

# Processes of Theoretical Orientation Development in CBT Trainees: What Internal Processes Do Psychotherapists in Training Undergo as They “Integrate”?

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The present study investigated the psychological mechanisms and processes of theoretical orientation development in psychotherapists during their training. Problem-centered interviews were conducted with 20 German psychotherapists in the last phase of their professional cognitive-behavioral therapy (CBT) training, and the data was analyzed using grounded theory. Results indicated that trainees could best be characterized by the core category “constructing jugglers”: To develop a coherent theoretical orientation, psychotherapists in training constantly defined and redefined CBT and other approaches. They alternated between assimilation (adapting new experiences to existing definitions of CBT and other approaches) and accommodation (reorganization of existing definitions). Their theoretical orientation development was influenced not only by therapeutic and scientific aspects, but also by strategic choices and territorial claims.

*Keywords:* psychotherapist training, cognitive-behavioral therapy, qualitative research methods, theoretical orientation

The integration of therapeutic approaches and methods has been the focus of a large number of empirical studies, theoretical models and political debates. Various different routes to integration have been described on a theoretical level and numerous empirical studies have been conducted (for an overview see [Norcross & Goldfried, 2005](#)). Different terms denoting theoretical orientation (such as school, approach, orientation and method) have also been defined. However, relatively little is known about what psychotherapists experience subjectively and

what internal processes they undergo as they “integrate” and develop a theoretical orientation.

In recent years a number of studies have been published on the professional development of psychotherapists which systematically investigate psychotherapists’ experiences and no longer see therapists as negligible in psychotherapy research. For instance, in the well-known Society for Psychotherapy Research (SPR) International Study of the Development of Therapists (SPR-ISDP), the therapist’s theoretical orientation is studied as one of nine important aspects of professional development ([Orlinsky & Rønnestad, 2005](#)).

## Research on Theoretical Orientation

Research on the theoretical orientations of psychotherapists has been based on a variety of definitions and used a wide range of different means of measurement (for an overview see [Poznanski & McLennan, 1995](#)). It therefore remains unclear what therapists are really referring to when they describe their theoretical orientation. Moreover, investigations of theoretical orientation often use simple self ascription measures that ask therapists to choose one or more

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The manuscript is based on data from the first author’s doctoral dissertation ([Wolff, 2009](#)). We thank the therapists who contributed to this study by sharing their experiences with us. Without them this study would not have been possible. We are also grateful to Janina El Jurdi, Carol Meier-Liehl, and Carina Poleh, each of whom conducted and transcribed some of the interviews.

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theoretical orientations from a list (e.g., “psychoanalytic,” “cognitive,” “behavioral,” “systemic,” “person-centered”). To overcome this categorical approach, the SPR International Study used a dimensional approach allowing therapists to rate their affiliations with six theoretical models on a 6-point-scale. Norcross, Karpik and Lister (2005) tried to differentiate therapists’ theoretical orientations even further by grouping self-identified integrative therapists into nine clusters (e.g., broad cognitive-behavioral therapy, interpersonal-humanistic, “ubercognitive” and traditional cognitive-behavioral). These categories reflect the authors’ attempt to go beyond categories of single theoretical orientations and to define the concept of theoretical orientation more clearly, as called for by Sundland as early as 1977. A number of authors followed this advice and developed concepts and measures to capture the underlying attitudes and beliefs that go to make up a theoretical orientation (e.g., the “Therapeutic Attitudes Scale,” TASC-2, Sandell et al., 2004 and the “Counselor Theoretical Position Scale“, CTPS, Poznanski & McLennan, 1999).

These studies have expanded our knowledge about therapists’ theoretical orientations in important ways. However, they also had limitations. First, in most studies the authors determined the categories (or dimensions) a priori. It therefore remains unclear what participating therapists really meant when they rated their affiliations to these categories. Thus, therapists’ subjective views and personal constructions need to be investigated. Second, the majority of studies focused mainly on the *content* of theoretical orientations and less on the complex *processes* of theoretical orientation development. While numerous factors correlated to orientation choice have been identified (for an overview see Bitar, Bean & Bermudez, 2007), these studies do not focus on *how* multiple factors interact during the theoretical development process: What are the processes that take place in the therapists? What mechanisms play a role as therapists develop their theoretical orientations?

### Models of Therapist Professional Development

The investigation of *processes* and *developmental* aspects is an explicit focus and strength

of various therapist development models (for a historical overview, see Skovholt & Rønnestad, 1995). These models were developed mainly as stage models in the field of supervision research and cover various aspects of therapist professional development, one of which is therapist theoretical orientation. In one of the older and simpler models (Hogan, 1964), theoretical orientation development is defined as follows:

During the first stage, or Level 1 . . . [the clinician’s] approach is heavily influenced by a method, the “method of choice” promulgated by his training. In the second stage, or Level 2, he adapts this method to his own personality, his own idiom. In the third stage, or Level 3, the method-person balance is reversed, and his approach to therapy is a reflection of his personal idiom through one or more methods. In the fourth stage, or Level 4, he goes beyond method and his own personal idiom to develop creative approaches which are an outgrowth of both method and person. (p. 139)

More than 30 years later, theoretical orientation development was described much more systematically and in more detail in the Minnesota Study on Counselor and Therapist Development by Skovholt and Rønnestad (1995; Rønnestad & Skovholt, 2003) in their empirically based, eight-stage model of therapist and counselor development. The authors differentiate several alternative routes toward incorporating a conceptual system. For instance, in the *Imitation of Experts Stage* (third stage of therapist development), Skovholt and Rønnestad distinguish four routes: (a) A few individuals never develop a conceptual system (*laissez-faire*). (b) Some combine elements and concepts from different conceptual systems. (c) Some choose a predominant conceptual system but also include other systems. (d) Some focus on learning one method intensively and exclude all other viewpoints. An important strength of this eight-stage model is its detailed characterization of theoretical orientation development at different stages and its empirical foundation, which is rare in the field of therapist development models. Nevertheless, the limitations of this model (and other similar models) are (a) theoretical orientation development is only one of many aspects and not the explicit focus of investigation, (b) all therapists are assumed to have a similar developmental path, (c) it remains unclear what *exact psychological mechanisms* take place in therapists when they combine dif-

ferent elements or choose one predominant concept at the *Imitation of Experts* stage.

