CLINICAL PSYCHOLOGY
SCIENCE AND PRACTICE

COMMENTARIES

Is Clinical Psychology Doctoral Training Becoming Less Intellectually Diverse? And If So, What Can Be Done?

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Longitudinal data of psychotherapy theoretical orientations (PTO) for faculty from within clinical psychology programs were analyzed for a period of over two decades. Results from multilevel modeling demonstrated that clinical psychology has moved from a field that was relatively balanced in percentages of faculty from cognitive-behavioral (CBT), psychodynamic, humanistic, behavioral, and family PTOs to one that has shown highly significant linear growth for a single PTO: CBT. All other PTOs (except family) showed significant linear decline. To some extent, important research findings from other PTOs have been co-opted into CBT, but essential aspects of this work have been stripped down, muddied, or lost in a conflation with CBT treatments. We suggest that the field has lost significant intellectual diversity during the past two decades and identify how intellectual monocultures have been damaging to the success of other scientific disciplines and research groups. Tangible solutions are offered to correct this trend, including the establishment of an intellectual diversity task force, the APA's dissuasion of the establishment of monocultures within its evaluation of training, increased support for research investigation of more diverse approaches to psychotherapy, organizing of minority PTOs in order to lobby for larger research and professional training goals, and increased mentoring opportunities from minority PTO faculty.

Key words: **diversity, professional training, psychotherapy, theoretical orientations.** ***[Clin Psychol Sci Prac 20: 211–220, 2013]***

Heatherington et al. (2012) argued that the narrowing of psychotherapy theoretical orientations (PTO) in clinical psychology training programs has resulted in negative consequences to the field. Using cross-sectional data from a recent survey of faculty theoretical orientations within clinical programs (Norcross & Sayette, 2012), Heatherington and colleagues found greater representation of those from a cognitive-behavioral orientation as compared with those from behavioral, psychodynamic, humanistic, and family systems orientations. The disparity was quite large. These authors outlined a number of negative consequences from such an imbalance and also proposed corrective measures. We are thankful to our colleagues for their thoughtful and stimulating article on what we also believe is a central issue for the future of clinical psychology.

In our commentary, we would like to highlight and elaborate on some of the issues that Heatherington and

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colleagues raised. First, we expand the examination of PTO representation by using longitudinal data from the last 22 years. Because the *Insider's Guide to Graduate Programs in Clinical and Counseling Psychology* (Norcross & Sayette, 2012) has been published every two years beginning in 1990, we were able to cull data from 11 editions over a 22-year period dating back to 1990. This allowed us to evaluate the longitudinal trends of faculty PTO over almost a quarter-century period. Finally, following up on Heatherington and colleagues' suggestions, we make a number of concrete recommendations.

SCOPE OF THE PROBLEM: RESULTS OF LONGITUDINAL ANALYSES

We used hierarchical linear modeling (HLM) to analyze the linear rate of change for the five most common faculty theoretical orientations of cognitive-behavioral (CBT), psychodynamic (PDT), behavioral (BT), humanistic (HT), and family (FT) across the last 20 years. These HLM analyses demonstrated that CBT faculty sharply increased at a highly significant rate of change, which amounted to a 2.5% per two-year reporting unit, $t(173) = 13.00$, $p < .0001$. In contrast, the remaining three individual orientations all significantly decreased during this 20-year period. Specifically, PDT decreased by 1.21% (per two-year unit), $t(173) = -6.72$, $p < .0001$, HT by 0.25%, $t(173) = -2.03$, $p = .04$, and BT by a 0.23% per reporting period, $t(173) = -2.11$, $p = .04$. FT, the only nonindividual therapy orientation, did not change during the last 20 years, $t(173) = 1.03$, *ns*. The actual mean values of PTO by year are presented in Figure 1, demonstrating the narrowing of PTO in clinical psychology training programs.

In our follow-up analyses, there were no differences in the rate of change in PTO for these clinical programs as a function of their university's Research 1 status versus non-Research 1 status, degree type of PhD versus PsyD, and Clinical Scientist versus non-Clinical Scientist program status. While the rate of change for these program characteristics did not interact with

