PERCEIVED PROFESSIONAL DEVELOPMENT AMONG MENTAL HEALTH PRACTITIONERS IN NEW ZEALAND

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NIKOLAOS KAZANTZIS

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TABLE OF CONTENTS

Page

Acknowledgments. iv

Table of Contents v

List of Tables vii

List of Figures viii

Foreword ix

CHAPTER 1

INTRODUCTION

1.1 Recent Advances in Psychotherapy Research 1

1.2 The Therapist as a Neglected Variable in Research ... 3

CHAPTER 2

PROFESSIONAL DEVELOPMENT

2.1 Conceptual and Theoretical Perspectives 5

2.2 Research on Professional Development 6

2.3 Collaborative Research Network Research Study ... 10

2.4 Measuring Therapist Development 11

2.5 Aims of the Present Study... 17

CHAPTER 3

METHOD

3.1 Sample 19

3.2 Measure 21

3.3 Procedure 26

Page

CHAPTER 4

RESULTS

4.1 Professional Development 28

4.2 Professional Development and Experience 31

4.3 New Zealand Data and CRN Database Compared ... 36

4.4 Interrelations between Professional Development Measures 39

CHAPTER 5

DISCUSSION

5.1 Perceived Career Development 40

5.2 Perceived Therapeutic Mastery 41

5.3 Perceived Growth 41

5.4 Implications for Training 43

5.5 Limitations of the Present Study 44

5.6 Relationship Between Professional Development Measures 46

5.7 Rationale for Future Research 47

5.8 Summary and Conclusions 48

REFERENCES 49

APPENDIX A DPCCQ Questionnaire 58

APPENDIX B Expression of Interest Flyer 71

APPENDIX C Cover Letter to Respondents 74

LIST OF TABLES

Page

Table 1	CRN Questionnaire Items on Professional Development ...	14
Table 2	Factor-Analytically Derived Scales of Professional Development	16
Table 3	Caseload of Mental Health Professionals Surveyed	20
Table 4	CRN Questionnaire Items on Professional Development ...	23
Table 5	Theoretical Orientations of Mental Health Professionals Surveyed	25
Table 6	Professional Development among Mental Health Professionals Surveyed	29
Table 7	Mean and Effect Sizes for Professional Development Subscales	30
Table 8	Correlations between Professional Development Subscales and Experience	33
Table 9	Comparison of Professional Development for Therapists in the CRN Database (N = 3795) and Present Study (N = 254) ...	37
Table 10	Intercorrelations between Professional Development Measures	39

LIST OF FIGURES

Page

Figure 1 Mean perceived professional development by years in practice 34

FOREWORD

Study of psychotherapy processes and outcomes has far outweighed study of its practitioners. New methodological advances in psychotherapy research have led to an increased emphasis on the role of therapist factors in ensuring successful psychotherapy outcome. Implicit in these methodological advances is the suggestion that the treatment procedures, and not the therapists delivering them, are ultimately the main determinants of successful treatment outcome.

Although researchers have incorporated therapist years of practice or extent of training when evaluating psychotherapy, this is often misleading as it fails to consider what it actually done during those training and practice years of professional development. Unfortunately, only a few studies have examined mental health professionals' professional development, and little is currently known about the process of development over the course of a practitioner's career. This thesis is an extension of the Collaborative Research Network's study of mental health professionals' professional development to New Zealand.

This thesis starts with a description of some recent advances in psychotherapy research, and how they have refocused the field's attention towards the role of the practitioner in influencing treatment outcomes. This is followed by a description of the existing theoretical and empirical work on practitioners' professional development, and an overview of existing methods of assessment. An outline of the CRN study aims and methods are then overviewed, before presenting and discussing the results of the New Zealand practitioner survey.

CHAPTER 1

INTRODUCTION

1.1 Recent Advances in Psychotherapy Research

The field of psychotherapy research has seen considerable changes in the past two decades. New methodological advances in treatment manualization and focus on treatment fidelity have led to an increased emphasis on the role of therapist factors in ensuring successful psychotherapy outcome. Treatment manuals are one of many methods developed to improve the science of psychotherapy research (Luborsky & DeRubeis, 1984), and are designed to provide a theoretical framework for treatment, case examples, and concrete descriptions of therapeutic techniques (e.g., Beck, Rush, Shaw, & Emery, 1979, Klerman, Weissman, Rounsaville, & Chevron, 1984; Strupp & Binder, 1984). Manuals can also standardize techniques, discriminate between alternative approaches, and enable the evaluation of treatment fidelity for the administered treatments (DeRubeis, Hollon, Evans, & Bemis, 1982; Waltz, Addis, Koerner, & Jacobson, 1993).

Treatment fidelity refers to a research study's ability to demonstrate that its treatments are distinct and delivered in an adequate manner. Attention is given to treatment fidelity in order to maximize internal validity and to improve its likelihood for replication (Luborsky & DeRubeis, 1984). Currently, there are two recognized components of treatment fidelity, treatment adherence and competence. The extent to

which the interventions of a treatment modality can be distinguishable from that of another treatment modality is commonly referred to as "adherence." The determination of whether a treatment modality is being delivered to an acceptable standard, or level of skill, is commonly referred to as "competence." The advent of the treatment manual and assessment of treatment fidelity is a reflection of the dissatisfaction of early psychotherapy research studies. Earlier studies were often inadequate, because of the overlap between interventions, and because little systematic information was provided as how to perform the interventions (McGlinchey & Dobson, 2002). Before the advent of manualization, the assumption was that the implementation of a treatment approach would be apparent and not require further documentation (Garfield, 1997).

Despite the advantages afforded by treatment manuals, a number of concerns have been raised regarding the applications of treatment manuals by therapists in clinical practice settings. These include the suggestion that manual-based treatments (a) do not allow therapists to provide an individual case formulation, and consequently, allow for individualized therapy; (b) do not allow for the common heterogeneity in the client population as compared to the research setting (e.g., where exclusion criteria include comorbid problems); and (c) will produce negative treatment effects because therapy will be provided in a rigid fashion (see Addis & Krasnow, 2000; Eifert, Schulte, Zvolensky, Lejuez, & Lau, 1997; Holloway & Neufeldt, 1995; Kendall, 1998; Silverman, 1996; Wilson, 1995, 1996). However, these concerns are not shared by all psychotherapy practitioner-researchers. For example, Wilson (1995, 1996) suggested that an idiographic case formulation does not necessarily guarantee

quality treatment. Wilson (1996) also suggested that manual-guided treatment does not necessarily preclude individualization of treatment, nor does using manuals preclude attention to comorbid problems. As an alternative, Kendall, Chu, Gifford, Hayes, and Nauta (1998) argued for a middle ground between the complete freedom of an unstructured treatment and the strict adherence to every detail of a treatment manual. They suggest that treatment manuals can be understood as general theoretical frameworks that provide guidelines and directions to therapists without restricting their clinical judgments.

1.2 The Therapist as a Neglected Variable in Research

In pursing these recent advances, the field of psychotherapy research has upheld a strong proposition that the treatment procedures are ultimately the main determinants of successful treatment outcome. Implicit in these methodological advances is the suggestion that a therapists' nature and characteristics are only important when evaluating their competency in providing treatments, and their ability to engage their clients in a sound therapeutic relationship (e.g., Elkin, Parloff, Hadley, & Autry, 1985). While this research has a crucial role in supporting the effectiveness of psychotherapy, it has slighted the importance of the individual practitioner to psychotherapy processes and outcome.

The limited available data suggests that variations among therapists within treatment frequently exceed the effects of different psychotherapy approaches (see review in Beutler, 1997). Consequently, there are a series of therapist variables such as

therapist experience and training that are likely to be important in explaining the variation between therapists, separate from their adherence or competence in administering a particular treatment manual. Moreover, the role of time in a professional role, and specific training experiences may change as a function of the severity of the problems presented by clients, the type of setting the therapist is working in, and the length and intensity of the psychotherapy itself.

Interest in the importance of identifying therapist characteristics within the context of evaluating psychotherapy has increased in recent times. The literature suggests that although therapist personality, demographics, and style of therapy do not produce main effects of a large magnitude on treatment outcome, differences do emerge when contrasting client personality, demographics, and coping styles are included as covariate or moderating factors in analysis (Beutler & Clarkin, 1990; Beutler et al., 1991, 1994). Given this disparity in the research on therapist and client factors, it seems the field should move away from straightforward unidirectional hypotheses about the impact of therapist factors. In fact, it can be misleading to include therapist years of practice or extent of training when evaluating psychotherapy, without consideration of what it actually done during those training and practice years of professional development.

CHAPTER 2

PROFESSIONAL DEVELOPMENT

2.1 Conceptual and Theoretical Perspectives

The concept of development implies a directional and intelligible state of change in a system or set of conditions (Lerner, 1986; White, 1983). Development is a process of transformations that, when viewed to some criterion, can be referred to as a pattern of change over time (Orlinsky, Ambühl et al., 1999). Within the context of studying development among mental health practitioners, a distinction must be drawn between the criteria set for university graduation and becoming registered as a mental health professional and other qualities required for being an effective practitioner. That is, development must be understood as attainment of increasing expertise in a task that therapists perceive as highly challenging and complex (Skovholt & Rønnestad, 1995). The issue is whether practitioners continue to develop in their professional skills after having attained a basic competency level (Dawes, 1994).

The traditional view of competency was that a trained competent practitioner who had the required experience would exemplify the maxim "once competent, always competent" (Shaw & Dobson, 1988). This "trait" position aimed to capture the individual therapists' potential and ability, and expects a highly competent therapist to exhibit more than average performance over a long period of months or years. An alternate position, now popularized among psychotherapy researchers, is that

competence varies across time and situation, and there are several factors that influence competence. While competence and development are not interchangeable concepts, it may be instructive to consider both as "state" variables. Specifically, that competency and professional development vary over time and career stages.

Most theoretical models of professional development have focused primarily on the early stages of practitioners' careers (e.g., Fleming, 1953; Hess, 1987; Hogan, 1964; Loganbill, Hardy, & Delworth, 1982; Stoltenberg & Delworth, 1987). The research literature has mirrored this theoretical emphasis by mainly examining therapists either in their student years or immediate postgraduate years, and has largely ignored more experienced practitioners (Skovholt, Rønnestad, & Jennings, 1997).

2.2 Research on Professional Development

Research on therapist characteristics, training, and therapeutic practice began in the 1950's (i.e., Fiedler, 1950; Holt & Luborsky, 1958; Kelley & Fiske, 1951; Strupp, 1955). Holt and Luborsky presented the findings of a 10-year account of the research methods and findings, personalities, and factors associated with competence among residents selected for psychiatric training. While this data provided a useful summary for other programmes interested in selecting their psychiatric residents, it provided no data on the course of their development after gaining residency. Similarly, Strupp examined the differences in therapeutic responses between a group of psychiatrists, psychologists, and psychiatric nurses, but was only able to observe differences at one point in these professionals' careers. This early literature has been reviewed on

several occasions (e.g., Gurman & Razin, 1977; Meltzoff & Kornreich, 1970), and in successive editions of the *Handbook of Psychotherapy and Behavior Change* (Beutler, Crago, & Azrimendi, 1986; Beutler, Machado, & Neufeldt, 1994; Matarazzo, 1971, 1978; Matarazzo & Patterson, 1986; Parloff, Waskow, & Wolfe, 1978; Truax & Mitchell, 1971). These reviews have concluded that research should address more complex issues than in the past. More specifically, research should attempt to do more than calculate treatment outcome associated with particular therapist groups defined by demographic status, and attempt to evaluate variation in a therapists' practice both during the course of a treatment study and over the course of their careers. For instance, one review of the literature by Stein and Lambert (1984) observed that the average experience level in studies of therapist expertise was only 2.9 years. Three notable exceptions are the surveys reported by Rachelson and Clance (1980) and by Morrow-Bradly and Elliot (1986), as well as the qualitative study by Skovholt and Rønnestad (1992).

The study by Rachelson and Clance (1980) surveyed members of the American Psychological Association Division of Psychotherapy (APA; Division 29) for their opinions of whether the experiences recommended in various APA-approved psychotherapy training models had been present in their doctoral training, and had assisted in their development as competent practitioners. The survey also asked practitioners to rank their experiences in graduate training with four other training methods (i.e., internship, personal therapy, their practice, advanced training workshops) for their opinions on which provided the most beneficial training on being an effective therapist. Of the 192 respondents, 89% endorsed their experience

in the practice of therapy (i.e., "experience in real-life setting delivering needed services") as the leading source of learning. Clinical supervision was the second most highly valued experience during training (66%), followed closely by education on psychotherapy designed to provide grounding in knowledge and skill (60%). Respondents ranked the training components that contributed most to their learning about becoming an effective therapist in the following order: practice of therapy (37%), personal therapy (30%), internship (16%), advanced training in workshops (15%), and graduate school (10%).

