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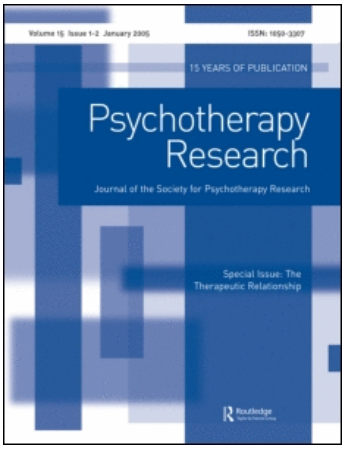

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Therapist attitudes and patient outcomes: II. Therapist attitudes influence change during treatment

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Abstract
Psychotherapists' beliefs and attitudes in therapeutic matters, according to the Therapist Attitudes Scales (TASC-2) (Sandell et al., 2004), were related to symptom distress, as measured by the Symptom Checklist-90, in 2 groups of patients: one in ongoing psychoanalytical psychotherapy and the other posttreatment. In the posttreatment group, the zero-order correlations with symptom distress were significant for the therapist's attitudes toward kindness and insight as curative factors and supportiveness as a therapeutic style and his or her views on the nature of psychotherapy as a form of artistry; however, they were all near zero and nonsignificant in the in-treatment group. To account for correlations among the attitude variables, multiple regression analyses were compared between the groups. The multiple correlation was essentially zero in the latter group, whereas there was a significant multiple correlation of .51 in the former group. Thus posttreatment outcome was significantly related to the therapist's position on the TASC-2 scales. Kindness and Artistry had particularly strong relations with the posttreatment results, with Neutrality acting like a suppressor. The pattern of relations suggested that therapist attitudes functioned as moderators rather than as mediators.

An important but much neglected finding about psychotherapy is that the outcome variance across patients, even among those in the same type of therapy, is quite large. Brown, Dreis, and Nace (1999) reported that the standard deviation for change in a large sample was about twice the mean change. According to Lambert (1992), the major part of this variance is related to patient and relationship factors. However, the variation among patients is, of course, confounded with the variation among therapists. As Lambert (1990) and others (Beutler, 1997; Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Crits-Christoph & Mintz, 1991; Crits-Christoph et al., 1991; Lafferty, Beutler, & Crago, 1989; Luborsky et al., 1986; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985) have shown, there are substantial individual differences in success rates among therapists. Using Wampold's (2001) estimates, therapists account for 6% to 9% of the variance, or about half the share of the outcome variance that is in any way related to the treatment (circa. 15%, corresponding to $d \approx 0.8$). The factors that explain the therapist's share of the variance are still quite obscure. For instance, level of professional experience and training do not seem to matter according to Stein and Lambert (1984, 1995) but do matter according to Sandell et al. (2002). Relationship qualities seem to be consistently involved, such as the capacity to establish a therapeutic alliance (Horvath & Bedi, 2002; Luborsky et al., 1985, 1986, 1997), using empathy (Bohart, Elliott, Greenberg, & Watson, 2002; Lafferty et al., 1989), and several other relationship factors (Norcross, 2002). Psychological health and adjustment also seem to matter (Luborsky et al., 1985, 1986, 1997). Beutler, Machado, and Neufeldt (1994) found rather few, weak associations between therapist qualities and patient outcome; those factors that did seem to make a difference were specifically related to psychotherapy rather than to transsituational factors such as personality or demographics. The review by Beutler et al. (2004) seems to confirm these conclusions but also refers to the "promising effects [that] have been noted with respect to a variety of attitudes and values" (p. 292).

In this study we have explored specifically the extent to which the therapist's values, beliefs, and attitudes in therapeutic matters may account for variance in patient outcome. Although there are