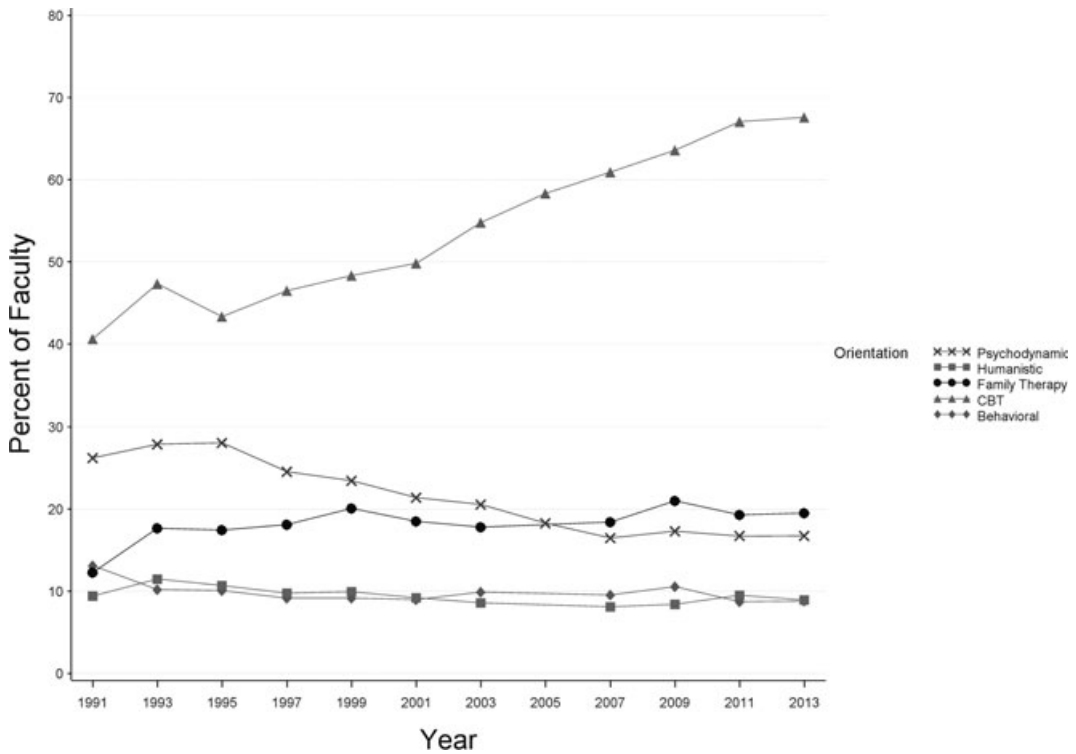

Figure 1. Percent of faculty by orientation by year.

PTO, some disparities of PTO were greater or less depending on these program characteristics. For example, the disparity was greater among Clinical Scientist programs (where CBT representation was 78.8% in the most recent reporting period). In contrast, for PsyD programs, the current disparity is about where the disparity was for PhD programs 22 years ago.

THE IMPORTANCE OF THEORETICAL/INTELLECTUAL DIVERSITY AND THE RISKS OF NEAR MONOCULTURES

We recognize that a narrowing of PTO in clinical psychology is a simple fact that can be open to numerous interpretations. Some might argue that the field is doing rather well despite this narrowing—maybe even better off because of it. It is difficult to argue with such a counterfactual, and hence the relative impact from the field's PTO narrowing cannot really be known. However, research has strongly suggested that there are many dangers associated with monocultures, including the potential for groupthink and loss of innovation (Esser, 1998; Park, 2011). Under such conditions, biases in judgments and decision making commonly increase in many disciplines, even in the face of abundant knowledge and accumulated facts by experts. Kahneman (2011) notes that overconfidence flourishes in monocultures; even when experts are aware of alternative explanations, those within such environments are quick to discount alternative explanations. Thus, the availability heuristic is enhanced in such monocultures because of the common disposition to selectively interpret observations in ways that are consistent with their existing beliefs and worldview. Threats to validity are especially pronounced in disciplines like our own—where the most pertinent expert predictions involve relatively long-term forecasting (e.g., psychotherapy outcome).

Additionally, science and psychology are replete with examples of the importance of diverse underrepresented and unappreciated views. For instance, Whitfield (2008) reviewed research that examined collaborations in scientific teams to identify the relative success of diverse versus tight-knit research teams. Overall, network analysis indicates that optimal productivity and research impact occur when there is a balance of competing ideas from different disciplines. When research teams lack intellectual diversity, network analysts describe the outcome as an "echo chamber." New and cross-disciplinary collaboration may help prevent stagnation. For example, Whitfield (2008) describes findings of a network analysis of nearly 90,000 authors from numerous scientific disciplinary journals in which authors were coded for whether they had previously collaborated on a journal article or whether the collaboration was new. Articles by research teams that included few repeating collaborators and more first-time collaborators tended to have higher impact than teams with higher rates of repeating authors. However, problems may also exist when teams become overly intellectually diverse, possibly because of synthesis from diverse orientations is too complex. In other words, scientists from different orientations may serve as bridge builders to link islands of thought, but linking many distant islands also presents formidable challenges. Our position is that clinical psychology is losing its capacity for bridge building.

