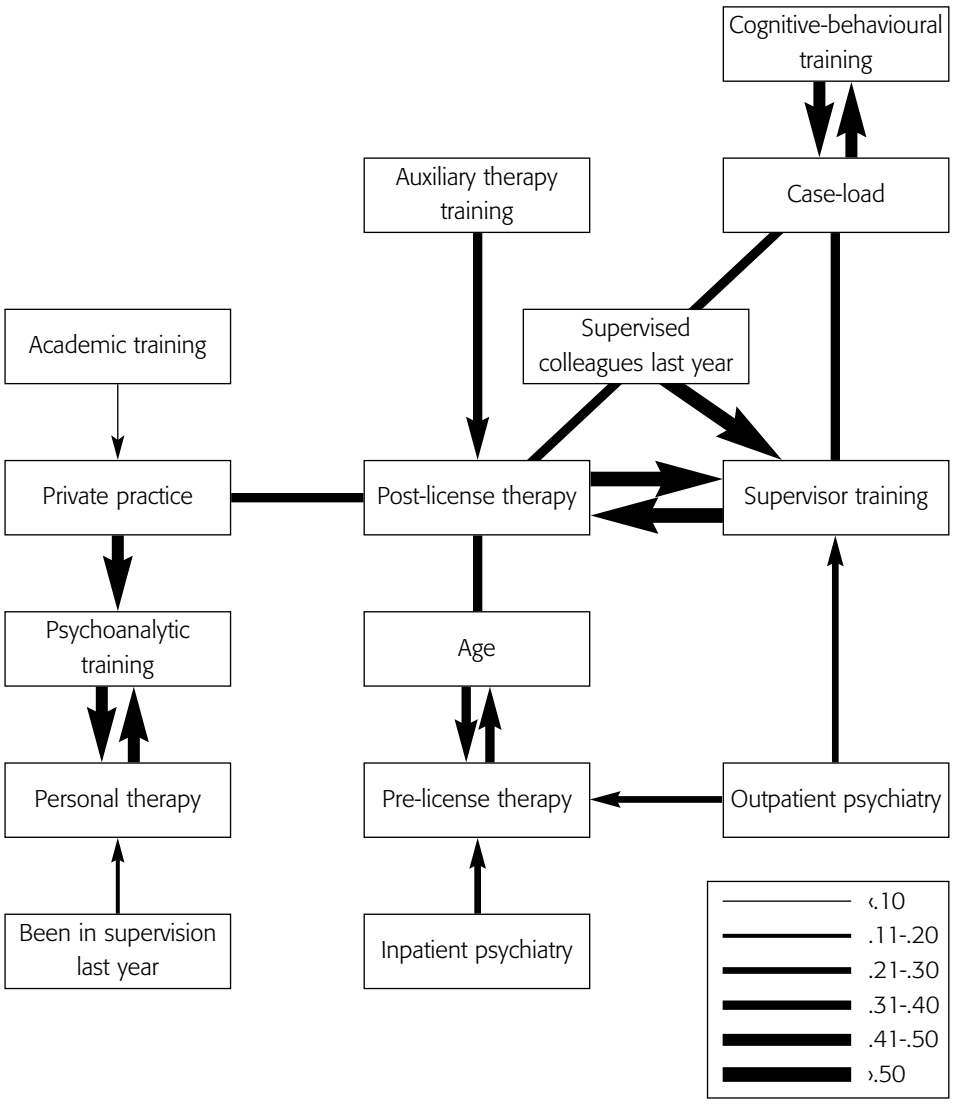

Figure 1. Links between experience indicators based on PRELIS-estimated correlations. An arrow indicates the strongest link (maximal correlation) from each variable, and its approximate strength is indicated by the thickness of the corresponding line. Links without arrowheads indicate submaximal correlations › .3.

A reasonable way to determine the number of clusters in Kamen's technique is, simply, to take only the strongest links of each variable into account. If one follows that principle, one will see that there were four distinct clusters of experience variables.