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studies on therapist attitude factors (Ambühl, Orlinsky, & SPR Collaborative Research Network, 1997; Fey, 1958; Fiedler, 1950a, 1950b; McNair & Lorr, 1964; Pope, 1977; Rice, Fey & Kepecs, 1972; Rice, Gurman, & Razin, 1974; Sundland, 1977; Sundland & Barker, 1962; Wallach & Strupp, 1964; Weissman, Goldschmid, & Stein, 1971; Wogan & Norcross, 1985) and on the general dependence of treatment outcome on therapist factors (Beutler, 1997; Beutler et al., 1994; Blatt et al., 1996; Crits-Christoph et al., 1991; Crits-Christoph & Mintz, 1991; Lafferty et al., 1989; Luborsky et al., 1985, 1986, 1997), we have been able to find only a few studies specifically on the relationships between treatment outcome and therapist attitudes. Howard, Orlinsky, and Trattner (1970) and Lafferty et al. (1989) both administered the Theoretical Orientation Questionnaire (Sundland, 1977) to samples of therapists. They used two different scoring systems—one content related and the other school related—but neither system revealed any association with session outcome (Howard et al.) or treatment outcome (Lafferty et al.). Beutler et al. (1994) found variable effect sizes ($.13 < r < .63$) for therapeutic philosophies–orientations. Blatt et al. (1996) analyzed attitudes toward the cause and treatment of depression in relation to client outcome in the Treatment of Depression Collaborative Research Program. The results were mainly negative. As in the studies by Beutler et al. and Lafferty et al., Blatt et al. summarized their attitude variables in terms of therapeutic schools. This assumes that therapeutic beliefs and attitudes are school consistent and school loyal. It would be more interesting, however, to know what therapists do, in fact, believe rather than which particular therapeutic school they claim to adhere to.

We have previously presented a set of therapeutic attitude scales (Sandell et al., 2004) as part of a comprehensive therapist questionnaire: Therapeutic Identity (ThId). On the basis of a series of factor analyses of a random sample of licensed Swedish therapists, nine factors were identified. Corresponding factor scales were developed, called the Therapist Attitudes Scales (TASC-2).[1] The scales have been found to predict the self-designated theoretical orientations of the therapists and to discriminate reliably between therapists with different levels of professional experience and different varieties of training.

In this study, we apply the TASC-2 scales to another sample of therapists in the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (STOPPP). This sample is linked to a sample of patients on whom we have outcome data at different stages of treatment and posttreatment. This allows us to analyze how therapist attitudes may influence treatment outcome.

If therapist attitudes influence treatment outcome, their role as a kind of third variable may be that of a predictor, a mediator, or a moderator. If a therapist (or patient) variable has a moderating effect on treatment outcome, the relation between different states of treatment (treatment vs. no treatment; different doses or stages of treatment) and outcome will depend on the moderator variable (Baron & Kenny, 1986), or, amounting to the same thing, the association between this variable and outcome will differ between subgroups of cases in different states of treatment (Owens et al., 2003, p. 542). If it is a predictor, it will contribute to a significant prediction of outcome regardless of the treatment variable (Owens et al., 2003). It will be realized that predictor and moderator effects are related the same way as main effects and interaction effects are in analysis of variance. If it is a mediator, finally, the association between the treatment variable and outcome will decrease significantly when the therapist (or patient) variable is kept constant by being partialed out (Baron & Kenny, 1986). Primarily, in this study, we explored the relationship between outcome in terms of symptom distress scores and therapist attitudes in two treatment groups in different states of treatment completion and compared these relationships between the groups. This comparison was considered analogous to a treatment/no-treatment comparison or an alternative-treatments comparison. Our specific hypothesis was that therapist attitudes would become more closely associated with outcome as the treatment progressed to completion from in-treatment to posttreatment. Secondarily, we explored the prediction and mediation hypotheses about the influence of therapist attitudes.

Method

Design

The design of the STOPP study has been described in detail by Blomberg, Lazar, and Sandell (2001) and is, therefore, only summarized here. It was a quasi-experimental, partly cross-sectional, and partly longitudinal design based on an annual postal three-wave panel survey among 756 persons in a population of subsidized psychotherapy cases.

The Well-Being Questionnaire (WBQ) was distributed to these 756 persons in 1994, and in 1995 and 1996 it was sent to everyone who had responded in 1994, each time with four reminders. Return rates of 78%, 86%, and 89%, respectively, produced a panel of 446 persons, or 59% of the initial sample. Complete data were obtained from 433 persons.

We identified a subgroup of 151 patients who were in treatment in all 3 years (the in-treatment group) and another subgroup of 156 patients who had terminated their treatments in the first year and did not commence any new treatment over the next 2 years (the posttreatment group). It was assumed that these groups had been differentially exposed to the influence of the therapists in their treatments.

There were 294 therapists and analysts involved in treatments with the patients in this sample. In fall 1995 the ThId questionnaire was mailed to all of them. After four reminders, 209 (71%) had returned their questionnaires. Analyses of the attrition showed no systematic sources of dropout.