Although the study by Morrow-Bradley and Elliot (1986) was designed to examine practitioners' integration of psychotherapy research in clinical practice, they also asked practitioners for their impressions of the feature of psychotherapy that they found most useful for practice. The researchers reported data on 384 members from APA Division 29 who indicated their impressions on a list of 10 forced-choice alternatives. Direct experience with clients (48%) was rated as more important than reading theoretical material relevant to practice (10%), and all other choices received were less popular (9% or less) among practitioners (i.e., experience in therapy, workshops or conferences not relating to psychotherapy, research presentations, discussions with colleagues, and conducting research). The forced-choice questionnaire methods used in the Morrow-Bradley and Elliot may have led to the low ratings for non-experience with client features. That is, while the relative ordering of these features of psychotherapy may not have been substantially different using a different questionnaire methodology, other features may have been more highly rated. This seems particularly likely when one considers that 31% of the same

sample reported having read research findings in the past year that changed the way that they practiced psychotherapy when asked directly.

By comparison, the study by Skovholt and Rønnestad (1992, 1995) involved an examination of various sources of influence of therapists' professional development (i.e., events in personal life, experiences with clients, theories, and specific people or groups). The researchers conducted a semi-structured interview with 100 practitioners selected to represent career levels ranging from graduate student to retirees, and asked their participants to rank sources of influence in order of importance for the clinical work. The results showed that interpersonal interactions (i.e., interacting with clients, supervisors, personal therapists, and mentors) and experiences from personal life were considered as the most important sources of influence. The open-ended interview methods used by the researchers allowed for a variety of sources of influence to be mentioned by therapists. The researchers noted, however, that therapists repeatedly mentioned the impact of personal experiences, and less frequently mentioned the impact of empirical findings.

Taken together, the results of this prior research highlight the perceived importance of experiential and interpersonal learning over didactic learning in the development in the clinical training. While it may be tempting to disregard the contribution of academic study in the development of clinical understanding and skillfulness, it is important to consider the limitations of the small number of studies on this topic. The total number of practitioners surveyed in these studies is small, but more importantly, practitioners in these studies were trained within the discipline of psychotherapy in

the United States. These limitations of the available data limit our ability to generalize the findings to the New Zealand context, even if we are to accept the various self-report methodologies that have been employed. Therefore, it can be concluded that more extensive research is required on mental health practitioners' professional development.

2.3 Collaborative Research Network Study

As a first step towards filling this gap in the literature, members of the Society for Psychotherapy Research in 1989 responded to a call for a program of research on the development of mental health professionals. This group organized a Collaborative Research Network (CRN) and designed a study of development over the course of the professional career, and included therapists of all training backgrounds, theoretical orientations, and countries. The CRN has a long-term agenda consisting of three phases (Orlinsky, Ambühl et al., 1999). Phase I involved the design of an initial survey questionnaire[1] to examine therapists' perspectives on development, initial data collection, data coding and construction of a database, and preliminary analysis. Phase II is currently underway and involves ongoing data collection to enlarge marginal groups in the initial database, extension of data collection to new geographic and cultural areas, and publication of initial analyses of development and related areas of functioning. Phase III is planned to expand and refine the research instruments, expand and refine the database, and most importantly, assessment of

[1] No measures of therapist development were available until the methods of the "Minnesota Study of Therapist Development" were published (Rønnestad & Skovholt 1991).

therapist development and related variables in relation to treatment processes and outcomes. The present study represents the New Zealand portion of this research program, designed to collect data for contribution to the cross-national CRN database.

2.4 Measuring Therapist Development

A first step towards the development of an empirically based model of professional development might reasonably be to survey actual perceptions of practitioners. Such an approach would involve surveying practitioners' self-observations and reflections on the factors that have most influenced their development as therapists. The resultant data would only provide preliminary data on development as there may be a host of beliefs that would influence self-observation and reflection. Ideally, such research would involve examination of actual clinical work over the course of the career. Nonetheless, practitioners receive training to observe and make sense of their own and their clients' experience, and it seems reasonable to drawn upon their personal experiences in training.

Although the limitations of self-report data in measuring professional development should be acknowledged, it is important to note the value of self-report data in several contexts. Self-report data is considered appropriate where descriptive data is obtained and where experienced experts are surveyed (Bradley & McKendree-Smith, 2001). For example, demographic information such as age, gender, or occupation are rarely corroborated in psychological research by checking birth certificates, calling

employers, or examining the results of chromosome studies (e.g., Weissman, Olfson, Gameroff, Feder, & Fuentes, 2001). Similarly, trainee evaluation of teaching is routine in academic institutions, as with other services and products, and necessarily relies on data from individuals who have received and used services and products. Moreover, in everyday clinical settings the opinions of expert practitioners regarding training and professional development is often sought and valued, particularly when a range of experienced practitioners' opinions are in agreement. Given the lack of empirical research on which to base a model of professional development, it seems like a reasonable first step to survey practitioners' views of their professional development using self-report methods. Given this rationale for proceeding this way, a team of 12 practitioner-researchers from different countries, professions, and theoretical orientations produced a self-report questionnaire designed to assess therapist development[2].

Two broad components of professional development were examined in the in the CRN questionnaire, these were currently experienced and retrospective professional development. That is, the questionnaire was designed to ask therapists to what extent they felt they were "developing" and had "developed" from the start of their careers, as defined by perceived learning, growth, and improvement. These two perspectives were considered to be conceptually related but methodologically independent and separated by temporal frame. Surveying self-reports of current development was considered the most direct approach to determine whether practitioners deem

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[2] Professions represented among team members were medicine, psychology, and social work; theoretical orientations were behavioral, cognitive, experiential, psychodynamic, and systemic.

themselves to be experiencing growth (or decline) in their ability and capacity to conduct therapy. Specifically, practitioners' perceptions on their ability to acquire new skills, learn new techniques, attain new insights, overcome past limitations, and increase their understanding to help clients (see Table 1). On the other hand, retrospective development self-reports were considered to be more complex than current development as they required an inherent comparison of present abilities, limitations, and disabilities with estimates of past abilities. Retrospective ratings are also susceptible to retrospective distortions as an additional source of bias. Given the preliminary status of the CRN study, however, it was decided that data would be obtained on these two features of development and gain additional information by comparing therapists according to whether they rate themselves as having developed to a greater or lesser extent to date.

A factor analysis of the CRN questionnaire was presented in the CRN preliminary report (Orlinsky, Ambühl et al., 1999). Principle Components factor analysis with Varimax rotation demonstrated that five factors were obtained, accounting for 58.7% of the variance. Dimensional scales for professional development were constructed based on these factors and included items on perceived career development, perceived therapeutic mastery, and perceived growth (see Table 2). Other items had minor loadings on several factors, or no strong loading on any, and were considered of peripheral importance to the issue of professional development. The resultant scales for development produced internal consistency (Chronbach's alpha) values from .67 to .80 and were judged satisfactory.

Table 1

CRN Questionnaire Items on Professional Development

Perceived Career Development
1. Have you changed overall as a therapist?
2. Do you regard this overall change as progress or improvement?
3. Do you regard this overall change as decline or impairment?
4. Have you succeeded in overcoming your past limitations as a therapist?
Perceived Therapeutic Mastery
1. How much mastery do you have of the techniques and strategies involved in therapy?
2. How well do you understand what happens moment-by-moment during therapy sessions?
3. How much precision, subtlety, and finesse have you attained in your therapeutic work?
4. How capable do you feel to guide the development of other psychotherapists?
Perceived Growth
1. Do you feel you are changing as a therapist?
2. Does this change feel like progress or improvement?
3. Does this change feel like decline or impairment?
4. Do you feel you are overcoming past limitations as a therapist?
5. Do you feel you are becoming more skillful in practicing therapy?
6. Do you feel you are deepening your understanding of therapy?
7. Do you feel a growing sense of enthusiasm about doing therapy?
8. Do you feel you are becoming disillusioned about therapy?
9. Do you feel you are loosing your capacity to respond empathically?
10. Do you feel your performance is becoming mainly routine?

Note. Items are from the Development of Psychotherapists Common Core Questionnaire (DPCCQ; Orlinsky, Ambühl et al., 1999). Items were rated on a 6-point scale (0 = *not at all*, 5 = *very much*).

Orlinsky, Ambühl et al. (1999) presented data from 3795 practitioners on these factor-analytically derived scales for professional development. Descriptive data for the entire sample revealed some general trends among the practitioner sample (see Table 2). On perceived career development, more than half of the sample felt they had changed "much" or "very much" overall (60%), and an even greater proportion felt that change represented "much" or "very much" progress (79%). On the other hand, a relatively small proportion of practitioners rated themselves as having attained "much" or "very much" therapeutic mastery (scale items ranged from 40% to 48%). By comparison, practitioners only reported having perceived growth on some features of therapy (i.e., 65% on improving and deepening understanding of therapy), and as few as 40% on others.

A report was published by the CRN that included comparisons of therapists' professional development according to descriptive characteristics, such as professional background, theoretical orientation, and years in practice (Orlinsky, Rønnestad et al., 1999). The sample demonstrated a broad range of years in clinical practice ($M = 11.20$, $SD = 8.88$), but there was a degree of uniformity between subgroups of the sample. Only three moderate differences were observed[3]. One difference was that social workers, nurses, and "lay" analysts rated themselves as lower in perceived therapeutic mastery compared to medicine and psychology ($ES = .40$). A second difference in therapeutic mastery was observed among broad-

[3] Effect sizes were calculated for the purpose of subgroup comparison. With a sample of 3800, there would have been a high likelihood of obtaining significant effects, regardless of whether such effects existed (i.e., increased Type I error).

spectrum therapists who rated 4 or 5 on the 0-5 scale[4], or who endorsed four or more theoretical orientations (*ES* = .50). The third difference was that the American subgroup was more experienced than other groups (*ES* = .48), but did not differ in terms of their perceived therapeutic mastery and perceived growth.

Table 2

Factor-Analytically Derived Scales of Professional Development

Perceived Career Development	*M*	*SD*	% High [a]
Changed overall.	3.7	1.1	59.4
Overall progress.	4.1	1.0	78.5
Perceived Therapeutic Mastery			
Mastery of technique.	3.4	0.9	48.2
Understanding moment-to-moment.	3.4	0.9	48.3
Precision, subtlety, finesse.	3.2	1.0	41.4
Capable to guide others.	3.0	1.3	39.5
Perceived Growth			
Improving.	3.7	1.1	64.7
Becoming more skillful.	3.5	1.0	58.2
Changing as a therapist.	3.3	1.1	44.1
Deepening understanding.	3.7	1.0	65.3
Overcoming limitations.	3.1	1.1	39.7
Growing enthusiasm.	3.2	1.3	46.1

Note. From "Development of Psychotherapists: Concepts, Questions, and Methods of a Collaborative International Study" by Orlinsky, Ambühl et al., 1999, *Psychotherapy Research, 9,* p. 144. Copyright 1999 by Oxford University Press. Adapted with permission of the author.

[a] High refers to the percent who rated either "*much*" or "*very much*" on the 6-point scale (0 = *not at all*, 5 = *very much*).

[4] Theoretical orientation rated their responses on a 0-5 scale (0 = *not at all*, 5 = *very greatly*) in response to the question "How much is your current therapeutic practice guided by each of the following theoretical frameworks?"

2.5 Aims of the Present Study

Despite the various published and unpublished surveys of New Zealand mental health practitioners (e.g., Kazantzis & Deane, 1998, 1999; Patchett-Anderson & Ronan, 2002; Rowe, 2001), very little is known about professional development. There are no previously published reports on the perceived professional development general mental health practitioner population, whether they consider themselves to have developed over the course of their careers, attained therapeutic mastery, or consider themselves to have grown in the skillfulness and understanding of therapy practice. For example, it is possible that perceived professional development may be different at different levels of experience, or for practitioners who integrate different theoretical orientations in therapy practice. It is also possible that professional development may differ as a function of the practitioner's professional identification. The present study was designed to provide specific data on these aspects of professional development for the population of general mental health professionals in New Zealand. A replication of the CRN study on the professional development of psychotherapists was conducted among a diverse sample of practicing mental health professionals in New Zealand (Orlinsky, Rønnestad et al., 1999).

The main purpose of the present study was to conduct an exploratory survey of perceived professional development among a diverse range of mental health professionals in New Zealand. The study was designed to provide comparative data for an examination of professional development according to descriptive characteristics, such as professional background, theoretical orientation, and years in

practice. The study was also designed to compare the data from New Zealand mental health professionals to the data from the cross-national CRN database. Since there has been a rise in the popularity of cognitive and cognitive-behavioral psychotherapies, evidenced in psychotherapy practice and the number of continuing education workshops (see also Kazantzis & Deane, 1998, Norcross, Karg, & Prochaska, 1997), it was hypothesized that therapists practicing within these approaches would have a higher level of perceived professional development than those practicing predominantly within other theoretical orientations.

CHAPTER 3

METHOD

3.1 Sample

Two hundred and fifty four practicing mental health professionals (age range 24 to 86 years, $M = 47.9$ years, $SD = 10.1$) participated in the survey. The sample was 25% male and 73% female, with most (79%) identifying themselves as part of the social, cultural, or ethnic majority for New Zealand. Only a small proportion of the sample identified as being part of the ethnic minority (12%), social minority (i.e., sexual orientation, 4%), or religious minority (2%). Just over half of the survey respondents were married (53%), with smaller proportions either living with a partner (17%), separated or divorced (16%), single (11%), or widowed (2%).