The core cluster, according to Kamen's technique, should be defined by the single strongest link in the correlation matrix. It is shown in the center right in Figure 1. The central variables were having formal training as supervisor and number of years working as a therapist after licensing, with a strong mutual link (.67). Also, current or recent activity as supervisor was strongly related to both, most strongly to supervisor training (.64). Further, training in additional varieties of therapy besides the one being the basis for one's licensing (auxiliary therapy training) had its strongest link to number of years after licensing (.31).

The second cluster, to the left in the figure, had, as its main variables, having a psychoanalytic training and duration of personal therapy (training analysis), which correlated .50. The hub in the cluster seems to be psychoanalytic training, which received the strongest link from number of years in private practice as a psychotherapist (.45). When missing observations were not imputed, auxiliary therapy training had its strongest link (.32) to private practice, so its primary connection is somewhat ambiguous, as it was most strongly connected to the first cluster when correlations were based on imputed data. Having been in supervision during the past 12 months was most strongly related (albeit only weakly in absolute measures) to this cluster, by way of length of personal therapy (.17). It was in fact as strongly related to recent activity as a supervisor, but that relation was weaker (.12) when missing observations were not imputed. Finally, having academic training (besides one's psychotherapy training) was only weakly (.09) related to this cluster and should in fact rather be considered an isolated variable, as this was its strongest connection.

The third cluster, in the top right corner of Figure 1, consisted of only two variables, having a large accumulated case-load and CBT training, with a fairly strong mutual link (.41).

The fourth cluster, in the lower right corner of the figure, is a rather loose one, judging from the generally weak correlations among its members. The main members were age and number of years working with psychotherapy before licensing (.35). In turn, the latter variable was linked to number of years working with outpatient psychotherapy (.28) and inpatient psychotherapy (.23). Outpatient experience had an equally strong link to supervisory training (but had not when missing values were not imputed).

Discussion

Although these findings are based on a sample from the outskirts of the therapeutic community, we believe that at least one conclusion is generalisable to non-Swedish, non-homogeneous therapist samples: Therapeutic experience is not a unitary phenomenon, not simply number of years in the profession, as has been the customary indicator. Some equally reasonable parameters of experience are only weakly related among themselves and order themselves in

four clusters. The reader should realise that the clusters of indicators identified in this study should not be looked upon as dimensions in the sense given by factor or principal components analyses but simply as "kinds of experience."

Although there are interconnections or overlap between the variable clusters, three, or possibly four, such kinds of experience seem to be supported by the analyses. The core variable cluster may be considered as the essence of what most people would intuitively regard as therapeutic experience and probably what makes a therapist most obviously eligible as a teacher of trainer. A therapist high on these variables has been a licensed therapist for a long time. She/he has a formal training as a supervisor and is in fact active supervising colleagues and students. Finally, she or he tends to have formal training in several modalities of psychotherapy, not just the one in which he or she was trained and licensed. Through connections to other clusters, she or he is also more experienced in terms of accumulated case-load, she or he is older, and she or he is more likely in private practice. That there is a rather strong relation between number of years in practice and supervisory activity has been reported before by Rönnestad et al. (1997), who also found that receiving supervision is unrelated to these variables, just as in this study. A proper name for this major kind of therapeutic experience may be seniority (Orlinsky, Rönnestad et al., 1999). This is meant to allude less to the age aspect than to the status differential of higher rank and longer service, implying a stroke of wisdom and elder statesmanship.

