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# *Estilo terapêutico e orientação teórica: Estudo comparativo através do Therapeutic Identity Questionnaire* - ThId

# Therapeutic style and theoretical orientation: Comparative study using the Therapeutic Identity Questionnaire – ThId

# *Estilo terapéutico y orientación teórica: estudio comparativo con el Therapeutic Identity Questionnaire* - ThId

## *Estilo terapêutico e orientação teórica: Comparação pelo ThId*

## Therapeutic style and theoretical orientation: Comparison through ThId

## *Estilo terapéutico y orientación teórica: comparación por ThId*

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**Resumo**

O estudo das variáveis relativas ao terapeuta é um tema de relevância empírica no âmbito da investigação sobre o processo e resultados terapêuticos. O objetivo deste estudo é verificar se há diferenças nas respostas dadas às três subescalas em avaliação na versão em língua portuguesa do *Therapeutic Identity Questionnaire* (ThId) (fatores curativos, estilo terapêutico e pressupostos de base) em função da orientação teórica, dos anos de experiência e da realização de terapia pessoal dos 34 terapeutas em estudo, e avaliar as características psicométricas do instrumento. Em conclusão, a versão em língua portuguesa do ThId apresenta boas qualidades psicométricas e revela-se útil para detetar diferenças de estilo e atitude terapêutica entre clínicos de diferentes orientações teóricas, mesmo em amostras de reduzida dimensão.
Palavras-chave: terapeutas cognitivo-comportamentais; psicanalistas; variáveis relativas ao terapeuta; ThId.

**Abstract**

The study of therapist variables is a matter of empirical relevance in the realm of the research on therapeutic process and outcome. The goal of this study is to ascertain the differences regarding the responses given to the 3 subscales of the Portuguese version of the Therapeutic Identity Questionnaire (ThId) in evaluation (curative factors, therapeutic style and basic assumptions) in relation to theoretical orientation, years of experience and previous personal therapy among the 34 therapists enrolled in the study, alongside the psychometric evaluation of the instrument. In conclusion, the Portuguese version of ThId displays good preliminary psychometric qualities and empirical usefulness to capture differences in style and attitude between clinicians of different theoretical models, even in reduced samples.
Keywords: cognitive-behavioral therapists, psychoanalysts, therapist variables, ThId.

**Resumen**

El estudio de las variables relacionadas con el terapeuta es tema de preminencia empírica en el contexto de la investigación sobre proceso y resultados terapéuticos. El objetivo de este estudio es verificar si hay diferencias en las respuestas a las tres subescalas en evaluación de la versión en lengua portuguesa del *Therapeutic Identity Questionnaire* (ThId) (factores curativos, estilo terapéutico y supuestos de base) en función de la orientación teórica, años de experiencia y realización de terapia personal de los 34 terapeutas participantes, y evaluar las

características psicométricas del instrumento. En conclusión, la versión en lengua portuguesa del ThId tiene buenas propiedades psicométricas y es útil para detectar diferencias de estilo y actitud terapéutica entre clínicos de diferentes orientaciones teóricas, incluso en muestras de tamaño limitado.
Palabras-clave: terapeutas cognitivo-comportamentales, psicoanalistas, variables relacionadas con el terapeuta; ThId.

## Introduction

The importance given to therapist related variables (personal style, theoretical assumptions, personality, professional experience, gender, age, and cultural values) is rising in the field of psychotherapeutic process and outcome studies (Beutler, Machado & Neufeldt, 1994; Okiishi, Lambert, Nielsen & Ogles, 2003; Beutler et al, 2004; Peuker, Habigzang, Koller & Araújo, 2009). Despite the subjective character of some of the more important variables (for example, therapeutic relationship, therapeutic model, personal style, and theoretical assumptions), the review of published meta-analyzes emphasizes their contribution to therapeutic outcome; however, the published studies are, generally, inconclusive on the topic of their real therapeutic impact (Beutler e cols., 2004).