Respondents identified a diverse range of professional identifications. Ten percent identified themselves as part of the medical profession (i.e., psychiatrist or physician), 31% identified themselves as psychologists, 47% as counselors, 39% as psychotherapists, and 11% as social workers. The sample also included a small proportion of nurses (6%) and ministers (4%). (Sum of percentages for professional identification exceeded 100 because multiple ratings were allowed.) Therapy experience ranged from 1 to 42 years ($M = 11.6$, $SD = 7.5$), with a modal number of 10 years. Table 3 presents detailed information on the caseload of therapists surveyed in the present study.

Table 3

Caseload of Mental Health Professionals Surveyed

	n	%	*M*	*Mdn*	*SD*	*Range*
Treatment Setting				[therapy hours]		
Public inpatient	11	4	8.0	4	7.0	1-16
Public outpatient	70	28	14.7	15	8.4	1-25
Private inpatient	7	3	16.4	15	11.3	2-25
Private outpatient	12	5	20.3	20	11.8	4-30
Group private practice	31	12	13.4	15	7.6	1-25
Individual private practice	101	40	12.8	12	8.9	1-35
Other	39	15	11.9	10	8.9	2-28
Total hours spent in therapy			16.7	15	8.9	1-44
Treatment Modalities				[therapy cases]		
Individual	234	92	17.0	15	11.1	1-49
Couples	111	44	3.8	2	4.2	1-25
Family	75	30	5.5	2	8.1	1-37
Group	66	26	2.6	1	2.7	1-14
Other	22	9	6.6	3	9.2	1-15
Total number of cases			21.6	20	14.6	1-60
Age groups				[therapy clients]		
12 years and younger	59	23	8.4	5	14.0	1-31
13-19 years	130	51	8.5	3	23.5	1-35
20-49 years	212	84	16.5	15	13.5	1-64
50-64 years	157	61	4.8	2	12.3	1-35
65 years and older	51	20	6.4	1	27.8	1-30

Note. Data represent the current caseload of those mental health professionals in clinical practice at the time of the survey. Sample sizes vary due to fluctuations in available data.

3.2 Measure

Respondents completed a self-report questionnaire to describe their perceived professional development. Given the lack of pre-existing measures designed to examine professional development among mental health professionals, the Development of Psychotherapists Common Core Questionnaire (DPCCQ; Orlinsky, Ambühl et al., 1999) was adopted for use in the present study. The DPCCQ is a lengthy multipurpose set of instruments designed to survey various aspects of the professional and personal experience of mental health practitioners (see Appendix A). The absence of alternative measures and the extensive use of the DPCCQ among mental health practitioners in prior research were considered sufficient basis for its use in a New Zealand sample[5]. Moreover, use of the DPCCQ would enable direct comparison of New Zealand results to practitioner data from other countries.

The content and rationale for the DPCCQ has been outlined in Chapter 2, and summarizes the results of factor analyses on several subsets of items relevant to practitioners' perceived career development, perceived therapeutic mastery, and perceived growth. The dependent and independent variables of the present study were based on the results of those factor analyses. That is, perceived career development, perceived therapeutic mastery, and perceived growth were dependent variables. Therapeutic experience was the independent variable.

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[5] Permission to use the DPCCQ was obtained from the Collaborative Research Network (CRN) on the condition that the questionnaire was not shortened and that data would be subsequently included in the CRN database for cross-national comparison.

Three factor-analytically derived subscales of the DPCCQ were used to assess professional development in this study. As shown in Table 4 these items were designed to measure perceived career development, perceived therapeutic mastery, and perceived growth. Items were rated on a 0-5 point scale ranging from 0 (*not at all*) to 5 (*very much*). Scores on these scales are then summed and dividing by the number of response items to retain the original scale anchors. This produced three indexes of professional development, which served as the dependent variables in the present study. Internal consistency of professional development subscales was assessed using Chronbach's alpha. In the present study, the alphas for perceived career development was .63, for therapeutic mastery was .76, and for perceived growth was .88.

The independent variable for the present study was therapeutic experience. Respondents indicated their experience by responding to the question: "Overall, how long is it since you first began to practice psychotherapy? (Include practice during training, but exclude any periods during which you did not practice.)" Practitioners responded by indicating the number of years and months they actually started to practice psychotherapy. Several demographic and other professional practice features were also surveyed on the questionnaire. This included information on age, gender, professional identity, current clinical caseload, and theoretical orientation. (Respondents completed the DPCCQ anonymously.) Table 3 shows the demographic and current clinical practice data for the present sample.

Table 4

CRN Questionnaire Items on Professional Development

Perceived Career Development
1. Have you changed overall as a therapist?
2. Do you regard this overall change as progress or improvement?
Perceived Therapeutic Mastery
1. How much mastery do you have of the techniques and strategies involved in therapy?
2. How well do you understand what happens moment-by-moment during therapy sessions?
3. How much precision, subtlety, and finesse have you attained in your therapeutic work?
4. How capable do you feel to guide the development of other psychotherapists?
Perceived Growth
1. Do you feel you are changing as a therapist?
2. Does this change feel like progress or improvement?
3. Do you feel you are overcoming past limitations as a therapist?
4. Do you feel you are becoming more skillful in practicing therapy?
5. Do you feel you are deepening your understanding of therapy?
6. Do you feel a growing sense of enthusiasm about doing therapy?

Respondents identified theoretical orientation in response to the question: "How much is your therapeutic practice guided by each of the following theoretical frameworks?" Therapists were asked to make their ratings on a list of 5 categories, analytic/ psychodynamic, behavioral, cognitive, humanistic, and systemic using a 0-5 scale (0 = *not at all*, 5 = *very greatly*). Therapists were able to make multiple

responses on theoretical categories on the questionnaire. In order to report the breadth of theoretical orientation in the sample, ratings of four or five were classified as "salient commitment" and examined separately (Ambühl, Botermans, Meyerberg, & Orlinsky, 1996). Where respondents identified three or more salient orientations, they were classified as "broadly influenced". Similarly, those who identified two salient orientations were classified as "jointly committed", those who identified one salient orientation were classified as "focally committed", and those who did not identify a salient orientation were classified as "uncommitted" in their theoretical orientation as in the main CRN study (Orlinsky, Rønnestad et al., 1999).

Table 5 shows the extent to which each type of theoretical orientation was salient, as well as the number of orientations endorsed by respondents. The most prevalent salient theoretical orientation in this group was cognitive (41%), with analytic/ psychodynamic and humanistic approaches similarly popular (each 40%). However, there was also a substantial proportion of therapists in the present sample that endorsed systemic and behavioral approaches. A similar number of therapists expressed a commitment to two or more theoretical orientations as those who expressed a focal commitment to one salient orientation.

The inclination towards eclecticism in the present sample is further highlighted by respondents' responses to the questions: "Please describe your theoretical orientation briefly in your own words" and "To what extent do you regard your orientation as Eclectic/ Integrative?" rated on a 0-5 scale (0 = *not at all*, 5 = *very greatly*). In response to the unstructured question, 52% of respondents described their orientation

as eclectic / integrative, 9% described their orientation as cognitive or cognitive-behavioral, and the diversity of other descriptions were used by 3% or less of the sample (e.g., analytic psychology, gestalt, humanistic, narrative, psychoanalytic, systems, transactional analysis). In response to the fixed response question asking the extent to which therapists' orientation was eclectic/ integrative, 73% of the sample made ratings of 4 or 5 ($M = 3.8$, $SD = 1.1$).

Table 5

Theoretical Orientations of Mental Health Professionals Surveyed

	n	%	*M*	*SD*
Salient Orientation				
Analytic/Psychodynamic	102	40.2	1.5	0.4
Behavioral	77	30.3	1.6	0.5
Cognitive	104	40.9	1.5	0.5
Humanistic	102	40.2	1.5	0.5
Systemic	84	33.1	1.6	0.4
Number of salient orientations			1.8	1.0
Uncommitted	16	6.3		
Focally Committed	54	21.3		
Jointly Committed	49	19.3		
Broadly Committed	58	22.8		

Note. Sum of percentages for theoretical orientation data exceed 100 as multiple ratings were permitted on the questionnaire.

3.3 Procedure

As the present study was designed as a primarily exploratory survey of mental health practitioners' perceived professional development, the procedure for data collection was focused on obtaining a large and diverse sample. Psychotherapy practice is not legally controlled in New Zealand, and there is no legal protection over professional identification [6]. Moreover, professional organizations in mental health providing training and accountability for practitioners report difficulty in keeping current records of their members' clinical practice. Consequently, a representative sampling of practicing therapists was considered practically impossible, and the present study employed a variety of data collection strategies.

Participation was solicited at professional conferences with the support of conference organizers, among staff and students of academic departments involved in the training of mental health practitioners, and through the distribution of a pre-addressed and postage paid "expression of interest flyer" inserted in the newsletters of professional organizations (see Appendix B). The following professional organizations were targeted: Alcohol and Advisory Council of New Zealand, Compulsive Gambling Society, New Zealand Association of Counselors, New Zealand Association of Psychotherapists, New Zealand College of Clinical Psychologists, New Zealand College of Psychiatrists, New Zealand Psychological Society, and the Salvation Army. In all instances, participation in the study was voluntary, anonymous, and without compensation. However, as an incentive to

[6] For instance, there was no legal protection over the term "psychologist" at the time of this study.

complete the questionnaire, the flyer noted that a summary report of the findings was available to interested participants. A sizeable proportion of participants (n = 58) elected to request a personal copy of the results, the majority of which sent this request under separate cover from the completed questionnaire. Those responding to the flyer were sent a questionnaire, cover letter, and prepaid return envelope (see Appendix C). The cover letter outlined the purpose and procedures of the study, and guaranteed the anonymity of individual responses. Data collection was conducted over a two-year period from May 1998 to June 2000.

Although this sampling methodology limits generalizability of resultant data to the heterogeneous populations from which they were drawn, the sample size did permit the examination of differences between subgroups of the sample, and comparisons with the broader CRN database. In addition, the gathering of sufficient demographic data for the practitioner sample allows for tentative generalization or "transferability" of findings to practitioners with similar practice and descriptive characteristics (Lincoln & Guba, 1985).

CHAPTER 4

RESULTS

4.1 Professional Development

Descriptive statistics for the items assessing therapists' perceived career and current development are presented in Table 6. With regards to perceived career development, 75% considered themselves to have changed 'much' or 'very much' overall, and 91% considered these changes to represent 'much' or 'very much' progress or improvement. By comparison, ratings on perceived therapeutic mastery were more conservative, with a range of 53% to 76% claiming 'much' or 'very much' on this subscale. Consistent with ratings of perceived mastery, therapists reported a moderate degree of perceived growth, with ratings were as low as 42% on items regarding current change, and 58% to 59% for overcoming limitations and growing enthusiasm.

In order to clarify the extent to which different sub-groups of the therapists surveyed differed in their professional development, scores on professional development subscales were summed and divided by the number of response items. As outlined in Chapter 3, this method produced three indexes of professional development and enabled the original scale anchors to be retained. Table 7 presents descriptive data on the three indexes of professional development along with data on years in practice for the therapists surveyed in the present study. The data demonstrate that the sample had a broad range of clinical experience ($M = 11.6$, $SD = 7.5$) and relatively high levels of

perceived career development, therapeutic mastery, and growth ($M = 4.2$, $M = 3.8$, $M = 3.7$, respectively). Table 7 also indicates the consistency between subgroups of the therapist sample by presenting the effect size of the difference between subgroup means and the total sample mean. This effect size calculation has been recommended as a more meaningful method of subgroup comparison in large samples, particularly where small effects would be likely to yield significant results (see Elliot, Stiles, & Shapiro, 1993).

Table 6

Professional Development among Mental Health Professionals Surveyed

Perceived Career Development	*M*	*SD*	% High [a]
Changed overall.	4.0	0.9	75.2
Overall progress.	4.4	0.7	91.3
Perceived Therapeutic Mastery			
Mastery of technique.	3.8	0.7	77.6
Understanding moment-to-moment.	4.0	0.7	78.3
Precision, subtlety, finesse.	3.8	0.8	72.8
Capable to guide others.	3.4	1.2	53.1
Perceived Growth			
Improving.	4.0	0.9	76.0
Becoming more skillful.	4.0	0.8	74.4
Changing as a therapist.	3.2	1.0	42.1
Deepening understanding.	4.0	0.9	75.2
Overcoming limitations.	3.6	1.0	57.9
Growing enthusiasm.	3.6	1.1	59.1

[a] High refers to the percent who rated either "*much*" or "*very much*" on the 6-point scale (0 = *not at all*, 5 = *very much*).