### Aim of This Study

As a first step toward filling the current gap in the literature and providing a fuller account of the dynamic and complex nature of the process, the present study was designed to propose a preliminary model of the influences and processes involved in theoretical orientation development and to describe the psychological mechanisms at work in psychotherapists as they find their personal stances. It has been argued that the concept of “therapeutic approach” is a “fuzzy concept” (Parfy, 1996) and several different definitions and classifications have been proposed. It is therefore of special interest to investigate what strategies therapists employ to deal with this fuzziness. How do therapists conceptualize the different “schools” of therapy? How do they create their own systems and locate themselves within these systems?

This issue has taken on special significance in Germany as a result of the laws governing the practice of psychotherapy. Since a law on psychotherapists (“Psychotherapeutengesetz”) was passed in 1999, psychotherapists in training have had to specialize in one “scientifically recognized” approach of psychotherapy,<sup>1</sup> while at the same time gaining at least a basic knowledge of other “scientifically recognized” approaches. The law does not specify how the specialized knowledge of one approach and the basic knowledge of others are to be linked. Given this fuzzy dual requirement, we decided to conduct this study with German therapists. Therapists in CBT training programs were taken by way of example, as the well-known “third wave” of CBT (Hayes, 2004) is defined by an overlapping of CBT with other approaches and because CBT seems to be an approach that is rapidly spreading in research and clinical practice. The central questions guiding this study were (a) What intrapsychic processes take place in CBT therapists as they develop their own stances toward the different “schools” of therapy during training? and (b) Can affiliation to a “school” be considered a necessary prerequisite for therapeutic identity? Given the process component of the study and the desire to develop a model that would be grounded in the experiences of therapists themselves, an in-

ductive approach to theory generation was utilized.

### Method

#### Participants

The participants in this study were 20 German psychotherapists in the final phase of their professional CBT training. They were recruited through four training programs. The average age of the participants was 35 (ranging from 27 to 43 years). The sample included 15 women and 5 men. Their professional backgrounds varied; all were psychology graduates. Except for one male therapist, the CBT training program was their first psychotherapy training experience. They had, on average, had 3 years of work experience (range: 0–14 years) as a psychologist before starting their CBT training programs. As part of this training, they had each completed an internship at a psychiatric hospital, after which they had conducted a minimum of 200 and a maximum of 600 hr of individual psychotherapy in an outpatient setting (average: 371 hr) as the last phase of their professional training.<sup>2</sup>

#### Procedure

So that different training programs would be represented, therapists were recruited from a broad spectrum of training institutes (maximum variation sampling, Strauss & Corbin, 1998) with

<sup>1</sup> In Germany, the following four approaches to psychotherapy have been declared “wissenschaftlich anerkannt” (i.e., “scientifically recognized,” which is similar but not identical to the concept of “empirically supported treatments”): CBT, psychodynamic psychotherapy, systemic psychotherapy, and client-centered psychotherapy. Only two of them, CBT and psychodynamic psychotherapy, are classified as “reimbursable by insurance companies.”

<sup>2</sup> According to the “Psychotherapeutengesetz” (law on psychotherapists) and the regulations on training and examinations, psychotherapy training programs *must* include the following components: 600 hr theoretical education, 120 hr personal therapy, 1,800 hr internship at a psychiatric hospital (lasting approximately 1 year), and 600–800 hr outpatient individual therapy under supervision. The training is postgraduate, that is, the trainee must have completed a degree in psychology. It is done in either a 3-year full-time format or a 5-year part-time format (or a mixture of the two), the mean actual duration of the training being somewhat more than 4.5 years (Ruggaber, 2008).

basic philosophies ranging from a “traditional” to an “integrative” understanding of CBT. The training philosophies of different training sites were established by carrying out an Internet search on training programs and their online presentations and conducting expert interviews with program directors (Meuser & Nagel, 1991). Program directors forwarded a letter providing information about the study and contact information to therapists in training via email. Due to time constraints and the busy schedules of therapists in training, recruitment was initially difficult. It was necessary to send two emails to each program before recruiting could be completed. Finally, we included eight therapists from program I, two from program II, seven from program III and three from program IV.

All interviews were conducted by the first author and three trained students between 2006 and 2008. They lasted an average of 70 minutes. Participants received EUR 20 per interview and all gave their written informed consent. Any possibly identifying information has been removed for confidentiality.

### Data Collection

Problem-centered interviews (Witzel, 2000) were conducted with therapists in training. This interview method is a theory-generating procedure designed to overcome the contradiction between theory-directedness and open-mindedness and thus allows for both inductive and deductive thinking. It consists of four instruments: (a) a brief questionnaire (data on social characteristics), (b) an interview protocol, (c) an audiotape & transcript, and (d) a postscript (comments and remarks on the interview). The semistructured interview protocol covered 11 topics (see Table 1).