If we take therapeutic style, one of the most studied subjective variables, it is possible to conclude after the analysis of specialized literature (e.g., Beutler, Clarkin & Bongar, 2000; Sandell et al., 2004; Oliveira, Nunes, Fernández-Álvarez, Garcia, 2006; Hill & Knox, 2008; Barber, 2009) that the therapeutic influence, either of a directive style, related to cognitive-behavioral therapists, or of a non-directive style, of psychodynamic tradition, is mediated by the patient's receptivity to the way the therapeutic process is carried, the pathology under treatment being the other source of outcome variance. Regarding the last issue, Borkovek and Costello (1993), through a randomized controlled trial, concluded by the superiority of the directive style in the treatment of patients suffering from general anxiety, whilst Beutler, Clarkin and Bongar (2000), through a multicentric study conducted in addicts and depressed patients, verified that those patients who were the most resistant to the treatment benefitted from non-directive styles, while the least resistant benefitted from a directive therapeutic style. Also on the subject of psychotherapeutic style, the impact of insight promotion (typical of the psychodynamic model) and the focus on the symptom resolution (characteristic of the cognitive-behavioral model) differ according to the introspective and self-reflexive, or contrarily, the aggressive and impulsive character of the patient's mental functioning (for example, Beutler et al, 1994; Beutler et al, 2000).

On the other hand, the psychotherapist's professional experience may be directly correlated to the quality of therapeutic outcome, despite the difficulty in the elaboration of the conclusions due to the variation of the correlation's value in the different studies (between .09 and .48), since no consistent pattern has been found (Beutler et al., 2004). The results from the Sandell, Carlsson, Schubert, Broberg, Lazar and Blomberg (2002) study, based on the *Stockholm Outcome of Psychoanalysis and Psychotherapy Project* (STOPP) database, which

included mostly psychodynamic therapists, show a statistically significant correlation between professional experience, especially the experience acquired after the specific psychotherapy training, and the therapeutic results [$t$ (755) > 2.30, $p$ <.05, for the comparison between the group of more experienced therapists and the group of less experienced therapists]. The influence of professional experience on therapeutic efficacy when treating patients suffering from different pathologies was also verified (Luborsky, McLellan, Diguer, Woody & Seligman, 1997). Other subjective aspects related to the therapist are the theoretical assumptions and cultural values, always associated to the theoretical model of reference and the technical procedures which stem from it. Therefore, in the Sandell et al. study (2007), the therapists' attitudes and ideals showed a statistically significant correlation ($r$=.51; $p$=.001) with the quality of therapeutic outcome in the post-treatment (follow-up) evaluation.

However, it is the quality of the therapeutic relationship that synthesizes the contribution of many of the variables mentioned above for treatment outcome, a finding that is in line with the crucial role of interpersonal dynamics, regardless of the therapeutic model and the expressive, or supportive, aim of the therapy in question (Bachelor & Salame, 2000; Fenton, Cecero, Nich, Frankforter & Carroll, 2001; Orlinsky, Ronnestad & Willutzki, 2004; Muran et al, 2009; Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz & Gallop, 2011).

In what regards therapeutic alliance, various researchers (Barber et al., 2001; Crits-Christoph et al., 2011) have confirmed its specific preditive power, whereas Beutler et al., (2004), in their review of the literature on the impact of therapeutic relationship on treatment outcome, estimated that this variable explains 17% of the variance related to the syntomatic improvement of patients with different pathologies and submitted to different treatment models. However, in a recent critical review on the assumptions of empirical research in psychotherapy, Barber (2009) relativizes this variable's specific contribution, preferring to valorize the complex character of the influence exerted by both the alliance and the specific techniques used by the therapist (interpretation, support, insight, and directivity) with regard to the patient's pathology, the type of treatment and the adhesion of the latter to the prescribed therapy. In this regard, it is important to note that the *Therapeuthic Identity Questionnaire* – ThId (Sandell et al., 2004), due to its factorial structure, allows for the establishment of correlations between objective variables (for example, psychotherapeutic training, professional experience, and therapeutic attitudes) and subjective variables (therapeutic style, therapeutic model, and theoretical assumptions) for the same therapist, a possibility that broadens the field of comparative analysis between factors whose contribution to therapeutic outcome is frequently evaluated. Therefore, in the 2004 study, these authors were able to