In psychotherapy research, diverse views often resulted in important conceptual and research breakthroughs. Eysenck's (1952) literature review of psychotherapy studies questioned the general effectiveness of psychotherapy. Although Eysenck's cross-disciplinary critique was unwelcomed by many within psychotherapy at the time, Eysenck's critique led to a number of important developments. It led Gene Glass (Smith & Glass, 1977) to develop meta-analysis, a technique that has not only served clinical psychology but all of science. In addition, Eysenck's (1952) publication is often attributed to the resurgence of a truly scientific field of psychotherapy research and strong evidence for the value of psychotherapy.

Is the Narrowing of PTO Justified by Data?

Some might argue that PDT and humanistic/existential approaches are causalities of an academic survival of the fittest. We agree that it is optimal that in science, good ideas—no matter how counterintuitive—survive and bad ideas—no matter how seemingly intuitive or aesthetically pleasing—are allowed to fade away. However, we contend that PDT and humanistic/existential approaches are not becoming less relevant due to converging evidence of the lack of value. Quite to the contrary, the evidence, although not unequivocal, strongly suggests the potential value of these approaches.

A convergence of findings from RCTs, meta-analyses, and effectiveness studies in aggregate indicates a value to these approaches, and the value appears to be equivalent to that of CBT. In terms of RCTs, there are now a number of studies suggesting the efficacy of psychodynamic and humanistic existential psychotherapies for a range of disorders, including depression (Cooper, Murray, Wilson, & Romaniuk, 2003; de Jonghe et al., 2004; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003), anxiety disorders (Leichsenring et al., 2009; Milrod, Leon, Busch, et al., 2007), and borderline personality disorder (Bateman & Fonagy, 1999, 2008; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Doering et al., 2010), as well as marital discord therapy (Snyder, Wills, & Grady-Fletcher, 1991). One particularly important example is the work of Milrod, Leon, Busch, et al. (2007), who in an RCT compared a short-term PDT for panic disorder with applied relaxation therapy. They not only found efficacy for PDT but also found effect sizes similar to those found in studies of CBT and a lower dropout rate than what is typical in CBT. Although one study, it is important because the notion that CBT is a superior treatment for anxiety disorder is not based on comparisons with bona fide PDT or humanistic treatments. Even more important, moderating analyses (Milrod, Leon, Barber, et al., 2007) revealed that PDT was particularly useful with panic patients who had a comorbid personality disorder. This finding is in stark contrast to the weight of evidence indicating that efficacy of CBT for panic is significantly reduced when the patient has a comorbid personality disorder (Mennin & Heimberg, 2000). This finding, if replicated, has immediate real-world prescriptive application for clinicians in private practice.

These findings are further supported by meta-analyses and reviews (Abbass, Hancock, Henderson, & Kisely, 2006; Leichsenring, 2001; Leichsenring & Leibing, 2003; Leichsenring & Rabung, 2008; Leichsenring, Rabung, & Leibing, 2004; Levy, Ellison, Temes, & Khalsa, 2013; Shedler, 2010; Wampold et al., 2011) and by naturalistic effectiveness studies (McLeod & Weisz, 2005; Stiles, Barkham, Mellor-Clark, & Connell, 2008; Weisz et al., 2009). Rather than suggesting psychodynamic and humanistic approaches are limited, the weight of the evidence (despite any limitations) clearly suggests that they have adequate value to the field and warrant further research. Therefore, it is our contention that the decrease in dynamically and humanistically oriented faculty in clinical psychology training programs is not based on the lack of scholarly value of their ideas, but instead it is based on a confluence of other nonscholarly processes, such as lack of organizational commitment, guild issues and biases, prejudices, and stereotyping (see Cava & Mulder, 2012; Larsson, Broberg, & Kaldo, 2013).

CBT AND BT ARE BECOMING MORE PSYCHODYNAMIC AND HUMANISTIC/EXPERIMENTAL

Other evidence of the value of dynamic and humanistic/existential concepts comes from CBT and BT theorists themselves. Rather than being discarded, aspects of dynamic and humanistic approaches are instead being appropriated and integrated into mainstream CBT and BT. For example, from psychoanalytic and humanistic/experimental psychology, ideas about the role of emotion in psychotherapy, experiencing, insight, attachment, the therapeutic relationship (e.g., corrective emotional experience), the alliance, and the use of transference and countertransference are being increasingly integrated into modern CBT and BT approaches (Beck, 1983, 1996; Castonguay & Hill, 2007, 2012; Koerner, Kohlenberg, & Parker, 1996; Kohlenberg & Tsai, 1994; Leahy, 2008; Samoilov & Goldfried, 2000). All too often, however; these ideas are appropriated without proper or adequate acknowledgment (see, e.g., Beck, 1983, 1996; Koerner et al., 1996; Kohlenberg & Tsai, 1994).[1] Without proper acknowledgment, over time, these techniques often lose the source of their original contribution, definitional integrity, and important contemporary elaborations. Without acknowledgment, as these constructs become pantheoretical rather than conveying the importance of the original approaches, the lack of acknowledgment devalues these orientations and creates a false sense of value in the approach that appropriated them. We suggest, for the sake of good scholarship and for promoting intellectual diversity, that original and continuing sources of information are acknowledged as such.