Table 7

Mean and Effect Sizes for Professional Development Subscales

	Years in Practice		Perceived Career Development		Perceived Therapeutic Mastery		Perceived Growth	
	$M = 11.6$		$M = 4.2$		$M = 3.8$		$M = 3.7$	
	$SD = 7.5$		$SD = 0.6$		$SD = 0.7$		$SD = 0.8$	
Therapist Subgroup	*M*	*ES*	*M*	*ES*	*M*	*ES*	*M*	*ES*
Gender								
Female	10.9	0.09	4.3	0.04	3.8	0.00	3.8	0.08
Male	14.8	**0.39**	4.1	0.14	3.8	0.04	3.5	**0.28**
Profession								
Medicine	19.6	**0.95**	4.0	**0.25**	4.0	**0.21**	3.0	**0.63**
Counseling	10.1	**0.21**	4.3	0.11	3.8	0.01	3.9	**0.28**
Nursing	11.2	0.05	4.2	0.02	3.8	0.04	3.7	0.03
Psychology	12.8	0.15	4.2	0.02	3.8	0.01	3.6	0.15
Psychotherapy	13.7	**0.27**	4.4	**0.25**	4.1	**0.48**	4.0	**0.28**
Social Work	10.6	0.16	4.0	**0.26**	3.8	0.01	3.7	0.05
Other	12.3	0.08	4.2	0.00	3.8	0.04	3.8	0.12
Salient Orientation								
Analytic/ Psychodynamic	13.6	**0.25**	4.4	**0.23**	3.9	**0.22**	3.8	0.12
Behavioral	9.8	**0.24**	4.2	0.00	3.7	0.18	3.8	0.11
Cognitive	10.6	0.14	4.2	0.05	3.7	0.09	3.8	0.02
Humanistic	12.0	0.04	4.2	0.11	3.9	0.14	3.9	0.15
Systemic	12.0	0.05	4.2	0.02	4.0	**0.27**	3.7	0.01

Note. Medicine includes those who identified themselves as either physicians or psychiatrists. Effect size estimates (Cohen's *d*) represent differences between subgroup mean and total sample mean, divided by the pooled standard deviation (Rosenthal & Rosnow, 1991). Effect sizes in bold are those that reach the conventional classification as a "small effect" ($d \geq .2$) as defined in Cohen (1988).

As shown in Table 7, there were only three medium size differences among sub-samples of the data ($d \geq .5$ as defined in Cohen, 1988). One difference was that those affiliated with medicine were more experienced than other therapists in the present sample ($ES = .95$). A second difference was produced by the same sub-sample, and showed that therapists affiliated with professions other than medicine were lower in levels of perceived growth ($ES = .69$). A third difference was that those affiliated with psychotherapy were higher in their rating of perceived therapeutic mastery ($ES = .48$). With the exception of these medium differences, only 14 of the 56 effect sizes computed showed small ($d \geq .2$ as defined in Cohen, 1988) differences based on profession, theoretical orientation, and gender. This result suggests that the independent and dependent variables in the present study show considerable generality across a large diverse sample of New Zealand mental health professionals. The implication of this finding is that any relationships demonstrated among subgroups of the sample are unlikely to be attributable to differences in profession, theoretical orientation, or gender.

4.2 Professional Development and Experience

Table 8 shows the Pearson correlation coefficients among years in practice, perceived career development, perceived therapeutic mastery, and perceived growth. This data is presented for the total sample and for each sub-group separately. There was an inconsistent relationship between perceived career development and years in practice in the present sample. While the total sample did not demonstrate a perceived development-experience relationship, there were significant relationships for various

subgroups in the sample. Specifically, therapists who were affiliated with either counseling or psychology (r = .21 and .26, respectively), those therapists who practiced primarily within a behavioral or cognitive theoretical orientation (r = .31 and .21, respectively), and those who were female (r = .16) reported perceived career development that was associated with experience. This result provided partial support for the a priori defined hypothesis that therapists working within behavioral and cognitive orientations would have a higher degree of perceived professional development.

Perceived therapeutic mastery was positively and significantly associated with therapists' years in practice across subgroups in the present sample. Although the mastery-experience relationships did not achieve significance for those professions that were underrepresented in the sample (i.e., medicine, nursing, and social work), the magnitude of the correlations were comparable to those obtained among other subgroups. The total sample correlation of .35 indicates that 12% of the variance in perceived therapeutic mastery is predicted by practice duration[7]. By contrast, there was a negative relationship between years in experience and perceived growth. The correlation coefficients for the growth-experience relationship were mainly negative, and ranged in magnitude from -.41 to .45. Only five of the 14 achieved statistical significance, despite the large numbers involved in many of the subgroups. Years of experience and perceived growth were negatively correlated for therapists who were affiliated with psychology or psychotherapy (r = -.26 and -.22, respectively), those therapists who practiced primarily within an analytic/ psychodynamic or humanistic

[7] The proportion of explained variance was computed using the formula [$r^2 \times 100$].

theoretical orientation (r = - .38 and -.24, respectively), and those who were male (r = -.41). Thus, a higher degree of perceived growth was reported by therapist subgroups in the earlier stages of their clinical practice.

Table 8

Correlations between Professional Development Subscales and Experience

	N	Career Development by Experience	Therapeutic Mastery by Experience	Growth by Experience
Total	254	.09	.35**	-.19**
Gender				
Female	184	.16*	.36**	-.05
Male	62	.25	.37**	-.41**
Profession				
Medicine	22	.13	.42	-.13
Counseling	119	.21*	.51**	.17
Nursing	14	.02	.49	.45
Psychology	79	.26*	.36**	-.26*
Psychotherapy	98	.02	.44**	-.22*
Social Work	27	.29	.30	.01
Other	51	.01	.26	.03
Salient Orientation				
Analytic/ Psychodynamic	102	-.08	.26*	-.38**
Behavioral	77	.31**	.34**	-.13
Cognitive	104	.21*	.33**	-.11
Humanistic	102	.07	.38**	-.24*
Systemic	84	.06	.31**	-.22

Note. Data reflect Pearson bivariate correlation coefficients.

* $p < .05$. ** $p < .01$.

The different relationships between perceived career development, perceived therapeutic mastery, and perceived growth are illustrated in Figure 1. The distribution of years in experience was divided into 4- year categories for convenience[8]. This categorization resulted in the following subgroups: (a) 1 to 4 years, $n = 37$; (b) 5 to 8 years, $n = 52$; (c) 9 to 12 years, $n = 59$; (d) 13 to 16 years, $n = 40$; (e) 17 to 20 years, $n = 31$; (f) 21 to 24 years, $n = 8$; (g) 25 to 28 years, $n = 8$; (h) 29 to 32 years, $n = 2$; (i) 33 to 36 years, $n = 4$; (j) 37 or more years, $n = 2$.

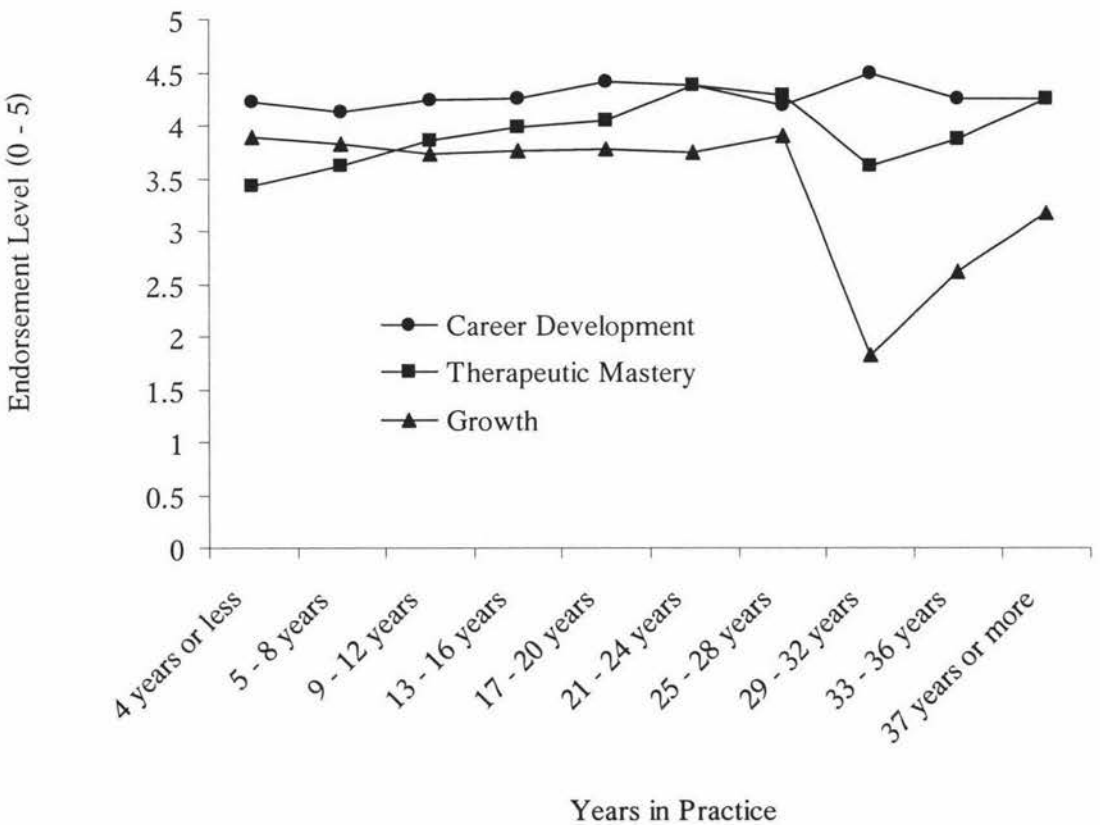

Figure 1. Mean perceived professional development by years in practice.

[8] A descriptive approach was taken in forming categories as professions differ in their conceptual division of the career span.

For perceived career development, Figure 1 shows that therapists in all experience subgroups reported similarly high ratings of perceived career development. That is, all subgroups remained close to the total sample mean of 4.2 (rated on 0-5 scale). Beginning practitioners had a rating of 4.23, and this increased gradually through to 4.25 for the most senior group. Another method of describing this data is to note the percentage of therapists in each group reporting high and low levels of perceived career development (arbitrarily defined as ≥ 4.0 on the 0-5 scale for high, and ≤ 3 for low). By this definition, the proportion in the total sample reporting a high level of career development was 80% and the proportion reporting a low level of career development was only 8%. There was little deviation from the overall sample among the 10 experience subgroups, even between novice (proportion high = 81%, proportion low = 8%) and highly experienced therapists (proportion high = 75%, proportion low = 0%).

For perceived therapeutic mastery, Figure 1 shows an increase in mean values (rated on 0-5 scale) over time, progressing from a low of 3.42 for beginning practitioners to 4.25 for the most senior group. Using the definitions of "high" and "low" described above, the proportion claiming a high degree of mastery in the total sample was 47%, but this proportion varied across the 10 experience subgroups from 14% to 33%, 54%, 63%, 67%, to between 88% to 100% for more experienced therapists. Not surprisingly, the corresponding proportion of therapists reporting low mastery across the 10 experience subgroups declined from 15% among novices to 0% among the most senior therapists.

For currently experienced growth, however, Figure 1 shows a decrease in mean values (rated on 0-5 scale) from a high of 3.88 for beginners, through to 3.17 for the most senior group. The proportion reporting a high degree of growth in the total sample was 41%, but this proportion varied across the 10 experience subgroups from 63% to 44%, 43%, 42%, to 38% among more experienced therapists. Consequently, the proportion of therapists reporting low growth across the 10 experience subgroups increased from only 14% to 50% and 75% among the more senior therapist groups.

4.3 New Zealand Sample and CRN Database Compared

The analysis in Table 9 compares groups of therapists in the main CRN database (N = 3795) with the therapists surveyed in the present study on the professional development measures. Professional subgroups were constructed based on professional training (medical vs. psychological training) and salient theoretical orientation. Statistical tests were not computed, as the aim in making this comparison was not to examine a priori determined hypotheses. Instead, the purpose of this comparison is to conduct and exploratory examination of national differences on professional development measures. The equivalence of each group was assessed on each measure by computing effect sizes for the differences of subgroup means from the total mean as in Table 7. However, the CRN criterion of $ES \geq .4$ was adopted for classification of small subgroup differences (Elliot, Stiles, & Shapiro, 1993; Rogers, Howard, & Vessey, 1993)[9].

[9] This CRN effect size criterion was not adopted for examination of subgroup differences in the New Zealand sample as it is more conservative than that commonly used in the behavioral sciences. Up until this point in this thesis, Jacob Cohen's (1988) conventional values have been adopted.

Table 9

Comparison of Professional Development for Therapists in the CRN Database (N = 3795) and Present Study (N = 254)

		Perceived Career Development		Perceived Therapeutic Mastery		Perceived Growth	
	N	*CRN*	*NZ*	*CRN*	*NZ*	*CRN*	*NZ*
Total	4049	3.9 (0.9)	4.2 (0.6)	3.3 (0.9)	3.8 (0.7)	3.4 (0.9)	3.7 (0.8)
Female	2244	3.9	4.3	3.2	3.8	3.5	3.8
Male	1757	3.8	4.1	3.3	3.8	3.3	3.5
Medicine	1367	3.7	4.0	**3.1**	4.0	3.2	**3.0**
Psychology	1846	4.0	4.2	**3.5**	3.8	3.5	3.6
Analytic/ Psychodynamic	1338	3.9	4.4	3.3	3.9	3.4	3.8
Cognitive / Behavioral	391	4.0	4.3	3.4	3.6	3.6	3.9
Humanistic	319	3.9	4.2	3.5	3.9	3.3	3.9
Germany	1059	3.9	-	3.2	-	3.4	-
Korea	538	**3.3**	-	**2.9**	-	**2.9**	-
Norway	371	3.9	-	3.4	-	3.4	-
Portugal	188	4.0	-	3.5	-	3.4	-
Switzerland	255	4.0	-	3.6	-	3.4	-
USA	329	3.9	-	**2.9**	-	3.6	-

Note. Sample sizes represent figures for the entire CRN database (Orlinsky, Ambühl et al., 1999) including the New Zealand sub-sample where appropriate. Standard deviations are presented in parentheses. Bold print means are classified as different from total sample mean based on CRN criteria ($ES \geq .4$). Therapist subgroups were determined by those available for the CRN database.