The study was guided by the principle of *theoretical sampling*, which is considered an important component of grounded theory methodology (Strauss & Corbin, 1998). Theoretical sampling means “seeking pertinent data to develop your emerging theory. The main purpose of theoretical sampling is to elaborate and refine the categories constituting your theory” (Charmaz, 2006, p. 96). If, for instance, during the data analysis process, “emphasizing boundaries” appears to be a crucial category in the emerging theory, par-

Table 1  
*Topics of Semistructured Interview Protocol*

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1. Personal path into psychotherapy training
  2. Psychotherapist role models
  3. Attitudes towards CBT: positive and negative experiences
  4. Change in attitudes towards CBT during training
  5. Identification with or allegiance to CBT
  6. Attitude towards other therapeutic approaches
  7. Attitude towards integrative psychotherapy
  8. Personal understanding/definition of psychotherapy
  9. Image of CBT therapists
  10. Vision of own psychotherapeutic work in ten years
  11. Preferred therapy approach for personal therapy
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*Note.* CBT = cognitive-behavioral therapy.

ticipants with high and low levels of emphasizing boundaries are then systematically compared and analyzed. According to Glaser and Holton (2004), the process of data collection is controlled by the emerging theory, and the researcher cannot plan data collection in advance of the emerging theory. Grounded theory methodology was chosen for this study because it fosters a rich and deep exploration of the phenomenon of interest while using a highly elaborated and stringent qualitative method.

### Data Analysis

For the data analysis, the interviews were coded according to the grounded theory methodology. Grounded theory is both a research paradigm and a set of coding methods that are used to develop a data-grounded theory about a given phenomenon inductively (Strauss & Corbin, 1998). Data collection, data analysis and theory development interweave. Almost reversing traditional social science research procedures, the inquiry does not begin with a hypothesis or theory to be tested but with a phenomenon to be investigated. The first step is data collection from which codes, concepts and categories are formed. These in turn form the basis for the creation of a theory. Data analysis consists of three steps that are recursive rather than linear.

**Open coding: Developing concepts and categories.** The first step in the constant comparative method of data analysis was coding (for coding examples see Table 2). Segments of data were categorized with a short

Table 2  
Examples of Coding

Open coding				
Step 1: Developing codes				
Transcript		Codes		
On the one hand, CBT has something very concrete about it and breaks things down to a very simple level. On the other hand, it blows things up and makes them sound very scientific so that you wonder what on earth's behind it. But really they are just common or garden everyday strategies that most people use anyway and that patients simply can't access in their current destabilized state. And then this is all packaged up to look like something impressive. These are moments when I think: "CBT can be so mundane!" That's a bit embarrassing, too.		Accusing CBT of blowing things up (of puffing up its image); criticizing CBT on a general level; half-heartedly acknowledging strengths of CBT; feeling embarrassed about CBT		
Step 2: Forming and defining more abstract categories in large batches of data				
Category	Property of category	Definition	Minimum	Maximum
Criticizing CBT	Partial vs. fundamental criticism of CBT	Refers to all passages in the interviews that deal with criticism of CBT. Not <i>content</i> of the criticism is coded but <i>amount</i> and <i>kind</i> of criticism.	Criticism of CBT is only partial. Interviewees only report it when specifically asked and not spontaneously. Criticism refers to practical and less important aspects of CBT. Criticism is expressed in a descriptive manner, often put into perspective and refers to single situations.	Criticism of CBT is general. Interviewees report it spontaneously. Criticism refers to theoretical and very important aspects of CBT. Criticism is expressed in a depreciative manner, rarely put into perspective and refers to general aspects of CBT.
Axial coding				
Relating categories to each other				
Transcript		Relationship of codes according to "coding paradigm"		
Q: "What experiences changed your identification with CBT?"		Phenomenon: identifying with CBT		
A: "It was a continuous process. It consisted of getting to know very likeable CBT therapists. And my own personal therapy was very important for me, too. It also contributed to my identification with CBT because I realized that it helped me and was good for me. In addition, negative experiences with psychodynamic therapists played a role. Our so-called integrative training was not so great, both on a practical (internship) and on a theoretical level".		Property: medium to maximum identification Conditions: – Own personal therapy (CBT: positive) – Personal exchange with other therapists (CBT: likeable, psychodynamic: negative experiences) – Experiences during internship (psychodynamic: negative)		

Note. CBT = cognitive-behavioral therapy.

name that simultaneously summarized and accounted for each piece of data (Charmaz, 2006) and remained close to the words used by the participants. The most useful initial concepts and categories were used to sort, integrate, and organize large amounts of data. The codes were then summarized to form more abstract categories, and the most salient

categories were developed and defined in large batches of data.

**Axial coding: Relating categories to each other.** The axial coding was used to relate categories to subcategories, specify the properties and dimensions of the categories, and reassemble the data that we had fractured during open coding to give coherence to the emerging

analysis (Charmaz, 2006). To reassemble the data, we employed an organizing scheme proposed by Strauss and Corbin (1998). This “coding paradigm” involves conditions, context, action/interactional strategies and consequences of the phenomenon that is being studied.

**Selective coding: Developing a core category.** Lastly, selective coding was used to develop a proposition that integrated the categories and subcategories into a cohesive “story line.” A single core category was developed that described and encompassed the experience of theoretical orientation development in CBT trainees. All other categories were related to that category.