Mechanisms Underlying Psychotherapy Efficacy

There is increasing interest in the mechanisms underlying efficacy in psychotherapy. However, all things

considered, the evidence is far from compelling that the hypothesized mechanisms in CBT are the ones actually operating in treatment (Ilardi & Craighead, 1994; Kazdin, 2006). Tests of mediation and evaluation of therapeutic changes quite early in the course of treatment suggest that improvements can readily occur without changes in cognitions or in advance of implementing cognitive-change strategies in treatment (Burns & Spangler, 2001; Ilardi & Craighead, 1994; Jacobson et al., 1996; Tang & DeRubeis, 1999). A host of studies have failed to find specific effects on specific, theory-driven mechanisms. Moreover, a number of studies have not only found that CBT therapists often utilize techniques from other approaches such as psychodynamic therapy, but that doing so is also related to good outcome (Ablon & Jones, 2002; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Jones & Pulos, 1993). Finally, studies of adherence to and competence to CBT technique have failed to find a relationship to outcome (Webb, De Rubeis, & Barber, 2010).

We contend that dynamic and humanistic approaches have had sufficient empirical support to warrant additional research, have stimulated important findings, and have been explicitly and implicitly recognized as having clinical utility through appropriation (and are thus influential—even if not recognized). Additionally, the outcome data, mechanisms research, and adherence data suggest that there is no special superiority of behavioral and cognitive-behavioral approaches as compared to psychodynamic and humanistic ones. Thus, the decreasing representation of psychodynamic and humanistic/experiential faculty in clinical training programs is inconsistent with the data and unwarranted.

RECOMMENDATIONS

Heatherington and colleagues (2012) offer a number of useful suggestions. They propose that graduate programs in clinical psychology ought to (a) prepare students to think integratively; (b) train psychotherapy clinicians, theorists, and researchers to understand the latest clinical science; (c) increase intellectual diversity; and (d) increase support and research efforts for promising approaches that are not widely available.

We do not disagree with these excellent recommendations; however, research has shown that it is difficult to change attitudes and behaviors, especially those that have formed over a long period of time, are uniformly negative, and are couched in morality (Haidt, 2012). There is also evidence from the multicultural literature that dominant cultures tend not to fully appreciate the concerns of minority cultures and moreover create structures that tend to privilege their own concerns over those of the minority group. In light of these concerns, we offer some concrete and tangible steps to implement. Although it is impossible to predict the future of our field, we believe the field will evolve toward a theoretically integrative-based, evidence-driven, cognitive-behavioral-affective-motivational, and relational approach. We believe this approach will incorporate biological, psychological, and social levels, drawing on the collective wisdom offered in various orientations to be applied at multiple levels of the clinical encounter. As this process evolves, distinctions between various disciplines that provide psychotherapy will break down and schools of psychology based on orientation, although retaining historical value, will become unneeded. Such a vision of the current trajectory of the field could open an exciting era of scientific and practice-based advancements. However, we are still far from a truly comprehensive and integrative theory of psychotherapy that operates across the different aspects of clinical work and the biological, psychological, and social levels of influence and experience. If we are going to reach such a goal, we are going to need thoughtful scholars with deep understandings of the various orientations to exist, thrive, and come together in a nonpartisan civil manner. Of equal importance will be the need for researchers who can translate complex concepts and operationalize them, teach them, and test them empirically. We do not think it is possible to achieve such integration without representation and input from diversely trained and knowledgeable scholars. The danger about which we are most concerned is that allegiance to a CBT monoculture is beginning to dominate to such an extent that scientists from alternative orientations are, for the most part, not seen as valuable bridge-builders, but as irrelevant folly or, at best, producing ideas that can be "cognitively restructured" and appropriated within the CBT complex. We focus on suggestions that can be implemented at the broad level of our discipline. There are other efforts that can be made within narrower organizations

such as the American Psychoanalytic Association of the Society for Humanistic Psychology, but those recommendations are beyond the scope of this commentary.