identify the differences between cognitive-behavioral therapists and psychodynamic therapists regarding the valorization of support and adjustment, among the first, and the valorization of insight for the second group. Curiously enough, they found a cluster of mainstream eclectic therapists, of psychoanalytical inspiration, who set themselves apart from psychoanalysts due to the use of the *here and now*, and who were closer to cognitive-behavioral therapists with respect to several factors related to therapeutic outcome.

Taking into consideration what has been referred to above with regard to the psychometric structure and the empirical usefulness of ThId (version 3), this study has the following objectives: 1) to evaluate the psychometric characteristics of the experimental version of the Portuguese language instrument; 2) to identify similarities and differences in the response to this instrument's subscales by cognitive-behavioral and psychodynamic therapists in relation to individual training, level of experience, and therapeutic style.

## Method

This study is part of a larger project aimed to create and validate an original psychometric instrument for the assessment of therapeutic setting in psychotherapy that has been approved by the Scientific Council of the *Instituto de Ciências Biomédicas Abel Salazar da Universidade do Porto* - Biomedical Science Institution, University of Oporto – (and respective Ethics Committee). This project has also received a grant from the *International Psychoanalytical Association - Evaluation of Research Proposals and Results Subcommittee* (IPA - CERP).

*Participants*

The experimental version of ThId in Portuguese language was distributed in paper and pencil format to a convenience sample of 34 psychotherapists that fully joined up the study. The participants were between the ages of 27 and 62 (M=40.35; DP=8.66), 25 being female. For the most part they are psychologists (24=70.6%), and only 29.4% (10) are medical doctors (10). Concerning theoretical orientation, 20 of them (58.8%) are cognitive-behavioral therapists (CBT), and 14 (41.2%) are psychoanalysts (qualified, respectively, by the Portuguese Association of Behavioral and Cognitive Therapies and the Portuguese Psychoanalytic Society).

The respondents have, on average, developed their work as psychotherapists for 12.8 years (DP=8.24), most (47.1%) having been psychotherapists for 8 to 15 years. The cognitive-

behavioral therapists (CBT) present an average of 12.7 years of experience (DP=7.1), while the psychoanalysts have an average of 12.2 years of experience (DP=9.8). The respondents dedicate an average of 22.0 hours (DP=13.0) per week to psychotherapy, during which they see an average of 18.29 clients/patients (DP=12.61). In terms of individual training, 21 of the subjects (61%) were subject to personal therapy, referring to varied theoretical orientation (psychoanalysis/psychodynamics, psychodrama, cognitive-narrative and Rogerian therapy, and transpersonal psychology). As regards their therapeutic setting, 18 subjects (52.9%) work in private practice, 6 (17.6%) in the public service sector, and 10 (29.4%) work in both settings. It is important to note that 52.9% of the participants have no need of changing cabinet between sessions, so keeping basically the same setting during the therapeutic process. With regard to their affiliation to psychotherapeutic societies/schools, 30 of them (88.2%) are affiliated to a society/association/school/board.

*Description of instrument*

ThId (*Therapeutic Identity Questionnaire*) developed by Sandell et al. (2004; 2007; 2010) has, in the version used in this study (version 3 of the instrument supplied by the author in 2010, along with its respective manual and psychometric scores for each subscale), 150 questions divided into 6 sections (A to F). The first four sections refer to: 1. socio-demographic characteristics, academic and professional qualifications (section A); 2. professional experience (for example, professional experience, duration and extension of psychotherapeutic practice) (section B); 3. data related to previous personal therapy by own initiative or under professional training (section C); 4. identification of theoretical orientation on which the respective psychotherapeutic work is based (for example, psychoanalysis, cognitive, cognitive-behavioral, experiential humanist therapy, family therapy) (section D), the latter section being assessed by a *Likert* type scale of 5 points, in accordance with the respondent's level of use of more than one theoretical orientation (0=not at all to 4=much).