### Research Process

Throughout the research process, the first author met weekly with two other doctoral students to discuss all steps of data collection and analysis in order to increase the intersubjectivity of the results. The research process was supervised by the second author. Preliminary results were presented and discussed at a fortnightly research seminar and at international conferences, which enabled the authors to further develop the results. According to Strauss and Corbin (1998), one important way of grounding the developing theory in the data is by memoing. Memos were maintained to record decisions and theoretical ideas and to reflect the authors’ own positions and biases.<sup>3</sup>

## Results

### CBT Trainees as Constructing Jugglers: Finding Themselves by Defining CBT

The analysis showed that CBT trainees and their theoretical orientation development can be subsumed under a core category that we have called *constructing jugglers—finding themselves by defining CBT*<sup>4</sup> to describe how they dealt with the fuzzy dual requirement of the German law for psychotherapists. Because the law does not specify how the different approaches are to be linked, the trainees developed their own therapeutic identity by *juggling* with experiences. During the years of their training, the therapists had numerous different experiences associated with

CBT and other approaches of psychotherapy. For instance, they worked in a psychodynamic unit, got to know different CBT trainers, did their own individual therapy with a gestalt therapist, or worked with clients according to a CBT manual. Whenever they had such experiences, they entered a process of juggling with these experiences. Different juggling balls (i.e., experiences with CBT and other approaches) were thrown at the jugglers (i.e., therapists in CBT training), and they were required to integrate these balls into their juggling routines (i.e., their constructions of CBT and other approaches and, thus, their self-definitions as therapists).

The goal of the trainees’ juggling processes was twofold, that is, to find themselves and to define CBT. *Finding themselves* characterizes a process of self-discovery. During this ongoing process, trainees tried to find themselves, discover who they were, what they believed, and how they felt about CBT and other approaches. Step by step, they developed their own theoretical positions and orientations. But how exactly did they do this? The analysis showed that the therapists in CBT training used a number of ways to achieve a subjectively coherent theoretical orientation as part of their therapeutic identity. For instance, in situations where they had had a very positive experience with another approach, the CBT trainees would use the strategy of *blurring boundaries* between CBT and other ap-

<sup>3</sup> The first author was both the researcher and a CBT trainee at the time of the study. This “insider” position had both advantages (greater theoretical sensitivity, implicit knowledge of the field) and disadvantages (more likely blind to her own biases). Her background can be characterized as follows: intensive and positive experiences with client-centered therapy during university education and employment; intensive and positive experiences with CBT during university education and training program. Other therapeutic approaches were secondary to her psychotherapeutic orientation. On the one hand, she was open to notions of “psychotherapy integration.” On the other hand, she was critical of them due to the discrimination against client-centered therapy in Germany and its “incorporation” by CBT therapists. The second author is a professor of clinical psychology, licensed psychotherapist, and trainer and supervisor in client-centered psychotherapy and CBT, with a stronger commitment to the former. At the time of the study, she was on the training faculties of two of the CBT programs recruited for the study.

<sup>4</sup> Categories obtained in the data analysis are printed in *small capitals*.

proaches. This enabled them to use the positive aspect as part of their own therapeutic identity. In contrast, they would *emphasize boundaries* between approaches if they had had a negative experience with another approach, thus protecting their CBT identity from the negative experience. The strategies used were actually somewhat more complex than illustrated in this example and are described in more detail below.

The example of *emphasizing boundaries* also demonstrates why the trainees were engaged not only in finding themselves, but also in an active process of *defining* CBT and other approaches, and thus inventing their own therapeutic orientations. Consider for instance, a CBT trainee who dislikes working in a psychodynamic hospital department and therefore starts to focus on problematic aspects of psychodynamic approaches and to emphasize the difference between CBT and these approaches. As a consequence, the therapist may try to adhere strictly to CBT concepts and techniques in his own therapeutic work and choose a CBT therapist for his personal therapy. The example illustrates that CBT trainees in this study actively contributed to their therapeutic orientation development by seeking out experiences that were compatible with their existing therapeutic orientation and also by identifying and distancing themselves and emphasizing or blurring boundaries. What is interesting is that during this process, CBT and other approaches were constantly defined and redefined, *constructed* in one way and then constructed in a slightly different way. In sum, that is why we decided to characterize therapists in CBT training as *constructing jugglers*.

**Different Constructing Juggling Strategies: Defining Oneself as a CBT Therapist Versus Defining Oneself as a Psychotherapist**

All the CBT trainees underwent a process of juggling. As a core category, it draws together the aspects of theoretical orientation development that were similar in all the trainees in this study. At the same time, there were important *differences* between the ways that trainees juggled and defined themselves. Based on the results of the data analysis the participants of this study could be classified along a continuum with the two poles “defining themselves as *CBT therapists*” and “defining themselves as *Psychotherapists*.” *CBT therapists* differed appreciably from *psychotherapists* in the extent to which they *identified with CBT* (high), *identified with other approaches* (low) and *emphasized boundaries between CBT and other approaches* (high). It is important to note, however, that trainees were categorized as *CBT therapists* even if they were not identified with CBT at every single moment during the interview—but were much more strongly identified than *psychotherapists*. The two poles of constructing juggling are illustrated in Figure 1.

So, what exactly is it that characterizes *CBT therapists* as opposed to *psychotherapists*? The two poles of the continuum and the corresponding processes of theoretical orientation development are illustrated in Figure 2. The differences between the trainees commenced even before the actual CBT training program began. Self-defined *CBT therapists* had more CBT-friendly *experiences before* they entered the CBT training program than self-defined *psychotherapists*. Prototypically, they had studied at a university

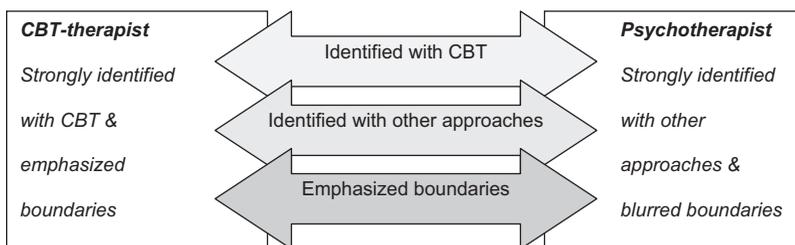


Figure 1. Dimensions of the core category “constructing juggling.”