Scores on perceived career development are shown in Table 9. These figures were highly consistent between gender and theoretical orientation subgroups of the main CRN database. The only exception was the psychiatrist subgroup that averaged a lower practice duration ($M = 8.3$) than the overall average for the CRN database ($M = 9.5$). There was also little variation across the larger national subgroups, with the exception of Korea. The means for perceived therapeutic mastery ranged from 3.2 to 3.6 in the main CRN database, ratings that were comparable with the New Zealand sample. Two exceptions were the Korean and USA subgroups, both of which were noticeably lower in practice duration ($M = 5.5$ and $M = 6.3$, respectively both $ES \geq .4$) than the total for the main CRN database ($M = 9.5$). Perceived growth ranged from 3.3 to 3.6 in the main CRN database, ratings that were again comparable with the New Zealand sample. The only exception was the rating among psychiatrists, who were underrepresented in the New Zealand sample ($n = 22$).

The comparison between data from the New Zealand sample and the main CRN database yields an impression of relative consistency across therapist groupings. The most notable consistent exceptions being the group of Korean therapists, who were consistently lower in their ratings of professional development, and the New Zealand therapists who were higher in their ratings of perceived career development. These observed differences are consistent with the fact that the Korean sample was comprised mainly of psychiatrists in-training, and the New Zealand sample was more experienced clinical experience (range 9.8 to 19.6 years practice) than the subgroups in the main CRN database (range 5.5 to 13.6 years practice).

4.4 Interrelations Between Professional Development Measures

The DPCCQ questionnaire asks therapists to reflect on their professional development on the same occasion. As a result, it could be expected that these separate judgments might influence each other. To examine the possibility of overlap between these subscales, the three measures were intercorrelated (see Table 10). Without exception, small to moderate positive correlations were found between all professional development measures. While this raises the possibility that there may have been a general evaluative factor, the Orlinsky, Ambühl et al. (1999) report provided evidence to contradict this suggestion. Orlinsky, Ambühl et al. conducted a second order factor analysis that showed that therapists in the main CRN dataset clearly differentiated between the different aspects of their professional development, as assessed by these measures. Their factorial differentiation clarified that the three measures used in the present study as appropriate for career development.

Table 10

Intercorrelations between Professional Development Measures

Variable	Perceived Career Development	Perceived Treatment Mastery	Perceived Growth
Perceived Career Development	-	.37**	.51**
Perceived Treatment Mastery		-	.29**
Perceived Growth			-

** $p < .01$

CHAPTER 5

DISCUSSION

While the present sample was diverse in its professional and demographic characteristics, the findings on professional development were highly consistent across subgroups. The New Zealand sample was also consistent in their use of higher ratings on professional development measures as compared to other countries in the CRN database. It is possible that these results reflect a consistency in perception regarding the features of professional development. The implications of each feature of professional development will be addressed below, before outlining limitations of the present study and the rationale for future research.

5.1 Perceived Career Development

The perceived career development scale was not consistently related to years in clinical practice. While there was no perceived development-experience relationship for the total sample, there were significant relationships for various subgroups. Therapists who were affiliated with either counseling or psychology, those therapists who practiced primarily within a behavioral or cognitive theoretical orientation, and those who were female reported perceived career development that was associated with experience. This result provided partial support for the hypothesis that therapists

working within behavioral and cognitive orientations would have a higher degree of perceived professional development.

5.2 Perceived Therapeutic Mastery

The perceived therapeutic mastery scale was consistently and positively related to years of clinical practice. While all correlations did not achieve statistical significance, the direction and magnitude of correlations were consistent for all subgroups of the therapist sample. The cross-sectional nature of the sample, however, limits confidence in the conclusion that increased mastery is achieved among therapists as they gain experience. This finding may be due to other factors, such as a decision to change professions either early or late in therapists' careers (i.e., attrition), or a consistent difference between older and younger practitioners unrelated to their therapeutic practice (i.e., cohort difference in describing mastery). These alternative interpretations can only be excluded through the collections of longitudinal data on therapists' professional development. Accepting the ambiguity with the present cross-sectional data, it seems reasonable to interpret the observed relationship between years in clinical practice and perceived therapeutic mastery as an indication of a trend in professional development.

5.3 Perceived Growth

The perceived growth scale was consistently and negatively related to years of clinical practice. This result suggested that perceived growth declined as a function

of years in clinical practice in the present study. Questionnaire responses indicated that this impression of growth concentrated on experiences of "changing", "improving", "becoming more skilful", a "deepening understanding of therapy", "overcoming past limitations as a therapist", and a "growing sense of enthusiasm about doing therapy". Accepting limitations of the present study, one plausible interpretation of a declining perceived growth is that more experienced practitioners' decreased interest and enthusiasm for therapy reflects the cumulative demands of clinical practice. Support for this interpretation can be derived from the extensive literature demonstrating that psychotherapy, in the broadest interpretation of the term, is often stressful and brings a psychological cost to the practitioner (e.g., Deutsch, 1984; Dryden, 1997; Farber, 1983, 1985; Farber & Heifetz, 1981, 1982; Hellman, Morrison, & Abramowitz, 1987). These empirical studies have demonstrated that the average practitioner tends to become exhausted by the demanding aspects of work, and implies the need for experiences that will increase enthusiasm and interest. However, it is also possible that the decrease in perceived growth among more experienced practitioners reflects a change in role within the service center (e.g., clinical coordinator, increase in administrative duties). Such increases in responsibility and demands on time may account for a lower degree of perceived professional development among the experienced practitioner, or may entail less available time for therapy practice. Further exploratory research into these factors is most certainly warranted.

5.4 Implications for Training

The findings of the present study have some relevance for the training of mental health professionals. Perhaps most importantly, the present study underscores the importance of clinical experience in the professional development of mental health practitioners. One implication is that clinical experience should feature in therapists' training as early as possible. Assuming appropriate theoretical and empirical grounding in treatment models, and suitable maturity in the trainee, these findings support early involvement in clinical practice. The extent of that clinical practice will depend on the requirements of a particular profession as, for example, a different degree of academic learning is required for social work students as to those practicing within the medical profession. Nonetheless, the role of experience in professional development supports early internship placements as is currently integrated into clinical psychology training programmes at the graduate level (4th year).

A second implication of the results relates to the continued supervision of mental health practitioners. While this is a requirement for some professional groups (i.e., those members of the New Zealand College of Clinical Psychologists), there are less *formal requirements* for other professionals providing therapy (i.e., psychotherapy). As mentioned at the outset of this thesis, the lack of legal protection over professional titles such as "psychologist" and "counselor" render the mandating of supervision impossible for those who are practicing without membership or affiliation with a professional organization or accrediting body. Clinical supervision

can take a variety of forms, but ideally should focus on increasing clinical understanding through regular review of the therapist's clinical caseload (Rønnestad & Orlinsky, 2000). As operationalized in the present study, increasing understanding is critical for maintaining perceived growth among more experienced practitioners, and consequently, supports the notion of ongoing clinical supervision.

5. 5 Limitations of the Present Study

The present study had several limitations. One important limitation is that the sample does not represent a random sample of mental health professionals in New Zealand. Despite the size and diversity of the sample, the lack of randomized sampling in the present study limits any claims that the findings are representative of New Zealand mental health practitioners working in the field. This limitation is offset by the fact that generalizability can only be confidently assured for relatively discrete subgroups of the practicing therapist population. For example, New Zealand psychologists who are both full members of the New Zealand Psychological Society (NZPsS) and the recently formed Institute of Clinical Psychology would not necessarily be representative of New Zealand practicing clinical psychologists who do not belong to the NZPsS or to that particular division. It is likely that such a random sample would be even less representative of New Zealand mental health professionals in other professions. As a pragmatic alternative, the present study used a large and professionally diverse dataset to assess the professional development across professional and demographic characteristics. The findings of the present study may be tentatively compared to therapist interest groups on the basis of similarity.

A second limitation of the present study is that the measures of professional development were self-report and based on the therapists' own experience. This suggests that the data many not reflect similar ratings of career development, mastery, and growth that may be made from other perspectives (e.g., clinical supervisor, see Najavits & Strupp, 1994). There is evidence in psychotherapy process and outcome research to suggest that differences may also be expected between assessments made by supervisors, peers, and therapists' own ratings of professional development (e.g., Orlinsky, Grawe, & Parks, 1994; Strupp, Hadley, & Gomes-Schwartz, 1977). Although other perspectives are important to the evaluation of a therapists' professional development, the present study was designed to focus on therapists' own experience (i.e., New Zealand extension of the CRN practitioner survey) and holds some interest for both researchers and practitioners.

A third limitation of the present study relates to the method of assessing development on the DPCCQ. For their evaluation of development, therapists were required to rate the extent to which they perceived multiple aspects of their practice to have changed on a single-item. For instance, when assessing mastery therapists were required to rate the extent to which they had attained "precision, subtlety, and finesse" in their therapeutic work. Conceivably, a highly experienced therapist may have recorded a low rating on this mastery item because of a low perceived finesse, despite having considered themselves to have greatly improved their precision and subtlety in therapeutic technique. The difficulty in questionnaire items is also evidenced on the perceived career development subscale where therapists were asked to rate the extent to which they had overcome "past limitations" as a therapist. It may have been more

helpful, and yielded more detailed data, to ask therapists to list their specific limitations at the time of training and then rate the extent to which they felt they had overcome these limitations over the course of their careers. Despite these difficulties in items, using a standardized questionnaire enabled the present study to employ previously factor-analytically derived measures of professional development and compare data to the main CRN database.

5.6 Relationship Between Professional Development Measures

There were moderate and significant positive correlations between the three professional development measures in the present study. Given that causality cannot be concluded from correlation, this finding may suggest that therapists who consider themselves as having developed and attained mastery to also feel that they are currently experiencing growth. At the same time, it is possible that some third unmeasured factor may be exerting a significant influence on the professional development measures completed on the same occasion (Fiske, 1971), or that the measures are related in some non-linear fashion. However, the different relationship between years of clinical experience and the three measures together with prior factor analytic work (Orlinsky, Ambühl et al., 1999) suggest that the three measures do reflect different dimensions of professional development.

5.7 Rationale for Further Research

The present study represented an exploratory study of the professional development of mental health practitioners. Using a questionnaire comprising three measures of professional development, the present study examined therapists' perceived career development, treatment mastery, and growth. This research is placed within the growing trend in psychotherapy research to focus on "therapist factors", and represents a beginning step towards the goal of understanding professional development. While psychotherapy research has sought to examine the differential effects produced by different therapists providing the same therapy (e.g., Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Crits-Christoph et al., 1991; Lafferty, Beutler, & Crago, 1989; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Najavits & Strupp, 1994), none have examined therapist development in relation to treatment outcome. Given the mounting evidence demonstrating that therapist competency in administering *portions* of a treatment protocol can predict treatment outcome (e.g., Bryant, Simons, & Thase, 1999; Shaw et al., 1999), it is highly likely that professional development is crucial to understanding a therapist's ability to deliver a treatment in a competent and efficacious manner. Beutler et al. (1994) reviewed studies that used duration of practice as a predictor of treatment outcome and concluded that "length of therapist experience by itself is neither a strong not a significant predictor of amount of improvement" in clients (p. 249). Thus, the role of therapists' professional development in treatment outcome, as assessed more broadly than experience, remains open for further exploratory research. Future research should build on this exploratory work and examine professional development as one

of the factors important in ensuring clinician performance (or competency) in providing therapy.

5.8 Summary and Conclusion

The present study demonstrated that experience in clinical practice, as assessed by years in practice, is positively associated with mental health practitioners' perceived therapeutic mastery, and negatively associated with their perceived growth. Practitioners affiliated with behavioral and cognitive therapeutic orientations described an increase in perceived career development and perceived treatment mastery. Perceived growth on the other hand, was consistently lower for all subgroups of the sample among more experienced practitioners. In addition to these findings, the present sample of New Zealand mental health professionals rated higher perceived career development and treatment mastery than other countries in the main CRN database.

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APPENDIX A

DPCCQ QUESTIONNAIRE

APA Division of Psychotherapy

in collaboration with the
Society for Psychotherapy Research

Collaborative Research Network (CRN)

INTERNATIONAL STUDY OF THE

DEVELOPMENT OF MENTAL HEALTH PROFESSIONALS

COMMON CORE QUESTIONNAIRE [APA.29.97]

This questionnaire forms part of a collaborative study of psychotherapists in several countries. Those of us who designed it tried to ask questions that were meaningful to us as therapists. Please answer all the questions you can. If a question seems difficult, give your best estimate and continue. If necessary, we would rather you return a mostly completed questionnaire than none at all. The information you provide is strictly confidential and will be used only for research purposes. Thanks for your participation!