Our specific recommendations include the following:

1. We believe that APA and other interested parties (e.g., Psychological Clinical Science Accreditation System [PCSAS]) should establish a task force to examine the problem more thoroughly and acquire broader and better quality of data than can be derived from the Norcross and colleagues surveys. Obviously, this task force will need to be populated with clinicians and researchers representing the interests and perspectives of a diverse range of orientations, even broader than narrowly construed in our article.
2. Clinical psychology broadly, but APA in particular, should emphasize the importance of intellectual diversity and the threat posed by monocultures. APA can develop guidelines and require that APA-approved programs show evidence of preparing students to think integratively through coursework, practicum experiences, available supervision, and available mentors. Such action would not only address the issue of increasing intellectual diversity, but also help ensure successful implementation. Psychiatry has developed the Y-model, in which residency programs provide didactic time, supervision, and treatment cases from psychodynamic, CBT, and supportive psychotherapy perspectives (Plakun, Sudak, & Goldberg, 2009). This model focuses on the core features or factors that are common to those approaches as well as features that are believed to be unique to each school. Through foresight and action, they developed a model, assessed barriers and readiness for implementation, advocated for and allocated resources, and continually assess progress (Sudak & Goldberg, 2012). Adopting such a model would not only prepare our students to think integratively but would also promote greater acceptance, appreciation, and civility across different schools of thought by teaching respect for different approaches by acknowledging similarities across approaches and basic skills in relationship management that will allow for better implementation of different treatments.
3. APA should establish a fund or a foundation, possibly in collaboration with other organizations that may have a stake in this larger issue (e.g., American Psychiatric Association, American Psychoanalytic Association, Society for Humanistic Psychology), concerned with supporting diverse investigations of psychotherapy to fund psychotherapy research on promising treatments that would be likely to have a high impact on the field and practice. Funding of RCTs of treatments for which another trial would raise the level of empirical support from moderate to strong support or for studies that could resolve a controversial issue would be highly useful. Additionally, seed funding to acquire pilot data that would enhance chances of receiving National Institutes of Health (NIH) funding would be very valuable to the field. In the past, APA has invested large sums of money for various lobbying efforts with regard to scope, guild, and training issues (e.g., to establish prescriptive privileges or to address the internship imbalance problem). APA could seed this fund or foundation. A number of organizations have developed foundations to fund research. The most successful and notable is the Brain and Behavior Research Foundation (BBRF, formally known as National Association for Research in Schizophrenia and Depression [NARSAD], which is the research foundation associated with the National Association for the Mentally Ill). However, most organizations' foundations tend to be much smaller, providing seed funds, relatively small grants, or training opportunities (including postdoctoral funding and dissertation support/salary). APA has a number of awards and small grant opportunities through various American Psychological Foundation programs, but it is time that efforts be made to establish the capacity for large funding geared at establishing a broader evidence base in psychotherapy.
4. In relation to point 3 above, APA should partner with NIH and other government agencies to

explore options for addressing the need for greater pluralism in clinical psychology. Such an effort could be coordinated with other stakeholders such as the American Psychiatric Association, the Society for Psychotherapy Research, and the Society for the Exploration of Psychotherapy Integration. Review of data from eReporter (repotnih.gov) shows that the number of grants awarded examining psychodynamic- or humanistic-based interventions has all but disappeared. Additionally, the intervention committees review rosters are increasingly dominated by those identified as psychopharmocologists, and although there are some psychotherapy researchers on the rosters, they are relatively few in number and almost exclusively from one orientation. It is not uncommon for consumer groups (e.g., Cure Autism Now) as well as scientific foundations (e.g., Borderline Personality Disorder Research Foundation) to lobby, advocate, and partner up with institutes to ensure that their concerns are known to larger funding agencies. These kinds of partnerships develop into conference meetings and training opportunities, task forces, and other initiatives. Occasionally, these organizations coordinate efforts to enhance funding opportunities. Recently, APS and PCSAS have been instrumental in garnering resources to facilitate dissemination of empirical evidence regarding treatment (Szegedy-Marszak, 2012).

5. Our last recommendation might be the most difficult to implement. However, this entire endeavor may rest on this one aspect. We need to provide students with diverse mentoring opportunities. The most straightforward and expedient way to address this issue is to hire more psychodynamic and humanistic/experientially oriented faculty. We believe that it is imperative for our field's continued development for clinical training programs to increase their emphasis on hiring more intellectually diverse faculty in general, and this will include theoretical orientation.

In conclusion, we owe a huge debt of gratitude to Heatherington and colleagues (2012) for raising this important issue. They conclude their article with an elegantly worded plea: "Healthy evolution in our field, as in all fields, requires new ideas that derive from varying perspectives. As clinical science progresses, this kind of flexibility, which transcends singular allegiances to one theoretical orientation versus another, will become increasingly important in the development of theory, research, and practice" (p. 373). We could not agree more; however, we want to emphasize that we believe our longitudinal data suggest the problem is more serious and that the remedy is going to require enacting difficult and concrete actions.