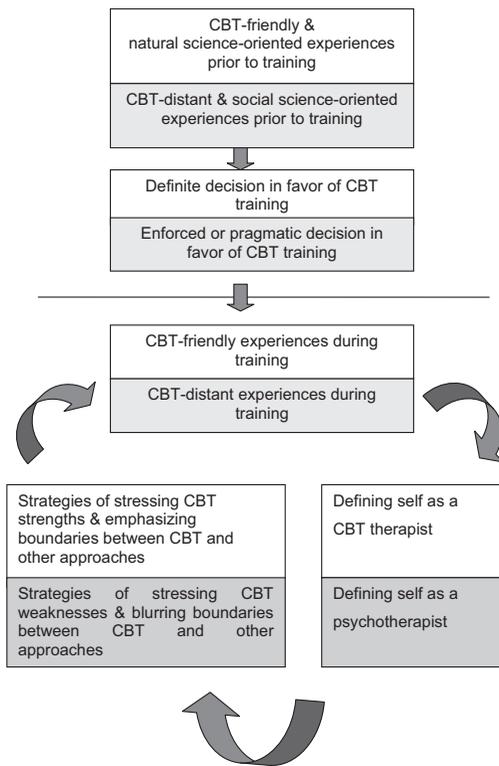


Figure 2. Processes of theoretical orientation development during cognitive-behavioral therapy (CBT) training—defining oneself as a *CBT therapist* (white boxes) versus defining oneself as a *psychotherapist* (gray boxes).

where the psychology course was oriented more toward the natural sciences and where CBT was predominant. If personal therapy was sought, it was either a successful CBT therapy or a mediocre psychodynamic therapy. Their work experience before the training program was, for instance, as a CBT-oriented consultant in a business company. These therapists had therefore entered the training program with a familiarity with and openness toward CBT concepts, whereas their experiences with other approaches had been rather superficial or ambivalent. The contrary was true for self-defined *psychotherapists* (e.g., successful systemic personal psychotherapy and an unhelpful CBT supervisor).

Self-defined *psychotherapists'* decisions in favor of the CBT program were therefore either enforced (e.g., they were not accepted by other training programs) or pragmatic (e.g., other training programs were too expensive). They

were not definite and intrinsically motivated as was the case for the *CBT therapists*, who chose their programs because they really believed in CBT and their particular program.

Interestingly, the two poles differed not only in regard to the therapists' experiences before training and during the decision process, but also to their experiences *during the training program itself*: During their training programs, very different "juggling balls were thrown at them," which resulted in different ways of constructing juggling. Self-defined *psychotherapists* reported having mainly "broad-spectrum" instructors. In contrast, self-defined *CBT therapists* talked mostly about "traditional" CBT instructors and supervisors. They typically reported that their CBT-oriented personal therapy had been successful and that they had had negative experiences during their internships in a psychodynamic hospital department. Their own therapeutic work was guided by CBT concepts and techniques and was evaluated as successful and fulfilling, whereas *psychotherapists* talked mostly about difficulties with using CBT in their own practice.

As a consequence of these differing experiences before and during training, trainees' *self-definitions* differed greatly. During the interview, *CBT therapists* presented the interviewer with a CBT identity and repeatedly conveyed a strong belief in CBT. They referred to themselves as "we CBT therapists" and used mostly CBT vocabulary. *Psychotherapists*, on the other hand, did not define themselves as CBT therapists. During the interview, they presented the interviewer with a non-CBT identity, for example, portrayed themselves as a "psychotherapist," a "psychodynamic therapist," or a "modern CBT therapist." These trainees only occasionally used CBT vocabulary. Their belief in CBT was limited. Interestingly, not only *psychotherapists* but also *CBT therapists* emphasized their belief that therapeutic approaches other than CBT are equally efficacious and effective.

The last major difference relates to the *strategies of defining CBT and other approaches* used by the study participants. These strategies were one of the most interesting findings of this study and further explicate the core category "trainees as *constructing jugglers*": When the *psychotherapists* defined CBT, they rarely mentioned its strengths but rather pointed out its

weaknesses. They drew a picture of CBT as generally deficient. Their criticism was leveled at core ideas of CBT, rather depreciative and seldom put into perspective, as was the case for the *CBT therapists*. For instance, one *psychotherapist* said, "I struggle with the neglect of emotions in CBT . . . and I strongly disagree with its trend to manualization," whereas one *CBT therapist* put his or her criticism this way: "At some point I thought that maybe psychodynamic therapists are right and CBT is not enough because it focuses only on behavior. But then I thought: 'No!' In practice, CBT is so much more than that!" Interestingly, being in a CBT training program and being highly critical of CBT at the same time did not constitute a dilemma for the *psychotherapists*, as they used various strategies to blur the boundaries between CBT and other approaches. For example, they used a very broad definition of CBT as a superordinate (or "umbrella") approach including CBT *plus* aspects of other approaches. *Psychotherapists* also distinguished "modern" CBT—which they described as overcoming limitations and thus easier to believe in—from "classical" CBT, which they deemed old-fashioned and not up-to-date. In contrast, *CBT therapists* defined "classical" CBT as a "standard" or "traditional" procedure and considered it to have not negative, but positive connotations. Another boundary-blurring strategy used by *psychotherapists* was to translate aspects of other therapeutic approaches into CBT language and concepts. For instance, one *psychotherapist* suggested that hypnotherapy could be integrated into CBT by calling it "imagination work." A similar strategy was to reduce other approaches: Systemic psychotherapy was, for example, defined as "integrating relatives into therapy." Client-centered psychotherapy was defined as "the three therapeutic variables of empathy, positive regard and congruence" that could be easily applied as a technique in CBT. One *psychotherapist* said, "I think that the client-centered variables are very important and should be implemented in CBT therapies. But I do not think that you need special client-centered training to do that."