Attitudinal data from the therapists were linked to data from their patients, yielding 124 patient cases in the in-treatment group and 113 cases in the post-treatment group and a total of 142 of the therapists who had responded to the ThId. The number of patients for each therapist varied between one and five. So that no single therapist should unduly influence the between-groups comparisons by having a much larger number of cases in one of the groups, we randomly deleted cases so that no therapist had greater than two cases more in one treatment group than in the other. This operation left 118 cases with 90 therapists in the in-treatment group and 107 cases with 87 therapists in the posttreatment group. There were 35 therapists with patients in both groups (52 in-treatment, 47 post-treatment), 107 with patients in only one of the groups (64 in-treatment, 62 posttreatment). Eighty-eight of the 142 therapists had one patient, 36 had two patients (of which 17 with one in patient each group), 9 had three, 7 had four, and 2 had five.

Patient Outcome Measures

The WBQ was designed to explore the patients' symptoms, social relations, and morale. The following standard self-rating scales were included: (a) Symptom Checklist (SCL-90; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974); (2) Social Adjustment Scale (Weissman & Bothwell, 1976; Weissman, Prusoff, Thompson, Harding, & Myers, 1978), in a revised version to suit Swedish users in the 1990s; and (3) Sense of Coherence Scale (Antonovsky, 1987).

In each panel wave, principal-components analyses of the three mean scores across all items showed that a single component accounted for more than 82% of the total variance and that the so-called General Symptom Index (GSI; the mean score across all 90 items) of the SCL-90 had the largest loading ($>$ .89). We concluded that the GSI adequately reflected patient outcome and decided to present the results only on the GSI. The internal consistency estimates for the GSI in the three waves varied between .83 and .96. Because the GSI was not normally distributed, we transformed it to its square root (GSIsqrt) and based our further analyses on the transformed scale . As a measure of outcome, in-treatment or posttreatment, we computed the average GSIsqrt for each patient across the three panel waves/years.

Patient Characteristics

The typical patient in this $n = 225$ sample was a woman ($n = 171$ women [76%] and 54 [24%] men), single ($n = 133$ [59%]) or divorced ($n = 38$ [17%]), with children ($n = 115$ [51%]). The majority ($n = 176$ [78%]) had at least some university education and typically worked in the health care, education, or social sector. The mean age was 38.2 years ($SD = 7.8$).

Therapists

All the therapists were licensed by the Swedish National Board of Health and Social Welfare. In this subsample of cases, the majority of the therapists were women ($n = 109/33$ women [77%] and 48 [23%] men), with a mean age of 54.1 years ($SD = 6.4$). Mean length of therapeutic experience was 20.4 years (range $= 10 - 35$; $SD = 4.9$). Further details on treatment providers are given in Blomberg et al. (2001).

Therapist Questionnaire

The ThId contains about 150 questions or items divided into six sections: Section a covers demographics and academic and professional training; Section b, professional experience; Section c, personal therapy or training analysis; Section d, theoretical orientation; and Sections e and f, therapeutic attitudes.

In Sections e and f, three sets of items chart the therapists' therapeutic attitudes (Grant & Sandell, 2004; Sandell et al., 2004). In Section e there are two sets of items. The first set (e:1) contains 33 items rating the belief in the curative value of a number of elements of psychotherapy (e.g., "Helping the patient avoid anxiety-provoking situations"). The items were rated on 5-point Likert-type scales, ranging from 0 (*does not help at all*) to 4 (*helps a lot*). The items were collected from various sources: experiences of the authors, suggestions from colleagues, theoretical literature, and earlier instruments (Rice et al., 1974; Sundland & Barker, 1962; Wallach & Strupp, 1964; Weissman et al., 1971). The second set (e:2) consists of another 31 items

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designed to describe the manner of conducting psychotherapy in the general case (e.g., "I do not answer personal questions from the patient"). We designed the items on the basis of our own experiences, suggestions from colleagues, and the theoretical literature. They also included adaptations and free translations of items from earlier instruments (Rice et al., 1974; Sundland & Barker, 1962; Wallach & Strupp, 1964; Weissman et al., 1971).

Section f contains a series of 16 items relating to more basic assumptions about the nature of psychotherapy and the human mind ("What are your general beliefs about the human mind and about psychotherapy?"). The items were inspired by Hjelle and Ziegler (1992), Sundland and Barker (1962), and Wallach and Strupp (1964). The rating scales were continuous bipolar scales, with each pole offering a completion of the item stem (e.g., "Psychotherapy may be described...as a science/as a form of art"). The respondents were instructed to indicate their agreement with either pole by a cross mark anywhere on the line between the poles. Five-step scores were derived by partitioning the line in five equal parts.