The 5$^{th}$ section (E) is made up of two subscales which explore the perception of the psychotherapist concerning his/her therapeutic attitudes (Sandell et al., 2004; Sandell et al., 2007). The first subscale, *Curative factors* (E1), has 33 items which are ticked on a *Likert* type scale of 5 points (0=not at all to 4=much) and evaluate the therapist's beliefs regarding the curative value of various aspects of psychotherapy (for example, *help the patient control their emotions; work with the patient's childhood memories).* The second subscale, *Therapeutic style* (E2), is made up of 35 items that describe the usual manner of conducting psychotherapy (for example, *I do not answer the patient's questions on my personal life, my*

*verbal interventions are brief and concise),* and is also ticked on a *Likert* type scale, same as the previous one.

The 6th section, *Assumptions* (F), is made up of 16 items that address the therapist's private theories and/or assumptions on the nature of psychotherapeutic work and the human mind. This last subscale is ticked on a continuous bipolar scale with an assertion on each pole, the respondent having to mark this line with the position believed to be correspondent to the level of agreement about the different assumptions (for example, *psychotherapy may be described as….a form of art / a science, human behavior is essentially governed….by external objective factors / by internal subjective factors, personality is determined by….heredity / environment*)

ThId also presents a final section (G) with a group of four open questions based on the *Psychotherapists Common Core Questionnaire* (Orlinsky et al., 1999), which was also translated and adapted but not included in this study as it is not directly related to its goals.

The construction of the original instrument was done by way of exploratory factor analysis and cross-validation of the sample until stable and interpretable factors were obtained (Sandell, 2010; Sandell et al., 2004). The items in the subscales E1, E2 and F were grouped into nine factors: E1 – *Curative factors (adjustment, insight* and *empathy),* E2 – *Therapeutic style (indifference, support* and *self-doubt),* F – *Assumptions (irrationality, art* and *pessimism).* As regards internal reliability, some subscales (*adjustment, insight, empathy, indifference* and *support/backing*) revealed good psychometric qualities (*Cronbach's* Alpha values between .75 and .87); however, the remaining scales (*self-doubt, irrationality, art* and *pessimism*) reveal low internal reliability, with *Cronbach's* Alpha values between .48 and .67 (Sandell, 2010).

*Procedures for the adaptation into Portuguese language*

With respect to the procedures for the adaptation into Portuguese, the first step was to acquire the instruments and authorization from the author, then it was necessary to translate and adapt a first experimental version to the Portuguese language. The procedures were based on the guidelines of the *International Test Commission* (ITC; 2003; 2010), the recommendations of Hambleton, Merenda & Spielberger (2005) and Gregoire & Hambleton (2009), and also the suggestions for the adaptation of instruments by authors experienced in these methodological procedures (Hill & Hill, 2005). According to the referred to guidelines, the translation should be done by two or more independent, bilingual translators, or official translators whose native language is the one to adapt (van de Vijver & Hambleton, 1996; van

de Vijver & Tanzer, 1997). Therefore, and in order to execute the translation with rigorous methodology, two independent, bilingual translators were hired in a first stage (official, licensed translators). At a later stage, a specialist in bilingual methodology (Portuguese-English) with training in psychology and previous participation in various studies of construction and validation of psychometric tools was included.

In order to comply with the guidelines of ITC (2010), it was ensured that the specialists who participated in the translation had different academic qualifications and were of different cultural backgrounds so as to guarantee that the final version of the text would simultaneously consider the linguistic and cultural aspects of the original language and the adapted language. The retranslated version was checked and approved by Rolf Sandell, the first author of the original instrument.