The opposite set of strategies was used by *CBT therapists*. They focused strongly on differences between CBT and other approaches: "We work strictly on dysfunctional behavior and do not pay attention to life patterns. That is

completely different from what psychodynamic therapists do." *CBT therapists* also tended to draw attention to incompatibilities and contradictions between different approaches: "The assumption of relationship transparency in CBT contradicts the assumption of interpretation in psychoanalysis." Another boundary-emphasizing strategy was to reflect on the skills and responsibilities of different approaches. One *CBT therapist* mentioned psychoanalytic colleagues' skill in dealing with countertransference and humanistic colleagues' skill in working with the therapeutic relationship. They also considered referring patients to colleagues if they reached their limits as CBT therapists, whereas *psychotherapists* assumed that they were competent and responsible for all patients and all problems. The last major difference was that the *CBT therapists* mentioned the origins of therapeutic theories and techniques much more frequently than *psychotherapists*, for example, "these methods are taken from hypnotherapy."

In sum, the experiences of *CBT therapists* and *psychotherapists* before and during training are almost diametrically opposed. They develop very different theoretical orientations and use contrasting strategies of defining CBT and other approaches. During this process, these antithetical experiences, self-definitions and strategies interact and reinforce each other.

### **Developmental Pathways of Constructing Juggling: The Interplay of Preexisting Beliefs and Training Programs**

So far, opposing processes of theoretical orientation development have been described for *CBT therapists* and *psychotherapists*. These processes characterize trainees whose theoretical orientation development can best be described as a *match* between preexisting beliefs and the philosophy of their training program. However, other pathways of constructing juggling can also be found in our data: In addition to such processes where preexisting beliefs and program philosophy *matched*, we found a process that we coded as *socialization* to describe trainees whose preexisting beliefs and training program philosophy did not match to begin with but who then completely adapted to the training program philosophy over the course of their training. For example, one trainee was initially very critical of CBT and interested in psychody-

namic therapy. But her negative psychodynamic internship, her CBT friendly instructors in a “traditional” CBT training program and her own positive CBT therapy socialized her to become a *CBT therapist*. In contrast, another trainee studied at a natural science and CBT-oriented university and later worked in a behavioral department of psychology. He was socialized as a *psychotherapist* during his training at an “integrative” training program. A third pathway we found is a process we termed *immunization*: Trainees reporting this kind of process stuck to their initial beliefs and experiences and did not seem to be influenced by the fact that their training program conflicted with them. For instance, one interviewee was in an “integrative” training program but was characterized as a *CBT therapist*. She said, “Just because it’s offered to me, I do not have to buy it.” The last pathway can be called a *blending* of preexisting belief and program philosophy. In this case, the trainee’s theoretical orientation is a compromise between preexisting belief and program philosophy. This can best be illustrated by the group of trainees who ranged in the middle of the continuum (identified with CBT: medium; identified with other approaches: medium; emphasis on boundaries between CBT and other approaches: medium). For instance, one trainee had a very CBT-friendly background but happened to enter a very broad and “integrative” CBT training program. Another trainee from this group had had positive experiences with both CBT and other approaches prior to his very “traditional” CBT training.

### Discussion

The present study investigated the processes involved in theoretical orientation development and described the psychological mechanisms at work in psychotherapists as they find their personal theoretical stances in the course of their CBT training. The following quotation puts the results of our study in a nutshell: “On surveys and questionnaires . . . [the] process of identification with a theoretical orientation seems so straightforward. Unfortunately, it is far from being that simple in real life” (Sperry, 2007, p. 126). Our study showed that participating in a CBT training program can lead trainees to develop very different theoretical orientations. The processes involved are very complex and

constantly changing. Theoretical orientation development is a process that is not random, but has direction, and also has a psychological function for trainees. The most important strategy that trainees use to develop a coherent theoretical orientation is to constantly define and redefine CBT and other approaches. To put it in Piagetian terms, they both assimilate new experiences into their existing definitions of CBT and simultaneously accommodate their definitions to fit new experiences. According to Piaget, to assimilate is to adapt reality to one’s own cognitive organization. In the process, the new experience is distorted to a certain extent so that it can be better understood and interpreted. For instance, by reducing systemic therapy to the integration of family members, one therapist was able to preserve his rather broad definition of CBT. At some point, however, the new experience becomes too different and can no longer be explained by existing definitions of CBT and other approaches, making it necessary to reorganize and redefine it. For example, one therapist had to give up her idea that CBT is superior to all other therapies after working with a systemic and Gestalt colleague.

Similar examples of assimilation and accommodation processes are given by Castonguay (2000) in his common factors approach to psychotherapy training: The author describes how he was able to *assimilate* the increased awareness of emotion that he had gained through psychodynamically oriented supervision as a potential mechanism of change within a CBT framework. On the *accommodation* side, some clinical experiences led to more radical shifts in his theoretical orientation and his search for a more comprehensive model.

Looking at our developmental pathways, we see that the *matching* and *immunization* pathways focus more on assimilating new experiences into existing definitions of CBT and other approaches. In contrast, *socializing* can better be related to accommodating existing definitions of CBT and other approaches to fit new experiences. Lastly, *blending* is a process involving both assimilation and accommodation. Irrespective of their main theoretical orientation development pathway, each trainee in our study engaged in both assimilation and accommodation processes.