On the basis of factor analyses in a random sample of 325 licensed psychotherapists throughout Sweden, of which 227 had responded (70%; Sandell et al., 2004), the items in Sections e:1, e:2, and were grouped into nine scales: Adjustment, Insight, Kindness, Neutrality, Supportiveness, Self-Doubt, Irrationality, Artistry, and Pessimism (see Appendix). The internal consistencies of the scales varied between .50 and .87 ($Mdn = .75$) and showed generally strong relationships with self-designated theoretical orientation and with training in different therapeutic modalities. For exploratory purposes we decided to test scales with internal consistencies less than .7 as well.

Treatments

In the referrals, psychotherapy was defined as once- or twice-weekly treatment with a licensed psychotherapist, and psychoanalysis was defined as treatment three to five times/week with a fully trained psychoanalyst who was a member of either of the two psychoanalytic societies in Sweden, which are component societies of the International Psychoanalytical Association. In the in-treatment group, 93 of cases were psychotherapies, 23 were psychoanalyses, and 2 were so-called low-dose therapies (e.g., brief therapy, low-frequency supportive therapy, family therapy, group therapy). The posttreatment group consisted of 94 psychotherapy cases, 12 psychoanalysis cases, and 1 low-dose case. These distributions were essentially unaffected by the fact that some therapists had patients in both groups. As an indication of the similarity of the distributions of cases in the treatment groups, $\chi^2(2, N = 225) = 3.27$, $p = .195$.

The treatments were not manualized or standardized with respect to duration, session frequency, technique, and so on. Without a manual, further specification of the treatments must necessarily be done ex post facto, in terms of provider characteristics, on the basis of information in the ThId. Thus, 96% of the treatment providers claimed to be rather strongly or strongly oriented toward a psychoanalytic or psychodynamic theoretical position. Twelve percent claimed to be rather strongly or strongly oriented toward an eclectic position. In terms of therapeutic attitudes (Sandell et al., 2004), using a national sample ($N = 227$) as a norm, the therapists in the present sample were significantly lower on Adjustment, Supportiveness, and Self-Doubt and higher on Insight and Neutrality (all ps $< .025$, two-tailed).

As a test of the assumption that the two groups varied in their progress in treatment—a completed treatment (the posttreatment group) and an ongoing, unfinished one (the in-treatment group)—we tested the GSIsqrt difference between the groups by regressing GSIsqrt on time (years) in each of the groups. In the in-treatment group, the regression function was GSIsqrt $= 1.06 - 0.066$*years, $p = .001$, for both the intercept and the slope, given one-tailed tests. In the posttreatment group, the corresponding function was GSIsqrt $= 0.85 - 0.039$*years, $p = .001$, for the intercept, $p = .054$ for the slope, one-tailed tests. The intercepts differed significantly between the groups, $t(223) = 3.14$, $p = .001$, but not the slopes, $t(223) = 0.88$, $p = .189$, both tests one-tailed. We concluded that the in-treatment group had not advanced as far in terms of outcome as the posttreatment group, although its progress was significant, whereas that in the posttreatment group was abating.

As another test of our design, this time of the equality of the groups on factors other than treatment progress, we tested the differences between the in-treatment group and the posttreatment group on more than 20 therapist variables (including the TASC-2 scales) and more than 20 patient variables. We found only one significant difference: The therapists in the posttreatment group had 2.2 more years experience in psychiatric outpatient care ($p = .028$, $\eta^2 = .03$). We concluded that the treatment stage difference between the groups was probably free of strong obvious confounds. Although not random, the assignment of patients to the groups was not self-selected but dependent on the timing of our questionnaire.

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Results

The product–moment correlations in each treatment group between GSIsqrt and the therapists' TASC-2 scores are shown in Table I. The correlations in the in-treatment group were nonsignificant throughout, and they were positive on most scales. The correlations in the posttreatment group were, with one exception, negative, indicating an association between higher therapist scores on the attitude scales and more positive patient posttreatment outcome (lower GSIsqrt scores). Significant negative correlations ($p < .05$, two-tailed) were found for Insight, Kindness, Supportiveness, and Artistry.