*Statistical analysis procedures*

The data was analyzed using the SPSS software, version 19, and the internal reliability of the subscales with the items of the instrument's original version, entitled "initial Portuguese language version", has been analyzed through the calculation of *Cronbach's* Alpha values. As shown in Table 1, *Cronbach's* Alpha values of the subscales of the *Curative Factors* section *(adjustment, insight* and *empathy)* are very close to those obtained in the validation of the original instrument (Sandell, 2010; Sandell et al., 2004). The factor *self-doubt,* which belongs to the *Therapeutic style* section, even presents a higher *Cronbach* Alpha value than the original version.

Table 1 Internal reliability (*Cronbach* α) by factor of ThId versions

| Subscale (or section) | Factor | Initial Portuguese language version | Improved Portuguese language version | Original version (Sandell, 2010; Sandell and cols., 2004) |
|---|---|---|---|---|
| E1. Curative factors | Adjustment | .83 | .83 | .83 |
| | *Insight* | .85 | .85 | .87 |
| | Sympathy | .79 | .79 | .82 |
| E2. Therapeutic style | Neutrality | .42 | .67 | .79 |
| | Support/Backup | .54 | .65 | .75 |
| | Self-doubt | .67 | .67 | .50 |

| | | | | |
|---|---|---|---|---|
| F. Assumptions | Irrationality | .42 | .51 | .67 |
| | Art | .36 | .51 | .57 |
| | Pessimism | .42 | .58 | .57 |

In contrast, the factors *indifference* and *support/backing*, which belong to the *Therapeutic style* section, and the factors *irrationality, art* and *pessimism*, which belong to the *Assumptions* section, present lower internal reliability values in the initial Portuguese language version than in the original version (Sandell et al., 2004; 2010). In order to assess and improve this aspect, a detailed analysis of the item-total correlation was carried out for each one of these factors, item by item, which is presented in Tables 2 and 3.

Table 2 Item-total Correlations for factors of the *Therapeutic Style* section

| | Neutrality | Support/ backup | Self-doubt |
|---|---|---|---|
| I do not express my own feelings in the sessions | *.57* | | |
| I do not answer personal questions from the patient | .12 | | |
| My verbal interventions are brief and concise | *.37* | | |
| If a patient asks, I might agree to talk with one of his/her relatives *(inverted item)* | *.33* | | |
| I keep my personal opinions and circumstances completely outside the therapy | *.31* | | |
| I am more neutral than personal in therapy | .21 | | |
| I want the patient to develop strong feelings in the therapy | -.23 | | |
| My countertransference is an important instrument in my work | -.18 | | |
| Keeping the therapeutic frame is fundamental in my work | .03 | | |
| I avoid physical contact with the patient | *.25* | | |
| I am active in sessions | | *.33* | |
| I have a positive attitude towards extra sessions | | .16 | |
| I do not want the patient to develop strong feelings towards me as person | | *.32* | |
| It is important to order and structure the material | | *.29* | |
| I often put questions to the patient | | -.01 | |
| It is important to convey hope to the patient | | -.12 | |
| I always communicate the therapeutic goals to the patient in the beginning of a therapy | | *.59* | |
| I always make the therapeutic goals explicit to myself during a therapy | | *.48* | |
| I am anxious for the patient to achieve his/her life goals | | .23 | |
| I find it difficult to deal with the patient's aggression | | | .23 |
| I do not allow long periods of silence during the therapeutic session | | | -.09 |

| | |
|---|---|
| I am frequently not sure whether my feelings during sessions reflect the patient's or my own problems | *.32* |
| I closely monitor my own feelings in order to learn what is going on in the patient | .03 |
| I seem easily to frustrate my patients | *.66* |
| Often I am not sure what to do or say in the session | *.59* |
| I doubt my own ability to contain the patient's feelings | *.35* |
| My involvement with the patient's life goals is an obstacle to therapeutic work | *.29* |
| I seem to do best with patients who resemble me in some ways | *.60* |
| I doubt whether I am a good therapist | *.59* |
| *Cronbach* Alpha | *.67* *.65* *.67* |