Thus, our core category “*trainees as constructing jugglers*” brings together three impor-

tant characteristics: (a) theoretical orientation development as an *ongoing process*, (b) theoretical orientation development as a process in which trainees are *actively* involved and not merely passive recipients of theoretical knowledge or practical experiences, and (c) theoretical orientation development as not simply a matter of client outcome or trainees' developing their skills, but as a process that also includes *identity and orientation development*. The latter is in line with Rønnestad and Ladany (2006), who state that research on psychotherapy training needs to expand the definition of training outcome beyond client outcome alone. It also supports Bennett-Levy's (2006) model, which suggests that therapist identity is actively constructed and emphasizes that both the therapist's professional self ("self-as-therapist schema") and his or her personal schema ("self-schema") are important for the complex process of developing therapeutic competence. While therapists enter training without a "self-as-therapist schema" and can only rely on their "self-schema," during training the development of the former is very dominant. Later, as therapists gain more experience of doing therapy and develop self-confidence, the "self-schema" becomes more and more important again.

The present study shows that measuring theoretical orientation using categories determined a priori by researchers does not capture the entire complexity of the therapists' developmental processes—even if a dimensional approach of theoretical orientation measurement is used as in the SPR International study (Orlinsky & Rønnestad, 2005). Moreover, our study goes beyond simply attempting to further specify theoretical orientation, as did Norcross et al. (2005), in that it provides a *glance behind the scenes* and an interesting new perspective by focusing more on the process (the "how") rather than on the content (the "what") of theoretical orientation development. In this respect, it resembles the Minnesota Study on Counselor and Therapist Development (Skovholt & Rønnestad, 1995), while additionally identifying different developmental paths and psychological mechanisms reported by trainees. Our study also shows a similarity with a study conducted by Ambühl et al. (1995), who distinguished between "formal patterns" and "specific contents" of therapists' theoretical orientation. Formal patterns are concerned not with the content

of theoretical orientation (e.g., psychodynamic, humanistic, behavioral) but with its form or quality: How broad or narrow is the theoretical orientation? Is there one salient orientation or are there several orientations? How eclectic or pure is the orientation? But again, the underlying assumption of our study was that it is not sufficient to describe content or patterns of theoretical orientation, but rather that it is necessary to analyze and characterize *psychological processes and characteristics* of therapists during their CBT training. This shift in study focus is similar to that effected by Sperry (2007), who describes psychological processes of therapist theoretical orientation development for Adlerian therapists as falling into two main categories: (a) self-identification as an Adlerian (ranging from *self-identification* to *denial of identification*), and (b) commitment to Adlerian concepts and techniques (ranging from *conserving-adapting-extending* to *no commitment to Adlerian ideas*). This is expanded into an eight-fold typology of theoretical orientations. For instance, some therapists self-identify as Adlerian and try to conserve and confirm Adlerian ideas empirically (Sperry calls them "*Adlerian I*"). Other therapists were former students of Adler who accept and value Adlerian concepts but do not see themselves as Adlerian (according to Sperry: "*friends of Adler*", e.g., Albert Ellis and Viktor Frankl). Still others use Adlerian concepts and techniques as their own, but do not refer to Adler at all (these Sperry calls "*Crypto-Adlerian*", e.g., Aaron Beck). Beyond their implications for future research, the results of this study also have important implications for psychotherapy training that are outlined in what follows.

### Implications for Psychotherapy Training

**Trainees' ability to develop a coherent theoretical orientation can be trusted.** An impressive finding of this study is that the CBT therapists in training engaged in theoretical orientation development with a sense of security and calm. Only one participant described herself as insecure and confused about her theoretical orientation and could therefore be seen as in the stage of *moratorium* according to Marcia (1966) and Skovholt and Rønnestad (1995). All other trainees conveyed the impression of having an *achieved identity* (Marcia, 1966). How-

ever, it is also possible that “the doing of identity and self-presentation during research interviews” (Lee & Roth, 2004) led to an exaggerated sense of security in our study participants. Similarly, Skovholt and Rønnestad (1995) argue that it is not possible for therapists in training to have an achieved identity. Following this argument, the trainees in this study could best be described as *true believers* (i.e., CBT-therapists) or *multiple attachments* (i.e., psychotherapists). The *CBT therapists* versus *psychotherapists* therefore need to master two antithetical developmental tasks. The *CBT therapists* are faced with the task of becoming more open toward other approaches and avoiding rigidity, whereas *psychotherapists* need to address the task of committing themselves and avoiding fuzziness. As regards rigidity, our *CBT therapists* were more similar to the participants in Carlsson, Norberg, Sandell, and Schubert’s (2011) psychodynamic study than to our *psychotherapists*. Only after the end of their training did the psychodynamic therapists in that study notice that they had “felt almost imprisoned by what they described as a rigid psychoanalytic tradition from which they could now break free” (p. 148). Interestingly, in Carlsson et al.’s sample, there was no group of therapists that was comparable to our *psychotherapists* (i.e., hardly identified with their own approach + strongly identified with other approaches + blurring boundaries). Future research should investigate whether such a theoretical orientation is unique to German therapists in CBT training, or whether it can be found in other orientations, countries, and also at other stages of professional development.

**However, it should not be assumed that trainees find their theoretical orientations as a matter of course; they may need support for this complex process.** Even if trainees have a sense of security, one cannot assume that they automatically know how *exactly* to link the therapeutic approaches and techniques they learn during their training to their previous knowledge or experience. It is not surprising that the trainees in our study did not, in fact, know exactly how to “integrate” different theories, methods, strategies and techniques, as even in the literature the debate about different *routes to integration* (Norcross, 2005) is complex and prolonged. Therefore, if training programs want to understand and influence theo-

retical orientation development in their trainees, we suggest that they make a specific effort to provide them with support for this aspect of therapeutic identity development. Therapists in training can either benefit from theoretical knowledge about different routes to integration, as Norcross and Halgin (2005) suggest in their chapter on training, or they can be supported individually in supervision or personal therapy to reflect on their theoretical orientation development. For instance, the majority of participants in our study used the research interview as an opportunity to reflect on their theoretical orientation. Bitar et al. (2007) give examples of questions that can be used for self-exploration. In sum, it is not wise to assume that the theoretical concepts imparted in a training program are imparted on a one-to-one basis; rather, a constructivist view of trainees should be adopted. They are not simply passive recipients, but actively involved in their theoretical orientation development.