1-1. Today's Date: month |___|___| year |___|___|

1-2. Date of Birth: month |___|___| year |___|___|

1-3. Sex: female _____ male _____

What is your professional identity? That is, how do you refer to yourself in professional contexts?
[Check as many as apply.]

1-4. ____ Psychiatrist.	1-7. ____ Psychotherapist.	1-10. ____ Physician.
1-5. ____ Psychologist.	1-8. ____ Psychoanalyst.	1-11. ____ Nurse.
1-6. ____ Social Worker.	1-9. ____ Counselor.	1-12. ____ Minister.

1-13. ____ Other [please specify]: _____.

1-14. What academic or professional degrees have you earned? _____.

How many hours per week do you work, and practice therapy, in the following?	Hours Worked	Hours Therapy
1-15. Public inpatient facility.....	_____	_____
1-16. Public outpatient facility.....	_____	_____
1-17. Private inpatient facility.....	_____	_____
1-18. Private outpatient facility.....	_____	_____
1-19. Group private practice.....	_____	_____
1-20. Individual private practice.....	_____	_____
1-21. School or college.....	_____	_____
1-22. Other [specify]:_____	_____	_____

Overall ...

1-23. How long is it since you first began to practice psychotherapy? ____ years ____ months

[Count practice during and after training but exclude periods when you did not practice.]

1-24. How much formal didactic training have you received in therapeutic theory and technique (courses, lectures, or seminars)? [Include both initial and subsequent therapeutic training.] ____ years ____ months

1-25. How much formal case supervision have you received for your therapeutic work (regular individual or group supervisory sessions)? [Count supervision during and after training but exclude periods when you received no supervision.] ____ years ____ months

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To be completed at CRN Centers: Entry Ctr |___|___| Serial ID |___|___|___|___|___| Collect Ctr |___|___| Sample |___|___|___|

Estimate the number of cases you have treated in each of the following:	0	1-3	4-9	10-15	16-24	25+
2-1. Individual therapy [number of patients]	0	1	2	3	4	5
2-2. Couple therapy [number of couples]	0	1	2	3	4	5
2-3. Family therapy [number of families]	0	1	2	3	4	5
2-4. Group therapy [number of groups]	0	1	2	3	4	5
2-5. Other [specify]: _____	0	1	2	3	4	5

2-6. In the past, have you undergone training in any specific type of psychotherapy (e.g., psychoanalysis, behavior therapy, family therapy, brief therapy)?

___ 1. No. [If no, skip to question 2-10.]
___ 2. Yes. [Describe your most important training experiences below.]

	Type of Therapy	Duration of Training	Value in Your Current Practice [0 = None .... 5 = Very great]
2-7.	**a.**_____	**b.**_____	**c.** 0 1 2 3 4 5
2-8.	**a.**_____	**b.**_____	**c.** 0 1 2 3 4 5
2-9.	**a.**_____	**b.**_____	**c.** 0 1 2 3 4 5

2-10. Are you currently undergoing training in a specific type of therapy?
___ 1. No. [If no, skip to question 2-12.]
___ 2. Yes. [Describe your current training in below.]

	Type of Therapy	Duration of Training	Value in Your Current Practice [0 = None .... 5 = Very great]
2-11.	**a.**_____	**b.**_____	**c.** 0 1 2 3 4 5

2-12. Overall, how many different supervisors have you worked with for your therapy cases? _____

2-13. Are you currently receiving regular supervision for any of your psychotherapy cases?
_____ 1. No. _____ 2. Yes. [**b.** If yes, for how many cases? _____]

Overall, when you first began your training as a therapist ...	[0 = Not at all ..... 5 = Very]
2-14. How effective were you at engaging patients in a working alliance?	0 1 2 3 4 5
2-15. How 'natural' (authentically personal) did you feel while working with patients?	0 1 2 3 4 5
2-16. How good was your general theoretical understanding of therapy?	0 1 2 3 4 5
2-17. How empathic were you in relating to patients with whom you had relatively little in common?	0 1 2 3 4 5
2-18. How much mastery did you have of the techniques and strategies involved in practicing therapy?	0 1 2 3 4 5
2-19. How well did you understand what happened moment-by-moment moment during therapy sessions?	0 1 2 3 4 5
2-20. How effective were you in communicating your understanding and concern to your patients?	0 1 2 3 4 5
2-21. How confident did you feel in your role as a therapist?	0 1 2 3 4 5

When you first began working as a therapist, how much was your therapeutic work guided by each of the following theoretical frameworks?	[0 = Not at all ..... 5 = Very]
2-22. Analytic/Psychodynamic	0 1 2 3 4 5
2-23. Behavioral	0 1 2 3 4 5
2-24. Cognitive	0 1 2 3 4 5
2-25. Humanistic	0 1 2 3 4 5
2-26. Systems Theory	0 1 2 3 4 5

Since you began working as a therapist ... [0 = Not at all ..... 5 = Very]

3-1.	How much have you changed overall as a therapist?	0	1	2	3	4	5
3-2.	How much do you regard this overall change as progress or improvement?	0	1	2	3	4	5
3-3.	How much do you regard this overall change as decline or impairment ?	0	1	2	3	4	5
3-4.	How much have you succeeded in overcoming past limitations as a therapist?	0	1	2	3	4	5

Overall, at the present time ... [0 = Not at All ..... 5 = Very]

3-5.	How effective are you at engaging patients in a working alliance?	0	1	2	3	4	5
3-6.	How 'natural' (authentically personal) do you feel while working with patients?	0	1	2	3	4	5
3-7.	How good is your general theoretical understanding of therapy?	0	1	2	3	4	5
3-8.	How empathic are you in relating to patients with whom you have relatively little in common?	0	1	2	3	4	5
3-9.	How much mastery do you have of the techniques and strategies involved in practicing therapy?	0	1	2	3	4	5
3-10.	How well do you understand what happens moment-by-moment during therapy sessions?	0	1	2	3	4	5
3-11.	How effective are you in communicating your understanding and concern to your patients?	0	1	2	3	4	5
3-12.	How much precision, subtlety and finesse have you attained in your therapeutic work ?	0	1	2	3	4	5
3-13.	How confident do you feel in your role as a therapist?	0	1	2	3	4	5

		Female	Male
3-14.	How many patients are you currently treating (in all forms of psychotherapy)?	**a.** _____	**b.** _____

How many cases are you currently treating in each of the following?

3-15.	Individual therapy [number of patients]	_____
3-16.	Couple therapy [number of couples]	_____
3-17.	Family therapy [number of families]	_____
3-18.	Group therapy [number of groups]	_____
3-19.	Other [specify]: _____	_____

Please estimate the number of patients you are currently treating, by age group and gender. [Write '0' if none.]

3-20.	Twelve or younger	_____
3-21.	Thirteen to nineteen	_____
3-22.	Twenty to forty-nine	_____
3-23.	Fifty to sixty-four	_____
3-24.	Sixty-five or older	_____

Please describe the types of patient you most frequently treat in your current therapeutic practice.
[List up to three types, using your usual diagnostic system.]

3-25. _____

3-26. _____

3-27. _____

		0	1-3	4-9	10-15	16-24	25+
3-28.	How many other therapists have sought you out to be their therapist?	0	1	2	3	4	5
3-29.	How many other therapists have you supervised in therapeutic work?	0	1	2	3	4	5

How disturbed or impaired are the patients you are currently treating in psychotherapy?
[Indicate the number of patients at each of the following levels of disturbance that you are personally treating in psychotherapy at present. Base your rating on the patient's current level of functioning.]

4-1. _____ Absent or minimal symptoms; socially effective; generally satisfied with life; no more than everyday problems or concerns.

4-2. _____ Symptoms present as transient and expectable reactions to psychosocial stressors; generally no more than slight impairment in social, occupational, or school functioning.

4-3. _____ Mild but enduring symptoms [e.g., depressed mood and mild insomnia], *or* some difficulty in social, occupational or school functioning, but generally functioning quite well; has some meaningful interpersonal relationships.

4-4. _____ Moderate symptoms [e.g., flat affect and circumstantial speech, occasional panic attacks], *or* moderate difficulty in social, occupational or school functioning.

4-5. _____ Serious symptoms [e.g., suicidal ideation, severe obsessional rituals], *or* serious impairment in social, occupational or school functioning [e.g., no friends, unable to keep a job].

4-6. _____ Significant impairment in reality testing or communication [e.g., speech is often illogical, obscure or irrelevant], *or* major impairment in several areas, such as work, family relations, judgment, thinking or mood.

4-7. _____ Serious impairment in communication or judgment [e.g., behavior considerably influenced by delusions or hallucinations], *or* inability to function in almost all areas.

4-8. _____ Real danger of hurting self or others [e.g., suicide attempts, recurrent violence], *or* failure to maintain minimal personal hygiene, *or* gross impairment in communication [e.g., largely incoherent or mute].

In the main setting of your therapeutic practice, how much control do you have:	[0 = None ..... 5 = Total]
4-9. In selecting the patients you treat.....	0 1 2 3 4 5
4-10. In setting the number of patients you treat.....	0 1 2 3 4 5
4-11. In setting your time schedule	0 1 2 3 4 5
4-12. Over the duration of treatment you offer.....	0 1 2 3 4 5
4-13. In setting treatment fees.....	0 1 2 3 4 5
4-14. Other conditions [specify]: _____	0 1 2 3 4 5
	[0 = Not at all ..... 5 = Fully]
4-15. How supported do you feel in the main setting of your therapeutic practice?	0 1 2 3 4 5
	[0 = None ..... 5 = Total]
4-16. How much satisfaction do you currently find in your work as a therapist?	0 1 2 3 4 5
4-17. How much dissatisfaction do you currently feel in your work as a therapist?	0 1 2 3 4 5

4-18. Check the one statement that best describes your current position regarding Accident Rehabilitation & Compensation Insurance Corporation (ACC) clients?

____ **a.** I do not intend to accept ACC clients as part of my practice.
____ **b.** I am willing or intend to ACC clients in the next year or so but have not done so yet.
____ **c.** I have accepted and seen ACC clients within the past year.
____ **d.** I have seen ACC clients for more than a year and continue to see their clients.

4-19. What percentage of your patients are ACC clients:
a. at the present time? ..... _____%
b. two (2) years ago? ..... _____%
c. anticipate 2 years from now? _____%

4-20. For a 50-minute session of individual psychotherapy, what is your most frequent [or average] fee for:
a. ACC patients (including ACC contribution)?$ _____
b. direct pay patients? $ _____
c. third-party patients? $ _____

How much is your current therapeutic practice guided by each of the following theoretical frameworks? [0 = Not at all ... 5 = Very greatly]

5-1.	Analytic/Psychodynamic	0	1	2	3	4	5
5-2.	Behavioral	0	1	2	3	4	5
5-3.	Cognitive	0	1	2	3	4	5
5-4.	Humanistic	0	1	2	3	4	5
5-5.	Systems Theory	0	1	2	3	4	5

5-6. Please describe your theoretical orientation briefly in your own words:

_____

[0 = Not at all ... 5 = Very greatly]

5-7. To what extent do you regard your orientation as Eclectic/Integrative? 0 1 2 3 4 5

5-7i. In your practice of therapy, do you recommend between-session homework assignments...?

___ 1. No. [If no, skip to question 5-8.]
___ 2. Yes. [Describe your use below.]

5-7ii. With patients in your practice over the last three months, how often have you... [0 = Never .... 5 = Very often]

a.	Recommended between-session assignments?	0	1	2	3	4	5
b.	Considered client ability when recommending assignments?	0	1	2	3	4	5
c.	Checked client attitude towards the activity prior to recommending assignments?	0	1	2	3	4	5
d.	Demonstrated the assignment activity prior to recommending the assignment?	0	1	2	3	4	5
e.	Discussed the rationale for the assignment activity with clients?	0	1	2	3	4	5
f.	Designed a specific schedule of assignments for each client's problems?	0	1	2	3	4	5
g.	Specified how often assignments should be practiced?	0	1	2	3	4	5
h.	Specified how long each assignment practice should take to complete?	0	1	2	3	4	5
i.	Specified where assignments should be practiced?	0	1	2	3	4	5
j.	Written down the assignments for clients to take away?	0	1	2	3	4	5
k.	Written down the assignments required of clients in your session note?	0	1	2	3	4	5
l.	Asked whether clients completed their assignments?	0	1	2	3	4	5
m.	Asked how well clients completed their assignments?	0	1	2	3	4	5
n.	Asked about clients' completion of assignments at the start of following sessions	0	1	2	3	4	5
o.	Made a note of clients' completion of assignments in your session note	0	1	2	3	4	5

5-7iii. In general, how important do you think between-session assignments should be in the treatment of the following patient problems? [0 = No importance .... 5 = Extreme importance]

a.	Anxiety	0	1	2	3	4	5
b.	Anorexia/ Bulimia	0	1	2	3	4	5
c.	Depression	0	1	2	3	4	5
d.	Delusions/ Hallucinations	0	1	2	3	4	5
e.	Insomnia	0	1	2	3	4	5
f.	Learning Disorders	0	1	2	3	4	5
g.	Non-assertiveness	0	1	2	3	4	5
h.	Obsessions and compulsions	0	1	2	3	4	5
i.	Physical illness and rehabilitation	0	1	2	3	4	5
j.	Sexual abuse	0	1	2	3	4	5
k.	Sexual disorder	0	1	2	3	4	5
l.	Social Skills	0	1	2	3	4	5
m.	Substance abuse	0	1	2	3	4	5

In your current work as a therapist, how important do you think it is for most patients to realize the following goals? [Check the 4 goals generally most important to you.]