Table 3 Item-total correlations for factors of the *Assumption* section

| | Irrationality | Psychotherapy as art | Pessimism |
|---|---|---|---|
| f2_6 Conscious *versus* Unconscious processes | *.27* | | |
| f3_1 Rational *versus* Irrational | *.25* | | |
| f4_1 Free will *versus* Uncontrollable factors | .09 | | |
| F4_2 External objective factors *versus* Internal subjetive factors | *.40* | | |
| f1_1 Form of art *versus* Science | | *.14* | |
| f1_2 Craft *versus* free creative work | | *.12* | |
| f2_1 Training *versus* Personality | | .19 | |
| f2_2 Intuition *versus* Systematic thinking | | *.51* | |
| f2_3 Relativistic views *versus* Absolutistic convictions | | .01 | |
| f2_4 Everything may be understood *versus* Not everything may be understood | | | *.34* |
| f5_1 Heredity *versus* Environment | | | *.31* |
| f6_1 Unchangeable *versus* Changeable | | | *.15* |
| f7_1 Completely understandable *versus* Not at all understandable | | | *.50* |
| f8_1 Humans may develop infinitely *versus* Not at all | | | -.13 |
| *Cronbach* Alpha | *.51* | *.51* | *.58* |

Through the analysis of the item-total correlation and the increase of the *Cronbach* Alpha, not including the items of low item-total correlation, it was possible to select the items that maximized the internal reliability of each factor (presented in *italics* in Tables 2 and 3). A version entitled "improved Portuguese language version" was then obtained (cf. Table 1), in which the *Cronbach* Alphas were closer to the original version (Sandell, 2010; Sandell et al., 2004).

*Kolmogorov-Smirnoff* tests were carried out to verify whether the distributions of the subscales were different from the normal distribution. For a level of significance of $p$= .05 and a confidence interval of 95%, none of the scales showed a distribution that was significantly different to the normal distribution. The correlations between the ThId subscales and the psychotherapist's variables: *carrying out of personal therapy, theoretical orientation* (through analysis of variance – ANOVA) and *years of experience* (through correlational analysis) were then tested. A discriminant analysis including all the individual items of the questionnaire as independent variables and theoretical orientation as a dichotomous dependent variable was then carried out in order to verify whether the items allowed for the significant discrimination of the two types of theoretical orientation. Finally, analyses of variance were carried out so as to verify which items presented significant differences between the two theoretical orientations.

## Results

Below are the results which show the existence or non-existence of statistically significant differences in the responses given to each one of the sections and the respective ThId factors regarding the therapist related variables: personal therapy, years of experience and theoretical orientation (cognitive-behavioral *versus* psychoanalytic), assuming 5% as significance level.

*Personal Therapy*

ANOVAS were carried out so as to verify whether statistically significant differences were identified in the results per factor between the therapists that did previous personal therapy (N=21) and those who didn't (N=13). Remarkable differences (statistically significant and marginally significant) were identified between the therapists that affirmed and those that denied having been subjected to personal psychotherapy as regards the factors *adjustment* of the *Curative factor* section (F [1.33] =3.75, $d$=0.47), *support*/*backing* of the *Therapeutic style*

(F [1.33] =10.29, *d*=1.10) and *psychotherapy as an art* of the *Assumptions* section (F [1.33] =3.08, *d*=0.62). Also the therapists that had not been subjected to personal therapy were more inclined towards the *support/backing* therapeutic style (M=3.46) than those that had done personal therapy (M=3.03), this difference being statistically significant ($p$ <.05). In line with the previous result, the valorization of *adjustment* as a therapeutic factor is higher among the psychotherapists that had not been subjected to an earlier personal therapy (M=3.45) than among those that had been (M=3.10), this difference being marginally significant ($p$=.06). Finally, the psychotherapists that had been subjected to personal therapy have more belief in the assumption *psychotherapy as an art* (M=5.49) than the ones that hadn't (M=4.73), this difference being marginally significant (for $p$=.10).