ACKNOWLEDGMENTS

We gratefully acknowledge the assistance of Lina Himawan, M.S., in analyzing the data and Colleen Blake, Meghan Bobb, Sinead Burrowes, Corbin Edmondson, B.A., Jennifer Fox, Laura Frey, Natalie Geleta, Brittani Hollern, Shannon McCarrick, Kristin McLaughlin, Colleen McLinden, Erin McTiernan, Kevin Medved, Neil Meyer, Matthew Perlman, Megan Renaut, Tyler Richardson, Shirely Rojas, and Hannah Shulman for their assistance with data entry.

NOTE

1. Koerner et al. (1996) proposed a behavioral approach to diagnosis based largely on the therapist's use of their countertransference reactions and analysis. Rather than citing psychoanalytic writers such as Racker (1957), Winnicot (1949), and Kernberg (1965), who wrote extensively on this topic, they cited Kohlenberg's work from a behavioral perspective and a personal communication from a former supervisor of the lead author. Similarly, Beck (1983; Beck, Epstein, & Harrison, 1983) proposed two personality dimensions related to depression—sociotropy and autonomy—without citing Blatt's (Blatt, 1974; Blatt, D'Afflitti, & Quinlan, 1976, 1979; Blatt & Shichman, 1983; Blatt, Wein, Chevron, & Quinlan, 1979) work on self-critical and dependent depression experiences despite the obvious connections. These are extreme examples of which there are many others. There are also many other examples in which psychodynamic ideas are given brief, fleeting, and general recognition, such as in Kohlenberg and Tsai (1994), in which they mention that their focus on the relationship between the patient and therapist in session is similar to that in psychoanalytic approaches without any specific reference or going into adequate detail. In later publications, they fail to mention any relation to psychodynamic technique despite technical descriptions that are clearly similar to

prototypical psychodynamic approaches, such as interpreting transference. Instead, they suggest that this approach is a technical advance in behavior therapy.

REFERENCES

Abbass, A. A., Hancock, J. T., Henderson, J., & Kisely, S. (2006). Short-term psychodynamic psychotherapies for common mental disorders. *Cochrane Database of Systematic Reviews*, *4*, CD004687. doi:10.1002/14651858.CD004687.pub3

Ablon, J. S., & Jones, E. E. (2002). Validity of controlled clinical trials of psychotherapy: Findings from the NIMH Treatment of Depression Collaborative Research Program. *American Journal of Psychiatry*, *159*(5), 775–783.

Bateman, A., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial. *American Journal of Psychiatry*, *156*(10), 1563–1569.

Bateman, A., & Fonagy, P. (2008). 8-year follow-up of patients treated for borderline personality disorder: Mentalization-based treatment versus treatment as usual. *American Journal of Psychiatry*, *165*(5), 631–638.

Beck, A. T. (1983). Cognitive therapy of depression: New perspectives. In P. J. Clayton & J. E. Barrett (Eds.), *Treatment of depression: Old controversies and new approaches* (pp. 265–290). New York, NY: Raven Press.

Beck, A. T. (1996). Beyond belief: A theory of modes, personality, and psychopathology. In P. M. Salkovskis (Ed.), *Frontiers of cognitive therapy* (pp. 1–25). New York, NY: Guilford Press.

Beck, A. T., Epstein, N., & Harrison, R. (1983). Cognitions, attitudes and personality dimensions in depression. *British Journal of Cognitive Psychotherapy*, *1*(1), 1–16.

Blatt, S. J. (1974). Levels of object representation in anaclitic and introjective depression. *Psychoanalytic Study of the Child*, *29*, 107–157.

Blatt, S. J., D'Afflitti, J. P., & Quinlan, D. M. (1976). Experiences of depression in normal young adults. *Journal of Abnormal Psychology*, *85*, 383–389.

Blatt, S. J., D'Afflitti, J., & Quinlan, D. M. (1979). *Depressive Experiences Questionnaire (DEQ)*. Unpublished research manual, Yale University.

Blatt, S. J., & Shichman, S. (1983). Two primary configurations of psychopathology. *Psychoanalysis and Contemporary Thought*, *6*, 187–254.

Blatt, S. J., Wein, S. J., Chevron, E. S., & Quinlan, D. M. (1979). Parental representations and depression in normal young adults. *Journal of Abnormal Psychology*, *88*, 388–397.

Burns, D. D., & Spangler, D. L. (2001). Do changes in dysfunctional attitudes mediate changes in depression and anxiety in cognitive behavioral therapy? *Behavior Therapy*, *32*(2), 337–369.

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology*, *64*(3), 497–504.

Castonguay, L. G., & Hill, C. E. (2007). *Insight in psychotherapy*. Washington, DC: American Psychological Association.

Castonguay, L. G., & Hill, C. E. (Eds.). (2012). *Transformation in psychotherapy: Corrective experiences across cognitive behavioral, humanistic, and psychodynamic approaches*. Washington, DC: American Psychological Press.