In view of the likelihood that some of these correlations were redundant because of correlations among the attitude variables, we explored these in each group and found one rather strong cluster, which included Adjustment, Supportiveness, and Kindness, with Insight added in the posttreatment group; intercorrelations ranged from .32 to .53 (in-treatment) or from .31 to .63 (posttreatment). The other variables displayed generally weaker correlations, at the highest in the .20s.

To take these associations into account in their relationships to treatment outcome, we performed a multiple regression analysis in each of the treatment groups. GSIsqrt was the dependent variable, and the TASC-2 scales were used as independent variables. Because of missing data and listwise deletion, the analyses were based on 112 cases in the in-treatment group and 102 cases in the posttreatment group. When all attitude variables were entered simultaneously, in the in-treatment group, $R = .26$ ($R^2 = .07$, adjusted $R^2 = -.02$), $F(9, 102) = 0.79$, $p = .624$. None of the attitude variables had a significant regression weight, as may be seen in Table I. In the posttreatment group, $R = .51$ ($R^2 = .26$; adjusted $R^2 = .19$), $F(9, 92) = 3.56$, $p = .001$. Three variables had significant weights (ps $< .05$): Kindness, Artistry, and Neutrality (Table I). We concluded that the moderator effect was supported.

Table I. Associations between SCL-90 GSIsqrt and therapist attitudes in the two treatment groups

	In-treatment		Posttreatment	
Therapist attitudes	*r*	MR β	*r*	MR β
Adjustment	.00	.01	−.12	.09
Insight	.01	−.02	−.20*	−.03
Kindness	.05	.11	−.36***	−.36*
Neutrality	.14	.16	−.10	−.23*
Supportiveness	.07	.04	−.24*	−.19
Self-doubt	.12	.06	.02	−.01
Irrationality	.04	.03	−.03	−.05
Artistry	−.10	−.08	−.26**	−.30**
Pessimism	.10	.13	−.08	.04

Note. Complete data were available on 112 patients in the in-treatment group and 102 patients in the posttreatment group. SCL-90 = Symptom Checklist-90; GSIsqrt = General Symptom Index transformed to its square root; *r* = product–moment correlations, MR = standardized multiple regression coefficients. *$p < .05$, two-tailed. **$p < .01$. ***$p < .001$.

Whereas these findings are consistent with a moderator interpretation (Baron & Kenny, 1986; Owens et al., 2003), therapist attitudes may also act as unconditional predictors of outcome regardless of treatment state, just as there may be a main effect at the same time as an interaction. When the treatment groups were pooled, the multiple correlation between therapist attitudes and outcome was $R = .28$ ($R^2 = .08$, adjusted $R^2 = .04$), $F(9, 204) = 1.86$, $p = .060$. Kindness and Artistry made significant predictions (ps $< .05$). We concluded that the predictor interpretation had borderline support.

To test whether it would be appropriate to consider the influence of therapist attitudes a case of mediation, we compared the zero-order correlation between the binary treatment variable (in-treatment vs. posttreatment) and outcome with the partial correlation between the same variables, controlling for the therapist attitudes. The two correlations were identical: −.24 ($p = .001$). Therefore, the mediator interpretation was not supported.

Discussion

We conclude that the influence of some components of the therapist's therapeutic attitudes increases as the treatment progresses and takes effect. In support of such a process interpretation, the findings in two additional groups are reported here, although these groups were too small to be included in the main study. One of the groups of patients ($n = 36$) finished their treatment between the first and second years in the panel, the other ($n = 21$) between the second and third years. Thus, they were between the in-treatment and the posttreatment groups in terms of progress. The multiple correlations between the GSIsqrt and the TASC-2 scales were .34 and .37, respectively, higher than in the in-treatment group and lower than in the posttreatment group.

Taking the main findings at face value, patients with therapists who value kindness as a curative factor and neutrality as a therapeutic style and who regard psychotherapy as a form of artistry show particularly positive long-term effects of psychotherapy. However, the role of neutrality may have to be explored further. Neutrality had a significant weight in the multiple regression despite its low zero-order correlation with GSIsqrt (−.10) in the posttreatment group. It seems that this was due primarily to mutual suppression between neutrality and artistry.

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Both were negatively correlated with GSIsqrt and were themselves negatively intercorrelated (−.27, $p = .004$). Thus, when artistry was partialed out, the correlation between neutrality and GSIsqrt rose from −.10 to −.19 ($p = .055$). Similarly, when neutrality was partialed out, the correlation between artistry and GSIsqrt rose from −.26 to −.30 ($p = .002$).