*Years of experience*

The analysis of variance resulted in the non-verification of significant differences of the average *years of experience* between cognitive-behavioral therapists (CBT) and psychoanalysts. No statistically significant correlations were also found either between *years of experience* and any other factor on the questionnaire, among the study's total sample. However, by dividing the sample between the subjects that had had personal therapy and those that hadn't, remarkable (Spearman's non-parametric) correlations were found: the subjects that hadn't had personal therapy showed a statistically significant negative correlation ($r_s$ =-.48; p <.05) between the number of years of professional experience and the use of a therapeutic style based on *insight*. This negative correlation was also identifiable with the factors *empathy* ($r_s$ =-.46; p=.058) and *indifference* ($r_s$=-.46; p=.057), despite the fact of being marginally significant for these two variables. To sum up, the therapists that had not been subjected to personal therapy were not so inclined to use *insight* techniques, felt less sympathy towards the patients and became more neutral in their techniques as their years of experience increased.

*Theoretical orientation: Cognitive-behavioral versus psychodynamic*

This analysis only included the psychotherapists that answered *yes* to the question *Registered with a society/association/school/board?* (N=29), so as to control the possible atypical effect of the psychotherapists that do not clearly follow the guidelines set by the respective scientific societies. ANOVAS were carried out in order to verify whether there were statistically significant differences in the results for each factor between the CBT (N=19) and the psychoanalysts (N=10). Although no statistically significant differences were

found (for p<.05) in any of the subscales, there was a marginally significant effect for the curative *adjustment* factor (F [1.28] =3.89; *p*=.059, *d*=0.74), where the participants of cognitive-behavioral orientation believe more in *adjustment* as a curative factor (M=3.35) than the participants of psychodynamic orientation (M=2.95).

In order to verify whether the items allow for the significant discrimination of the two types of theoretical orientation, a discriminant analysis was conducted, including all individual items of the questionnaire as independent variables. A discriminant function with a significant value was obtained (Chi-squared=40.33; p <.05). Category membership of the two groups was also calculated based on the statistical model including all the items. The conclusion was that the discriminant function allows for the prediction of the category membership in all psychotherapists of psychodynamic orientation, and in 18 of the 19 cognitive-behavioral therapists.

The ANOVAS permitted the detection of univariate statistically significant differences, shown in table 4, in 9 items found in the E1 subscales – *Curative factors* (the first four items shown in the table) and E2 – Therapeutic style (the remaining five items).

Table 4 Differences per item concerning the main theoretical orientation

| | Main Theoretical Orientation | | |
|---|---|---|---|
| items | Cognitive-Behavioral | Psychodynamic Psychoanalytic | F |
| Stimulating the patient to think about his problems in more positive ways | 3.88 | 3.00 | 4.14* (0.89) |
| Educating the patient about his/her symptoms and psychic problems | 3.82 | 2,80 | 7.47* (1.10) |
| Giving the patient concrete goals | 3.88 | 3,10 | 5.78* (0.91) |
| Working with the patient's symptoms | 4.06 | 3.40 | 4.45* (0.92) |
| I find it difficult to work with the patient's aggression | 2.10 | 1.60 | 4.15* (0.85) |
| I admit my own mistakes to the patient | 3,17 | 2.30 | 5.88* (0.97) |

| | | | |
|---|---|---|---|
| If a patient asks, I might agree to talk with one of his/her relatives | 3.94 | 2.80 | 8.53* (1.19) |
| It is important to convey hope to the patient | 4.10 | 3.30 | 4.26* (0.94) |
| Keeping the therapeutic frame is fundamental in my work | 4.00 | 3.30 | 5.47* (0.89) |

* $p < 0.05$
*d Cohen* values are presented in parenthesis

## Discussion and conclusions

As it happened previously with the presentation of the results, the psychometric characteristics of the experimental version of the ThId in Portuguese will be discussed first. So, with regard to the internal reliability per factor, especially for the E1subscale – *Curative Factors,* the values obtained are very close to those obtained in the validity study of the original instrument, which is not the case for the subscales E2 - *Therapeutic Style* (except for the *self-doubt factor*, which presents a higher *Cronbach* Alpha than the original version) and F – *Assumptions*, which present lower values. These results may be related to the limitations inherent to the international adaptation of the instruments (Harkness, Pennell & Schoua-Glusberg, 2004), especially the difficulties of the participants in the study in interpreting some of the items.