Cava, A. L., & Mulder, P. (2012, August). *Assessing bias against psychodynamic psychologies with implications for training and research*. Poster presented at the Annual Convention of the American Psychological Association, Orlando, FL.

Clarkin, J., Levy, K. N., Lenzenweger, M., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *American Journal of Psychiatry*, *164*(6), 922–928.

Cooper, P. J., Murray, L., Wilson, A., & Romaniuk, H. (2003). Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression: 1. Impact on maternal mood. *British Journal of Psychiatry*, *182*(5), 412–419.

Doering, S., Hörz, S., Rentrop, M., Fischer-Kern, M., Schuster, P., Benecke, C., et al. (2010). Transference-focused psychotherapy v. treatment by community psychotherapists for borderline personality disorder: Randomised controlled trial. *British Journal of Psychiatry*, *196*(5), 389–395.

Esser, J. K. (1998). Alive and well after 25 years: A review of groupthink research. *Organizational Behavior and Human Decision Processes*, *73*(2), 116–141.

Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, *16*(5), 319–324.

Haidt, J. (2012). Left and right, right and wrong. *Science*, *337*, 525–526.

Heatherington, L., Messer, S. B., Angus, L., Strauman, T. J., Friedlander, M. L., & Kolden, G. G. (2012). The narrowing of theoretical orientations in clinical psychology doctoral training. *Clinical Psychology: Science and Practice*, *19*(4), 364–374. doi:10.1111/cpsp.12012

Ilardi, S. S., & Craighead, W. E. (1994). The role of nonspecific factors in cognitive-behavior therapy for

depression. *Clinical Psychology: Science and Practice*, *1*(2), 138–155.

Jacobson, N. S., Dobson, K. S., Truax, P. A., Addis, M. E., Koerner, K., Gollan, J. K., et al. (1996). A component analysis of cognitive-behavioral treatments for depression. *Journal of Consulting and Clinical Psychology*, *64*, 295–304.

Jones, E. E., & Pulos, S. M. (1993). Comparing the process in psychodynamic and cognitive-behavioral therapies. *Journal of Consulting and Clinical Psychology*, *61*(2), 306–316.

de Jonghe, F., Hendricksen, M., van Aalst, G., Kool, S., Peen, V., Van, R., et al. (2004). Psychotherapy alone and combined with pharmacotherapy in the treatment of depression. *British Journal of Psychiatry*, *185*(1), 37–45.

Kahneman, D. (2011). *Thinking, fast and slow*. New York, NY: Farrar, Straus and Giroux.

Kazdin, A. E. (2006). Arbitrary metrics: Implications for identifying evidence-based treatments. *American Psychologist*, *61*(1), 42–49.

Kernberg, O. F. (1965). Notes on countertransference. *Journal of the American Psychoanalytic Association*, *13*, 38–56. doi:10.1177/000306516501300102

Koerner, K., Kohlenberg, R. J., & Parker, C. R. (1996). Diagnosis of personality disorder: A radical behavioral alternative. *Journal of Consulting and Clinical Psychology*, *64* (6), 1169–1176.

Kohlenberg, R. J., & Tsai, M. (1994). Functional analytic psychotherapy: A radical behavioral approach to treatment and integration. *Journal of Psychotherapy Integration*, *4*(3), 175–201.

Larsson, B. P. M., Broberg, A. G., & Kaldo, V. (2013). Do psychotherapists with different theoretical orientations stereotype or prejudge each other? *Journal of Contemporary Psychotherapy*, 1–10. doi:10.1007/s10879-013-9231-2

Leahy, R. L. (2008). The therapeutic relationship in cognitive-behavioral therapy. *Behavioural and Cognitive Psychotherapy*, *36*(6), 769–777.

Leichsenring, F. (2001). Comparative effects of short-term psychodynamic psychotherapy and cognitive-behavioral therapy in depression: A meta-analytic approach. *Clinical Psychology Review*, *21*(3), 401–419.

Leichsenring, F., & Leibing, E. (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: A meta-analysis. *American Journal of Psychiatry*, *160*(7), 1223–1232.

Leichsenring, F., & Rabung, S. (2008). Effectiveness of long-term psychodynamic psychotherapy. *Journal of the American Medical Association*, *300*(13), 1551–1565.

Leichsenring, F., Rabung, S., & Leibing, E. (2004). The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: A meta-analysis. *Archives of General Psychiatry*, *61*(12), 1208–1216.

Leichsenring, F., Salzer, S., Jaeger, U., Kächele, H., Kreische, R., Leweke, F., et al. (2009). Short-term psychodynamic psychotherapy and cognitive-behavioral therapy in generalized anxiety disorder: A randomized, controlled trial. *American Journal of Psychiatry*, *166*(8), 875–881.