_____ 5-8. Have a strong sense of self-worth and identity.
_____ 5-9. Think realistically about the meaning of events in their lives.
_____ 5-10. Allow themselves to experience feelings fully.
_____ 5-11. Learn to behave effectively in problematic situations.
_____ 5-12. Understand their feelings, motives and/or behavior.
_____ 5-13. Develop the courage to approach new or previously avoided situations.
_____ 5-14. Integrate excluded or segregated aspects of experience.
_____ 5-15. Experience a decrease in their symptoms.
_____ 5-16. Improve the quality of their relationships.
_____ 5-17. Modify or control problematic patterns of behavior.
_____ 5-18. Evaluate themselves realistically.
_____ 5-19. Identify and pursue their own goals.
_____ 5-20. Develop a more tolerant and accepting attitude toward others.
_____ 5-21. Learn to recognize and change how they create or contribute to their own problems.
_____ 5-22. Develop better ability to meet important familial and social responsibilities.
_____ 5-23. Clarify their overall sense of values, priorities, and philosophy of life.
_____ 5-24. Resolve or cope with confusions caused by conflicts in cultural ideals and expectations.

With patients in your current practice, how often do you...	[0 = Never .... 5 = Very often]					
5-25. Initiate or make yourself available to receive telephone calls or letters for purposes other than procedural arrangements (such as making appointments)?	0	1	2	3	4	5
5-26. Schedule periodic additional or emergency sessions?	0	1	2	3	4	5
5-27. Agree to meet in locations other than your normal therapy setting?	0	1	2	3	4	5
5-28. Allow some sessions to overrun the scheduled time by a substantial margin?	0	1	2	3	4	5
5-29. Intercede on their behalf with other individuals or agencies?	0	1	2	3	4	5
5-30. Have social or professional relationships outside the therapeutic situation?	0	1	2	3	4	5
5-31. Initiate or accept non-sexual physical contact other than a handshake?	0	1	2	3	4	5
5-32. Allow interruptions during sessions (e.g., for phone calls)?	0	1	2	3	4	5

In the last few days, how often have you found yourself ...	[0 = Never .... 5 = Very often]					
5-33. Thinking about how best to help resolve a patient's problems.	0	1	2	3	4	5
5-34. Remembering the feelings expressed by a patient.	0	1	2	3	4	5
5-35. Reflecting on your own feelings towards a patient.	0	1	2	3	4	5
5-36. Imagining a conversation with a patient of yours.	0	1	2	3	4	5
5-37. Experiencing something similar to what a patient of yours has experienced.	0	1	2	3	4	5

How would you describe yourself as a therapist -- your actual style or manner with patients?

		[0 = Not at all ... 3 = Very much]						[0=Not at all ... 3 = Very much]				
6-1.	Accepting.	0	1	2	3	6-13.	Guarded.	0	1	2	3	
6-2.	Authoritative.	0	1	2	3	6-14.	Intuitive.	0	1	2	3	
6-3.	Challenging.	0	1	2	3	6-15.	Involved.	0	1	2	3	
6-4.	Cold.	0	1	2	3	6-16.	Nurturant.	0	1	2	3	
6-5.	Committed.	0	1	2	3	6-17.	Organized.	0	1	2	3	
6-6.	Critical.	0	1	2	3	6-18.	Protective.	0	1	2	3	
6-7.	Demanding.	0	1	2	3	6-19.	Reserved.	0	1	2	3	
6-8.	Detached.	0	1	2	3	6-20.	Skillful.	0	1	2	3	
6-9.	Determined.	0	1	2	3	6-21.	Subtle.	0	1	2	3	
6-10.	Directive.	0	1	2	3	6-22.	Tolerant.	0	1	2	3	
6-11.	Effective.	0	1	2	3	6-23.	Warm.	0	1	2	3	
6-12.	Friendly.	0	1	2	3	6-24.	Wise.	0	1	2	3	

In your recent psychotherapeutic work, how much ...	[0 = Not at all ... 5 = Very much]					
6-25. Do you feel you are changing as a therapist?	0	1	2	3	4	5
6-26. Does this change feel like progress or improvement?	0	1	2	3	4	5
6-27. Does this change feel like decline or impairment?	0	1	2	3	4	5
6-28. Do you feel you are overcoming past limitations as a therapist?	0	1	2	3	4	5
6-29. Do you feel you are becoming more skillful in practicing therapy?	0	1	2	3	4	5
6-30. Do you feel you are deepening your understanding of therapy?	0	1	2	3	4	5
6-31. Do you feel a growing sense of enthusiasm about doing therapy?	0	1	2	3	4	5
6-32. Do you feel you are becoming disillusioned about therapy?	0	1	2	3	4	5
6-33. Do you feel you are losing your capacity to respond empathically?	0	1	2	3	4	5
6-34. Do you feel your performance is becoming mainly routine?	0	1	2	3	4	5
6-35. How capable do you feel to guide the development of other therapists?	0	1	2	3	4	5
6-36. How important to you is your further development as a therapist?	0	1	2	3	4	5

Recently in sessions with patients, how often have you found yourself feeling...

		[0 = Not at all ... 3 = Very much]						[0=Not at all ... 3 = Very much]				
6-37.	Anxious.	0	1	2	3	6-45.	Focused.	0	1	2	3	
6-38.	Available.	0	1	2	3	6-46.	Inattentive.	0	1	2	3	
6-39.	Bored.	0	1	2	3	6-47.	Inspired.	0	1	2	3	
6-40.	Calm.	0	1	2	3	6-48.	Pressured.	0	1	2	3	
6-41.	Creative.	0	1	2	3	6-49.	Relaxed.	0	1	2	3	
6-42.	Distracted.	0	1	2	3	6-50.	Stimulated.	0	1	2	3	
6-43.	Drowsy.	0	1	2	3	6-51.	Tense.	0	1	2	3	
6-44.	Engrossed.	0	1	2	3	6-52.	Unsure.	0	1	2	3	

How much influence is each of the following having on your current development as a therapist?
[You may circle both a positive and a negative response.]

		[-3 = Very negative ... +3 = Very positive]						
6-53.	Experience in therapy with patients.....	-3	-2	-1	0	+1	+2	+3
6-54.	Taking courses, seminars, or workshops.....	-3	-2	-1	0	+1	+2	+3
6-55.	Getting formal supervision or consultation.....	-3	-2	-1	0	+1	+2	+3
6-56.	Having informal case discussion with colleagues.....	-3	-2	-1	0	+1	+2	+3
6-57.	Reading books or journals relevant to your practice.....	-3	-2	-1	0	+1	+2	+3
6-58.	Getting personal therapy, analysis or counseling.....	-3	-2	-1	0	+1	+2	+3
6-59.	Giving formal supervision or consultation to others.....	-3	-2	-1	0	+1	+2	+3
6-60.	Teaching courses or seminars.....	-3	-2	-1	0	+1	+2	+3
6-61.	The institutional conditions in which you practice.....	-3	-2	-1	0	+1	+2	+3
6-62.	Experiences in your personal life outside therapy.....	-3	-2	-1	0	+1	+2	+3

Difficulties in practice: currently, how often do you feel ...?	[0 = Never ... 5 = Very often]					
7-1. Lacking in confidence that you can have a beneficial effect on a patient.	0	1	2	3	4	5
7-2. Afraid that you are doing more harm than good in treating a patient.	0	1	2	3	4	5
7-3. Unsure how best to deal effectively with a patient.	0	1	2	3	4	5
7-4. In danger of losing control of the therapeutic situation to a patient.	0	1	2	3	4	5
7-5. Unable to have much real empathy for a patient's experiences.	0	1	2	3	4	5
7-6. Uneasy that your personal values make it difficult to maintain an appropriate attitude towards a patient.	0	1	2	3	4	5
7-7. Distressed by your powerlessness to affect a patient's tragic life situation.	0	1	2	3	4	5
7-8. Troubled by ethical issues that have arisen in your work with a patient.	0	1	2	3	4	5
7-9. Unable to generate sufficient momentum to move therapy with a patient in a constructive direction.	0	1	2	3	4	5
7-10. Irritated with a patient who is actively blocking your efforts.	0	1	2	3	4	5
7-11. Demoralized by your inability to find ways to help a patient.	0	1	2	3	4	5
7-12. Unable to comprehend the essence of a patient's problems.	0	1	2	3	4	5
7-13. Unable to withstand a patient's emotional neediness.	0	1	2	3	4	5
7-14. Unable to find something to like or respect in a patient.	0	1	2	3	4	5
7-15. Angered by factors in a patient's life that prevent a beneficial outcome.	0	1	2	3	4	5
7-16. Conflicted about how to reconcile obligations to a patient and equivalent obligations to others.	0	1	2	3	4	5
7-17. Bogged down with a patient in a relationship that seems to go nowhere.	0	1	2	3	4	5
7-18. Frustrated with a patient for wasting your time.	0	1	2	3	4	5

Coping strategies: when in difficulty, how often do you ...?	[0 = Never ... 5 = Very often]					
7-19. Try to see the problem from a different perspective.	0	1	2	3	4	5
7-20. Share your experience of the difficulty with your patient.	0	1	2	3	4	5
7-21. Discuss the problem with a colleague.	0	1	2	3	4	5
7-22. Consult relevant articles or books.	0	1	2	3	4	5
7-23. Involve another professional or agency in the case.	0	1	2	3	4	5
7-24. Seek some form of alternative satisfaction away from therapy.	0	1	2	3	4	5
7-25. Step out of the therapist role in order to take some urgent action on a patient's behalf.	0	1	2	3	4	5
7-26. Make changes in your therapeutic contract with a patient.	0	1	2	3	4	5
7-27. Simply hope that things will improve eventually.	0	1	2	3	4	5
7-28. Criticize a patient for causing you trouble.	0	1	2	3	4	5
7-29. Seriously consider terminating therapy.	0	1	2	3	4	5
7-30. Review privately with yourself how the problem has arisen.	0	1	2	3	4	5
7-31. Just give yourself permission to experience difficult or disturbing feelings.	0	1	2	3	4	5
7-32. See whether you and your patient can together deal with the difficulty.	0	1	2	3	4	5
7-33. Consult about the case with a more experienced therapist.	0	1	2	3	4	5
7-34. Sign up for a conference or workshop that might bear on the problem.	0	1	2	3	4	5
7-35. Invite collaboration from a patient's friends or relatives.	0	1	2	3	4	5
7-36. Postpone the work of therapy so as to take care of a patient's more immediate needs.	0	1	2	3	4	5
7-37. Modify your therapeutic stance or approach with a patient.	0	1	2	3	4	5
7-38. Avoid dealing with the problem for the present.	0	1	2	3	4	5
7-39. Show your frustration to the patient.	0	1	2	3	4	5
7-40. Explore the possibility of referring the patient on to another therapist.	0	1	2	3	4	5

8-1. Are you currently in personal therapy, analysis, or counseling? ____ 1. No. ____ 2. Yes.
8-2. Have you previously been in personal therapy, analysis, or counseling? ____ 1. No. ____ 2. Yes.

[If you answered 'No' to items 8-1 and 8-2, skip to item 8-8.]

8-3. Overall, how many different therapists have you worked with in your personal therapy/analysis? _____
8-4. Estimate the total amount of time you have devoted to personal therapy/analysis ? ____ years ____ months

Please describe your experiences in personal psychotherapy. [If you have had more than three, select the three that were in some way most significant for you].

Type of Therapy	Sessions per Week	Duration	Value to You as a Person [0 = None .... 5 = Very great]
8-5. **a.** _____	**b.**_____	**c.**____ years ____months	**d.** 0 1 2 3 4 5
Reason for this therapy [check as many as apply]:		**e.**____ Training; **f.**____ Growth; **g.**____ Problems.	

Type of Therapy	Sessions per Week	Duration	Value to You as a Person [0 = None .... 5 = Very great]
8-6. **a.** _____	**b.**_____	**c.**____ years ____months	**d.** 0 1 2 3 4 5
Reason for this therapy [check as many as apply]:		**e.**____ Training; **f.**____ Growth; **g.**____ Problems.	

Type of Therapy	Sessions per Week	Duration	Value to You as a Person [0 = None .... 5 = Very great]
8-7. **a.** _____	**b.**_____	**c.**____ years ____months	**d.** 0 1 2 3 4 5
Reason for this therapy [check as many as apply]:		**e.**____ Training; **f.**____ Growth; **g.**____ Problems.	

How much influence has each of the following has had on your overall development as a therapist?