Whether the correlations, even when significant, are low or not is a matter of opinion. Obviously, in a nonmanualized or unstandardized therapy with a diagnostically uncontrolled and heterogeneous patient sample, high correlations with outcome are not to be expected. On the other hand, the significant correlations, albeit not cross-validated, were at the same level as is generally found with therapeutic alliance, one of the most consistent predictors of outcome. Indeed, some of the attitude variables, such as the therapist's kindness and supportiveness, are probably closely related to the fostering of therapeutic alliance.

It should be noted that these results were found in a sample in which almost all the therapists designated themselves as psychodynamically or psychoanalytically oriented. The results cannot, therefore, be generalized to therapists in other modalities or schools of psychotherapy.

Furthermore, one might expect the sample to have been more homogeneous on psychodynamically orientated attitude scales such as Neutrality and Insight and less so on scales such as Adjustment, Supportiveness, and Kindness, on which cognitive and behavioral therapists in the national sample had scored higher (Sandell et al., 2004). Such a restriction of range on some scales would have suppressed their associations with treatment outcome. As it turned out, however, the variances were rather similar across the variables, except for the higher variance for Kindness and the lower variance for Insight. The influence of Kindness may thus have been facilitated by the variance factor, whereas the correlation between GSIsqrt and Insight may have been attenuated by it. On the other hand, Artistry had a relatively strong effect even though it had one of the four lowest variances in the posttreatment group.

Another issue has to do with the fact that some of the TASC-2 scales had low internal consistencies. We are aware that some may not consider it a reasonable strategy to use scales with such psychometric properties. They would have to agree, however, that internal consistency is not actually a measure of the absence of random error. According to classical test theory, "a measure that has no internal consistency may be quite stable over time. Thus, a relatively high retest correlation can arise with low internal consistency" (Nunnally & Bernstein, 1994, p. 255). Furthermore, paradoxically, "when item covariance is at a minimum. . .the scale [has] the best chance of correlating with an external variable" (Dawis, 2000, p. 86). Indeed, Artistry turned out to be a significant predictor in the posttreatment group. Nevertheless, we urge the reader to consider the findings with these scales (Self-Doubt, Irrationality, Artistry, and Pessimism) with caution.

Obviously, one should not confuse therapeutic attitudes and therapeutic action. Indeed, we do not know the extent to which the therapists acted in accordance with their attitudes. On the other hand, we suggest that such attitudes are likely to provide the background for the staging of the therapeutic process. There is most likely some convergence between therapeutic attitudes and behavior in sessions. However, it should be emphasized that the rationale of our analyses was not to test outcome as caused by therapeutic attitudes but rather to test the facilitating or inhibiting effects of attitudes on the treatment process. Our analyses suggest that these effects are more in line with a moderator interpretation than a mediator interpretation. A predictor interpretation, on the other hand, found some support in the data.

The consequence of multiple observations of therapists with more than one patient requires special comment. Since the within-therapist component of the correlations necessarily was zero, because GSIsqrt was correlated with a constant therapist attitude, the total correlations were, in fact, attenuated. Indeed, the between-therapists components of the correlations were from .04 to .07 higher than the data presented in Table I. If anything, therefore, the present findings are conservatively biased.

The results of this study are in line with the finding of striking differences in treatment results among therapists within the same modality (Wampold, 2001). "The psychotherapist matters" (Luborsky et al., 1997). Where therapist attitudes, specifically, are concerned, Blatt et al. (1996) speculated that "although attitudes of therapists about . . . the nature of the therapeutic process may not have a direct relationship to therapeutic efficacy, these attitudes may still influence therapeutic outcome, possibly indirectly in interaction with the attitudes and expectations that their patients have" (p. 1282). The notion of such interaction had already been suggested by Sundland (1977) and has been promoted, with some supportive findings, in particular by Beutler (e.g., Beutler & Harwood, 2000) and Blatt (e.g., Blatt & Felsen, 1993; Blatt, Shahar, & Zuroff, 2002). Our findings suggest that it may be worthwhile to probe more deeply into the mechan-

isms through which therapeutic attitudes may influence the therapeutic process.

Note

[1] Based on preliminary analyses, an initial and somewhat different set of scales has been presented by Grant and Sandell (2004) as the TASC. The scales used here (TASC-2) have been refined and redefined on the basis of further analyses.