Even so, the procedures for *Cronbach* Alpha increase allowed for the attaining of higher values and an improved version of the instrument (cf. Table 1).

Despite the small sample size, in relation to the number of subjects traditionally considered necessary for a correct estimate of *Cronbach* Alpha index, psychometric studies using Monte Carlo simulations (MacCallum, Widaman, Zhang & Hong, 1999; Yurdugul, 2008) have shown just the opposite. A recent study has shown that when the 1st eigenvalue of a set of items extracted by Principal Component Analysis (PCA) is close to or higher than 6.0, a sample of n=30 may be enough for a correct estimate (Yurdugul, 2008). As regards the present study, the 1st eigenvalue obtained by PCA for the set of items from the *Curative Factors* section was 7.85, for the set of items from the *Therapeutic style* section it was 5.45, and for the set of items from the *Assumptions* section it was 4.04.

Getting more specifically to the correlational data, it is noticeable that the participants that had not had a previous personal therapy were more inclined towards a *support/backing* style, and valued the curative factor *Adjustment* more than the ones that had had a previous personal therapy. Even if it is important to keep in mind the small sample size and the predictable influence of the therapists' own theoretical orientation (not assessed in the analyses carried out) this finding can be explained by the fact that the therapists that had had personal therapy do not feel the need for a therapeutic alliance in order to favor the retention of the patient being treated, contrary to those that did not benefit from previous personal therapy. In agreement with this data, one may refer to both the positive correlation between the psychotherapist's previous personal therapy and the patient's retention, identified by Greenspan and Kulish (1985), and the stronger personal trust and higher quality of therapeutic alliance, identified by Gold and Hilsenroth (2009), among the clinicians in psychotherapeutic training enrolled in their study who benefitted from previous personal psychotherapy.

On the other hand, the lower tendency towards the use of insight and the keeping of a neutral attitude in the therapeutic relationship along with the years of professional experience among the psychotherapists that had not had personal therapy may be related to the fact that psychoanalysts (i.e. those that most make use of a therapeutic style based on these two variables) are the ones that include personal therapy as a basic training prerequisite (Beutler et al., 2004; Sandell et al., 2006). Therefore, it may be assumed that the cognitive-behavioral therapists will be the ones that, in this study, most contribute to the negative correlation identified between professional experience, use of insight and neutrality in the relationship with the patient.

With reference to the lack of statistically significant differences for the variables that compose the ThId subscales E1 and E2 in the analyses of variance carried out among psychoanalysts and CBT, it is important to mention that these results are in line with data from various studies and meta-analyses published in the specialized literature which indicate that the correspondence between technical procedures and the specific theoretical model is a relatively modest one (Beutler et al., 2004).

In relation to the therapeutic style, which has been defined in this study after Sandell et al. (2004) as the usual way of conducting psychotherapy, a definition that is in line with the one advanced by Oliveira et al. (2006) that values the integrated functions that shape the therapist's character and usual attitude, it is important to note that the results of the discriminant analysis carried out indicate that CBT are more likely to educate the patient on his psychic problems, to work on his symptoms, to contact the family, when requested to do

so, and to actively strengthen empathy than their psychoanalyst counterparts. These results are in line with data from the study by Oliveira et al. (2006), despite the fact therapeutic style is assessed, in this last study, through the Brazilian version of another instrument (The Therapist's Personal Style TPS-Q).

Finally, it is important to note, as limitations of this study, the small sample size (which, despite allowing for the preliminary psychometric assessment of ThId, restricts its full empirical exploration), as well as the non-assessment of the specific contribution of the variables being studied for therapeutic efficacy (symptomatic relief, psychic change). This shortcoming, which stems from the non-use of a patient sample in this study, will be resolved by its inclusion in future studies.

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