[You may circle both a positive and a negative response.] [-3 = Very negative ... +3 = Very positive]

8-8. Experience in therapy with patients.....	-3	-2	-1	0	+1	+2	+3
8-9. Taking courses or seminars.....	-3	-2	-1	0	+1	+2	+3
8-10. Working with co-therapists.....	-3	-2	-1	0	+1	+2	+3
8-11. Getting formal supervision or consultation.....	-3	-2	-1	0	+1	+2	+3
8-12. Having informal case discussion with colleagues.....	-3	-2	-1	0	+1	+2	+3
8-13. Reading books or journals relevant to your practice.....	-3	-2	-1	0	+1	+2	+3
8-14. Observing therapists in workshops, films or on tape.....	-3	-2	-1	0	+1	+2	+3
8-15. Getting personal therapy, analysis or counseling.....	-3	-2	-1	0	+1	+2	+3
8-16. Giving formal supervision or consultation to others.....	-3	-2	-1	0	+1	+2	+3
8-17. Teaching courses or seminars.....	-3	-2	-1	0	+1	+2	+3
8-18. Doing research.....	-3	-2	-1	0	+1	+2	+3
8-19. The institutional conditions in which you practice.....	-3	-2	-1	0	+1	+2	+3
8-20. Experiences in your personal life as an adult	-3	-2	-1	0	+1	+2	+3
8-21. Experiences in your personal life as a child or adolescent	-3	-2	-1	0	+1	+2	+3

Overall, at present... [0 = Not at all ... 5 = Very often]

8-22. How much positive impact does doing therapy have on your own life?	0	1	2	3	4	5
8-23. How much negative impact does doing therapy have on your own life?	0	1	2	3	4	5

9-1. In this country, would you be considered a member of a social, cultural or ethnic minority?
____ 1. No.
____ 2. Yes. [specify]: **b.**_____

9-2. What is your current marital status?
____ 1. Single.
____ 2. Living with a partner.
____ 3. Married.
____ 4. Separated or divorced.
____ 5. Widowed.
____ 6. Other [specify]: _____]

9-3. Do you have children? [Include natural, adopted, and step-children.]
____ 1. No.
____ 2. Yes. [if yes]: **b.** How many? _____ **c.** Age of oldest? _____ **d.** Age of youngest? _____

9-4. Do you have grandchildren? [Include natural, adopted, and step-children.]
____ 1. No.
____ 2. Yes. [if yes]: **b.** How many? _____ **c.** Age of oldest? _____ **d.** Age of youngest? _____

9-5. Do you have brothers or sisters? ____ 1. No. ____ 2. Yes - If yes, how many of each:
b. Older sisters?____ **c.** Older brothers?____ **d.** Younger sisters?____ **e.** Younger brothers?____

9-6. Is your father living? ___ 1. Yes. ___ 2. No [**b.** If no, how old were you at the time he died? ____]

9-7. Is your mother living? ___ 1. Yes. ___ 2. No [**b.** If no, how old were you at the time she died? ____]

9-8. Were your parents divorced or separated? ___ 1. No. ___ 2. Yes [**b.** If yes, how old were you? ____]

Overall, when growing up, how much ...	[0 = Not at All .... 5 = Very]					
9-9. Did you experience a sense of being genuinely cared for and supported?	0	1	2	3	4	5
9-10. Did the family you grew up in function well, psychologically or emotionally?	0	1	2	3	4	5

In your own life at present, how frequently do you...	[0 = Never ... 5 = Very often]					
9-11. Freely express your private thoughts and feelings?	0	1	2	3	4	5
9-12. Feel hassled by the pressures of everyday life?	0	1	2	3	4	5
9-13. Experience moments of unreserved enjoyment?	0	1	2	3	4	5
9-14. Experience a sense of being genuinely cared for and supported?	0	1	2	3	4	5
9-15. Feel a sense of significant personal conflict, disappointment or loss?	0	1	2	3	4	5
9-16. Feel a heavy burden of responsibility, worry or concern for others close to you?	0	1	2	3	4	5
9-17. Feel a satisfying sense of intimacy and emotional rapport?	0	1	2	3	4	5
9-18. Worry about money or financial security?	0	1	2	3	4	5
9-19. Worry about your physical health?	0	1	2	3	4	5
9-20. Take opportunities to relax and refresh yourself as an individual?	0	1	2	3	4	5

Overall...	[0 = Not at all ... 5 = Very often]					
9-21. How stressful is your life at present?	0	1	2	3	4	5
9-22. How satisfying is your own life at present?	0	1	2	3	4	5

9-23. How would you describe your present state of emotional and psychological wellbeing? [Circle one.]
1 - Quite poor; I am barely managing to deal with things.
2 - Fairly poor; life is pretty tough for me at times.
3 - So-so; I manage to keep going with some effort.
4 - Fairly good; I have my ups and downs.
5 - Quite good; I have no major complaints.
6 - Very good; I get along much the way I would like to.

10-1. In what religious faith or denomination were you raised? _____

[If you were raised in more than one, specify each; if you were not raised in any specific faith or denomination, write 'None'; if raised in an atheistic or anti-religious manner, please indicate.]

Please answer questions 10-2, 10-3, and 10-4, by selecting a number from 0 to 10, where **0** = "not at all important in my life" and **10** = "the most important thing in my life."

10-2. Generally, how important was religion in your life during your childhood [up to age 12]? _____

10-3. Generally, how important was religion in your life during your adolescence [age 13-19]? _____

10-4. How important is religion in your life at present? _____

10-5. Do you currently identify with or belong to a specific religious faith or denomination?

___ 1. No. ___ 2. Yes. [**b**. please specify: _____]

Listed below are various aspects of spiritual or religious experience. How important is each in your own life at the present time? [Please rate each aspect with a number from 0 to 10, where **0** = "this is not at all important in my life at present" and **10** = "this is the most important part in my life at present."]

10-6. _____ A specific creed or set of beliefs.

10-7. _____ Personal moral and ethical standards.

10-8. _____ A sense of spiritual dimension in personal experience.

10-9. _____ Participation in a religious fellowship or community.

10-10. _____ Celebrating the beauty and dignity of the worship service.

10-11. _____ Finding a source of discipline and purpose in living.

10-12. _____ Observing traditional religious holy days.

10-13. _____ Expressing personal devotion through service to others.

10-14. _____ Seeking inner assurance and communion through prayer.

10-15. _____ Upholding a personally valued historical tradition.

10-16. _____ Other. [**b**. Please specify: _____]

10-17. How much is your work as a therapist influenced by your religious or spiritual experiences? _____

[Answer by selecting a number from 0 to 10, where **0** = "my work as a therapist is not influenced in any way by my religious experience" and **10** = "my work as a therapist is very deeply and thoroughly influenced by my religious experience."]

How would you describe yourself [e.g., as you are in your close personal relationships]?

	[**0** = Not at all ... **3** = Very much]					[**0** = Not at all ... **3** = Very much]			
10-18. Accepting.	0	1	2	3	10-32. Nurturant.	0	1	2	3
10-19. Authoritative.	0	1	2	3	10-33. Optimistic.	0	1	2	3
10-20. Challenging.	0	1	2	3	10-34. Organized.	0	1	2	3
10-21. Cold.	0	1	2	3	10-35. Pragmatic.	0	1	2	3
10-22. Critical.	0	1	2	3	10-36. Private.	0	1	2	3
10-23. Demanding.	0	1	2	3	10-37. Protective.	0	1	2	3
10-24. Demonstrative.	0	1	2	3	10-38. Quiet.	0	1	2	3
10-25. Determined.	0	1	2	3	10-39. Receptive.	0	1	2	3
10-26. Directive.	0	1	2	3	10-40. Reserved.	0	1	2	3
10-27. Energetic.	0	1	2	3	10-41. Skeptical.	0	1	2	3
10-28. Friendly.	0	1	2	3	10-42. Subtle.	0	1	2	3
10-29. Guarded.	0	1	2	3	10-43. Tolerant.	0	1	2	3
10-30. Intense.	0	1	2	3	10-44. Warm.	0	1	2	3
10-31. Intuitive.	0	1	2	3	10-45. Wise.	0	1	2	3

What would your most likely action be in the following scenarios? ... [0 = Agree ..... 5 = Disagree]

11-1.	If a child younger than 13 years is my client, I would allow the parents access to information or records without the child's permission.	0	1	2	3	4	5
11-2.	If a client admits to taking illegal drugs, I would notify the police.	0	1	2	3	4	5
11-3.	If the family doctor requires information about the client, I would give the information without the client's permission.	0	1	2	3	4	5
11-4.	If the client reveals committing major theft, I would notify the police.	0	1	2	3	4	5
11-5.	If a client is going to commit suicide, I would contact the family.	0	1	2	3	4	5
11-6.	With an ACC referred client I would allow the ACC access to my case files without the client's permission.	0	1	2	3	4	5
11-7.	If a client is planning to kill someone, I would notify the police.	0	1	2	3	4	5
11-8.	If I was summoned to court to testify about a client, I would testify without the client authorizing this.	0	1	2	3	4	5
11-9.	If during therapy, a client confesses to an unsolved murder, I would notify the police.	0	1	2	3	4	5
11-10.	If a client admits to child abuse, I would notify the police.	0	1	2	3	4	5
11-11.	If the client's spouse requests information, I would provide it without the client's permission.	0	1	2	3	4	5
11-12.	If a client admits to treason or sabotage against New Zealand, I would inform the authorities.	0	1	2	3	4	5
11-13.	If a client is planning to kill someone, I would warn the intended victim.	0	1	2	3	4	5
11-14.	I would discuss a client with other mental health professionals.	0	1	2	3	4	5
11-15.	I would allow Insurance companies to have access to a client's therapy records without the client's permission.	0	1	2	3	4	5
11-16.	If I have a fifteen year old client, I would allow the parents access to information or records without the teenager's permission.	0	1	2	3	4	5
11-17.	If a client admits to selling illegal drugs, I would notify the police.	0	1	2	3	4	5

Please return to: CRN Study, School of Psychology, Massey University, Palmerston North [c/o N. Kazantzis].

APPENDIX B

EXPRESSION OF INTEREST FLYER

Collaborative Research Network

Call for Participants

What is the Collaborative Research Network (CRN)?

Studies of psychological treatments have far outweighed the study of its practitioners, both in terms of the number of studies and the attention they have received. To remedy this situation, members of the Society for Psychotherapy Research (SPR) responded to a call for a program of research on the development of mental health professionals and organized the CRN study. This study is designed to examine development of practicing psychologists of all professional backgrounds, theoretical orientations, and countries. Because little comparative international data on practicing psychologists exists, the CRN study also aims to collect systematic information about the characteristics, and practices of psychologists in different countries. The local researchers working on this project are Nikolaos Kazantzis and Kevin Ronan at the School of Psychology, Massey University, together with Frank Deane at the Department of Psychology, University of Wollongong, Australia.

Convince me, why should I participate?

You have the opportunity to participate in the largest-ever international study of mental health professionals. Previous surveys of psychologists' practice of therapy (including our own) have been restricted to particular organizations and have not used standardized questionnaires designed for international comparative purposes. Your participation in this study will make the most detailed study of NZ's mental health professionals possible, and will enable comparisons of the NZ data to therapists in other countries.

Assuming I decide to do so, what do I get for participating?

Subject to approval from the NZPsS Conference Committee, we hope to present the preliminary findings at next year's Psychology Conference. The data obtained from New Zealand respondents will be compared in various ways to the main international CRN database to examine similarities and differences between countries. If you miss the conference, you will also be able to request your personal copy of the reports written from the NZ database (including clinical psychologists, counselors, psychotherapists, psychiatrists and social workers).

And what does my participation involve?

Simply the completion of an anonymous questionnaire that generally takes 30 to 60 minutes to complete. The fact that as of June 1997 more than 4,000 psychologists, psychotherapists, counselors, and social workers in various parts of the world had spent their time without compensation to complete a lengthy questionnaire about their own development is a testimony to mental health professionals' interest in this project.

Ok, you have convinced me! How do I participate in your study?

Thanks for expressing interest in our study. Simply fill in your contact details over the page, fold, staple, and mail this piece of paper. It is already addressed and the postage is paid. Upon receiving this flyer, we will send you the questionnaire and a postage paid return envelope. **Thank you!**

Please enter your contact details here (they will be kept completely confidential)

Title, name, initials, surname

Address details

PO Box/ Street Number

Suburb

City/ Post code

Work Ph

Fax

E-mail

☛ *Please Fold Here First*

Collaborative
Research
Network

Post Paid

FREEPOST 86
NIKOLAOS KAZANTZIS
SCHOOL OF PSYCHOLOGY
MASSEY UNIVERSITY
PALMERSTON NORTH

☛ *Please Fold Here Second (back of envelope) and staple together*

APPENDIX C

COVER LETTER TO RESPONDENTS

Collaborative
Research
Network

Dear Mental Health Practitioner,

Thank you for returning our flyer. Please find your copy of the anonymous questionnaire enclosed with this letter. Please return your completed questionnaire within the next **two weeks.**

Please feel free let your colleagues know about the study. The more who participate, the more we can say about the professional development of practitioners in New Zealand.
Thank you for taking part in this important research!

Best wishes,

Nikolaos Kazantzis Kevin R. Ronan Paul L. Merrick

NZ-CRN Research Team
School of Psychology at Albany
Massey University
Private Bag 102904
NSMC, Auckland

Phone: 09 4439693
Fax: 09 4439732
E-mail: N.Kazantzis@massey.ac.nz