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Appendix

The TASC-2 Scales

Subscale	Example
Curative factors ("What do you think contributes to long-term and stable therapeutic change?")	
Adjustment	
$\alpha = .82$ (.83 in norm sample)	Giving the patient concrete goals
	Working for the patient's adjustment to prevailing social circumstances
	Stimulating the patient to think about his/her problems in more positive ways
	Helping the patient to avoid repeating old mistakes
	Helping the patient avoid anxiety-provoking situations
	Working with the patient's symptoms
	Giving the patient concrete advice
	Helping the patient to adapt or adjust to his/her symptoms
	Helping the patient to become reality oriented
	Letting the therapist take the initiative and lead the sessions
	Helping the patient to control his/her emotions
	Educating the patient about his/her symptoms and psychic problems
	Helping the patient to forget painful experiences
Insight	
$\alpha = .72$ (.87 in norm sample)	Helping the patient to see the connections between his/her problems and childhood
	Helping the patient to understand that old reactions and relations are being repeated with the therapist
	Working with the patient's defenses
	Helping the patient to understand that old behavior and relations are being repeated
	Supporting the patient in the therapy to reflect on early painful experiences
	Helping the patient to remember and confront possible sexual abuse
	Working with the patient's childhood memories
	Bringing the patient's sexuality to the fore
	Giving the patient the opportunity to work with his/her dreams
	Interpreting the patient's body language

Subscale	Example
	Helping the patient to clarify his/her feelings
	Letting the patient act out his/her feelings (catharsis)
	Letting the patient her-/himself take the initiative in the therapy
Kindness	
$\alpha = .81$ (.82 in norm sample)	Being a warm and kind therapist
	Making the patient feel well liked by the therapist
	Supporting and encouraging the patient
	Consideration and good care taking
	Letting the patient get things off his/her chest
	Therapeutic style factors ("What are you like as a therapist?")
Neutrality	
$\alpha = .74$ (.79 in norm sample)	I do not answer personal questions from the patient
	I keep my personal opinions and circumstances completely outside the therapy
	I do not express my own feelings in the sessions
	I am more neutral than personal in therapy
	My verbal interventions are brief and concise
	If a patient asks, I might agree to talk with one of his/her relatives (R)
	My countertransference is an important instrument in my work
	I avoid physical contact with the patient
	Keeping the therapeutic frame is fundamental in my work
	I want the patient to develop strong feelings in the therapy
Supportiveness	
$\alpha = .75$ (.75 in norm sample)	I often put questions to the patient
	It is important to order and structure the material
	I always make the therapeutic goals explicit to myself during a therapy
	I always communicate the therapeutic goals to the patient in the beginning of a therapy
	I have a positive attitude toward extra sessions
	I am active in sessions
	It is important to convey hope to the patient
	I do not want the patient to develop strong feelings toward me as a person
	I am anxious for the patient to achieve his/her life goals
Self-doubt	
$\alpha = .54$ (.50 in norm sample)	I do best with patients who are similar to myself
	My involvement with the patient's life goals is an obstacle to therapeutic work
	I do not allow long periods of silence during the therapy session
	I doubt my own ability to contain the patient's feelings
	I easily frustrate the patient
	I find it difficult to deal with the patient's aggression
	Basic assumptions factors
Irrationality	
$\alpha = .66$ (.67 in norm sample)	By nature, man is . . . rational/irrational
	Human behavior is governed . . . by free will/by uncontrollable factors
	Human behavior is governed . . . by external, objective factors/internal, subjective factors
	Psychotherapeutic work is governed by. . .conscious processes/unconscious processes
Artistry	
$\alpha = .63$ (.57 in norm sample)	Psychotherapy may be described . . . as a form of art/as a science (R)
	Psychotherapy may be described . . . as a craft/as free creative work
	Therapeutic work is governed . . . by training/by personality
	Psychotherapeutic work is governed by . . . intuition/systematic thinking (R)
	Psychotherapeutic work is governed by . . . relativistic views/absolute convictions (R)
Pessimism	
$\alpha = .30$ (.48 in norm sample)	The underlying principles of human behavior are . . . completely understandable/not at all understandable
	Humans may develop . . . infinitely/not at all
	Psychotherapeutic work is governed by the idea . . . that everything may be understood/that not everything may be understood
	Personality is fundamentally . . . changeable/unchangeable
	Personality is formed by . . . heredity/environment (R)

Note. R = Item reverse-scored.

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