**Therapists do not necessarily need to identify with a single therapeutic approach in order to develop a coherent theoretical orientation.** The results of our study demonstrate that there is no single developmental path that is followed by all therapists in training. Not all trainees rely on identifying with one “school” of therapy (CBT) for their theoretical orientation development. In our study, this was only the case for *CBT therapists*. For them, theoretical orientation development was clearly linked to their “attachment” to CBT theory and practice (Hagehülsmann, 2000). This is consistent with Willutzki and Laireiter (2005), who conclude from comparative outcome research that therapists’ consistent theoretical orientations have a positive effect on outcome. In contrast, for *psychotherapists*, theoretical orientation development was not linked to identification with CBT. For them, a consistent theoretical orientation is not necessarily limited to one therapeutic approach. According to Wampold (2001), it is crucial that “the therapist delivering the treatment believes that the therapy is efficacious” (p. 159) and that “there is a [cogent and coherent] rationale that underlies the treatment” (p. 161). Similarly, Grawe and Fliegel (2005) argue that for novice therapists structure and orientation cannot be provided only by allegiance to a single “school” of therapy, but can also be developed in relation to five

different perspectives (i.e., the mental disorder, interpersonal, resources, developmental, and motivational perspectives). Similarly, Norcross and Halgin (2005) argue that psychotherapy training should be integrative from the very beginning to allow “an informed pluralism” (p. 439) and suggest a six-stage ideal model of integrative psychotherapy training.

In sum, the variations we found in theoretical orientation development are consistent with the range of views of American training directors: “About one third believe that students should be trained first to be proficient in one therapeutic model; about half believe that students should be trained to be minimally competent in a variety of models; and the remainder believe that students should be trained in a specific integrative or eclectic model from the onset” (Lampropoulos & Dixon, 2007 as cited in Norcross & Halgin, 2005 ).

### Implications From the Perspective of Mental Health Policy

The results of our study are also relevant in the context of mental health policy. Trainees’ strategies of emphasizing and blurring boundaries between CBT and other approaches, for instance, are not influenced exclusively by therapeutic and scientific considerations and experiences. Our data reveal that participants clearly pursue two additional goals: (a) therapists in training want to be reimbursed by insurance companies and therefore choose CBT as one of two reimbursable approaches in Germany, and (b) therapists in training want to benefit from being a CBT therapist. Carlsson et al. (2011) stated that “the therapist community was considered a privileged group and the participants wanted full membership in it. [ . . . ] A degree and a license [ . . . ] is also a strategic choice, for a career, to get more opportunities” (p. 146). In our study, trainees seemed to view the *CBT community* as a privileged group in which they wanted full membership. Theoretical orientation development seems to be a *strategic choice* and *territorial claims* appear to be relevant. Our results point in a direction similar to that suggested by Petzold (1994), when he stated that psychotherapy is not only a scientific discipline but also a practice-oriented community of interest for professionals. This could explain why and how our *psychotherapists* still managed to

continue the long CBT training program, despite their low identification with CBT.

*Boundary emphasizing*, as one of the key empirical categories, thus mirrors the conceptual changes that have taken place within the third wave of CBT (Hayes, 2004). In addition, it reflects the trend toward the proliferation of CBT that Holmes (2002) critically summarized in his article, “All you need is CBT?” According to Daiminger (2007), reasons for CBT’s attractiveness are its ability to integrate different approaches and techniques, its compatibility with the principles of health insurances, its conformity with empirical and experimental psychology, and its natural science-oriented conceptualization of psychotherapy. Our data show that therapists in CBT training in Germany clearly want to benefit from these strategic advantages.

### Methodological Considerations

The current sample consisted only of therapists in their first training program, as we assumed that the time therapists spend in training is a sensitive developmental phase. Thus, it remains unclear if the core phenomenon of *constructing juggling* would also apply to more experienced therapists who have a clearer idea of who they are as therapists. Accordingly, Carlsson et al. (2011) found that the therapists they studied a few years after they had concluded their training and who had all been very experienced before entering the training program were “preoccupied with obtaining approval of the ideas about therapy that they possessed before they entered the training program” (p. 148). Another limitation is that only therapists in Germany and from CBT training programs were included because we wanted to study one group thoroughly and systematically. We do not therefore know to what extent these findings may apply to therapists in other countries and with other orientations. In our study, we investigated only the therapists’ perspectives and relied on their descriptions of their experiences during training. It remains unclear what trainees actually *did* in their therapies and how judges would rate their theoretical orientations if they saw them working. The present study had a retrospective design. It would have been interesting to interview trainees on several occasions before, during and

after training. Lastly, the application of theoretical sampling in this study was somewhat limited by the availability of study participants.

### Conclusions

For therapists in CBT training in Germany the process of theoretical orientation development can be summarized as *constructing juggling*. In so doing, we advocate a shift in focus toward analyzing and characterizing *psychological processes* of trainees that goes beyond simply establishing theoretical orientation on the basis of self-ascriptions or describing formal patterns of orientation. Our investigation of the psychological processes that trainees undergo revealed that theoretical orientation development was influenced not only by therapeutic and academic aspects, but also by strategic choices and territorial claims. An interesting project for future research could be to review the literature (e.g., on the great psychotherapy debate or on psychotherapy integration) and systematically to investigate the authors' psychological processes and the strategic choices that influence their theoretical orientations.

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Received June 11, 2013

Revision received March 22, 2014

Accepted May 7, 2014 ■