But there are other aspects of therapeutic experience as well. Consider the therapist who is high on the variables making up the second cluster. She or he is in private practice and may have a psychoanalytic training, which in turn involves long and/or repeated training analysis. Additionally, he or she is likely to be in supervision, and there is also a slightly higher probability of academic training besides that in psychotherapy. The core variables in the cluster are psychoanalytic training and length of personal therapy (or training analysis), but therapists with psychoanalytic training proper are indeed in the minority in the therapist community. However, in Sweden there is a large number of psychotherapists in private practice with strong psychoanalytical or so-called psychodynamic persuasions, with long personal therapies in psychoanalysis and often with continuous or intermittent supervision with psychoanalysts. In those circles, having a psychoanalytic training and being oneself in psychoanalysis are highly regarded and quite effective in gambits of therapeutic one-upmanship (Potter, 1952). These are prestige indicators of quite different, superficial import than those indicating seniority, and we propose to refer to this kind of experience as psychodynamic repute. The value of this kind of psychoanalytically inclined experience for psychotherapy, especially of non-psychodynamic kinds, is of course doubtful and is probably also so considered by non-psychodynamic therapists.

The third variable cluster is primarily a matter of case-load, and its strong relation to experience with cognitive or cognitive/behavioural therapies is only natural in view of the relative bre-

vity of such treatments, generally. Therefore, insofar as the varieties of psychotherapy are typically or systematically different in duration, number of years in practice and number of patients seen will necessarily become rather independent experience parameters. At this point, one may only speculate on their differences in terms of consequences for the development of the therapists and for the benefit or their patients, and it is still probably more a matter of opinion than knowledge which pays off best. Some would believe that brief treatments with a high number of patients (preferably of different types) provides higher-quality experience than working long-term in depth with a small number. We shall consider this cluster a provisional one and simply refer to it as case-load.

The therapist with high values on the variables assigned to the fourth cluster is relatively older and has long experience of doing psychotherapy before licensing. The results suggest that it may be important to distinguish between pre-training and post-training practice from an experience perspective. These periods are obviously independent in terms of duration, but are they differentially important? As Skovholt and Rönnestad (1992a, b) have suggested, "Post-training years are critical for optimal development" (Skovholt & Rönnestad, 1992a, p. 114). In this study, it is not altogether clear to what extent pre-training and pre-license years coincide, because in Sweden the licensing system, under the National Board of Social Welfare, was introduced in 1985, although several psychotherapy training institutes, with different orientations, had been active long before that. Therefore, older therapists are likely to have been in psychotherapy practice long before licensing but after training – and some in the very oldest generation even without any formal training at all. Instead, they often had on-the-job-training in psychiatric institutions rather than the national standard type of training of later days. It is also significant that in the early days the psychiatric institution was the natural habitat for psychotherapists, and that quite a few remained loyal to public health care, eventually being only part-time in private practice. This is a honourable career but surely not the most prestigious one in the therapeutic community. We suggest that the variables in this cluster, taken together, indicate long and faithful service rather than an enterprising career in the therapeutic profession.

When characterizing a psychotherapist as "experienced," or when evaluating applicants for training or for therapeutic jobs or teaching positions, it may turn out to be an important practical difference in which of these four ways he or she is indeed experienced. Here, it remains to be seen how these varieties of therapeutic experience relate to therapeutic development. Skovholt and Rönnestad (1992a, b) describe the core developmental process as one of "continuous professional reflection" (1992a, p. 114). This means to think about, and learn from, one's experiences in professional and personal relationships. It is in the interactions with clients, supervisors, teachers, and peers that the conceptual and theoretical knowledge of the therapist come to exert its impact. The question is, now, to what extent the experience variables may produce, facilitate, or permit the development of a reflective stance. Whereas formal training, working

with clients, supervision, and personal therapy themselves may produce experiences to reflect on, the mere passage of time in the profession produces nothing of itself, of course. The important thing is in what ways time is spent, doing what how, whether pre- or post-training, whether in private or psychiatric practice, or merely by growing older. It is conceivable that different professional contexts or environments offer better or worse opportunities for fertile continuous professional reflection on one's experiences. And it is reasonable to consider the benefits of the patients as the ultimate criterion of fertility. Our continuing study will now turn to the associations between the different varieties or indicators of therapeutic experience and therapeutic success. It is our hypothesis that disaggregating them will reveal that some have positive relations and some no relations – and that some may even have negative relations – to patient benefit, thus proving the omnibus non-association incorrect.

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