Levy, K. N., Ellison, W., Temes, C. M., & Khalsa, S. (2013, April). *The outcome of psychotherapy for borderline personality disorder: A meta-analysis*. Paper presented at the Annual Conference of the North American Society for the Study of Personality Disorders, Boston, MA.

McLeod, B. D., & Weisz, J. R. (2005). The Therapy Process Observational Coding System-Alliance Scale: Measure characteristics and prediction of outcome in usual clinical practice. *Journal of Consulting and Clinical Psychology*, *73*(2), 323–333. doi:10.1037/0022-006X.73.2.323.

Mennin, D. S., & Heimberg, R. G. (2000). The impact of comorbid mood and personality disorders in the cognitive-behavioral treatment of panic disorder. *Clinical Psychology Review*, *20*, 339–357.

Milrod, B. L., Leon, A. C., Barber, J. P., Markowitz, J. C., & Graf, E. (2007). Do comorbid personality disorders moderate panic-focused psychotherapy? An exploratory examination of the American Psychiatric Association practice guideline. *Journal of Clinical Psychiatry*, *68*(6), 885–891.

Milrod, B., Leon, A. C., Busch, F., Rudden, M., Schwalberg, M., Clarkin, J., et al. (2007). A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. *American Journal of Psychiatry*, *164*(2), 265–272.

Norcross, J. C., & Sayette, M. A. (2012). *Insider's guide to graduate programs in clinical and counseling psychology: 2012/2013 edition*. New York, NY: Guilford Press.

Park, W. W. (2011). A review of research on groupthink. *Journal of Behavioral Decision Making*, *3*(4), 229–245.

Plakun, E., Sudak, D. M., & Goldberg, D. (2009). The Y model: Integrated, evidence-based approach to teaching of psychotherapy competencies. *Journal of Psychiatric Practice*, *15*(1), 5–11.

Racker, H. (1957). The meanings and uses of countertransference. *Psychoanalytic Quarterly*, *26*, 303–357.

Samoilov, A., & Goldfried, M. R. (2000). Role of emotion in cognitive-behavior therapy. *Clinical Psychology: Science and Practice*, 7(4), 373–385.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist*, *65*(2), 98–109.

Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, *32* (9), 752–760.

Snyder, D. K., Wills, R. M., & Grady-Fletcher, A. (1991). Long-term effectiveness of behavioral versus insight-oriented marital therapy: A 4-year follow-up study. *Journal of Consulting and Clinical Psychology*, *59*(1), 138–141.

Stiles, W. B., Barkham, M., Mellor-Clark, J., & Connell, J. (2008). Effectiveness of cognitive-behavioural, person-centred, and psychodynamic therapies in UK primary-care routine practice: Replication in a larger sample. *Psychological Medicine*, *38*(5), 677–688.

Sudak, D. M., & Goldberg, D. A. (2012). Trends in psychotherapy training: A national survey of psychiatry residency training. *Academic Psychiatry*, *36*(5), 369–373.

Szegedy-Marszak, M. (2012). Clinical science training and beyond. *Observer*, *25*(7), 21–23.

Tang, T. Z., & DeRubeis, R. J. (1999). Sudden gains and critical sessions in cognitive-behavioral therapy for depression. *Journal of Consulting and Clinical Psychology*, *67* (6), 894–904.

Wampold, B. E., Budge, S. L., Laska, K. M., Del Re, A. C., Baardseth, T. P., Flűckiger, C., ... Gunn, W. (2011). Evidence-based treatments for depression and anxiety versus treatment-as-usual: A meta-analysis of direct comparisons. *Clinical Psychology Review*, *31*(8), 1304–1312.

Watson, J. C., Gordon, L. B., Stermac, L., Kalogerakos, F., & Steckley, P. (2003). Comparing the effectiveness of process-experiential with cognitive-behavioral psychotherapy in the treatment of depression. *Journal of Consulting and Clinical Psychology*, *71*(4), 773–781.

Webb, C. A., DeRubeis, R. J., & Barber, J. P. (2010). Therapist adherence/competence and treatment outcome: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *78*(2), 200–211.

Weisz, J. R., Southam-Gerow, M. A., Gordis, E. B., Connor-Smith, J. K., Chu, B. C., Langer, D. A., … Weiss, B. (2009). Cognitive-behavioral therapy versus usual clinical care for youth depression: An initial test of transportability to community clinics and clinicians. *Journal of Consulting and Clinical Psychology*, 77(3), 383–396. doi:10.1037/a0013877

Whitfield, J. (2008). Collaboration: Group theory. *Nature*, *455*, 720–723.

Winnicott, D. W. (1949). Hate in the countertransference. *International Journal of Psychoanalysis*, *30*, 69–75.

Received January 21, 2013; revised March 6, 2013; accepted March 6, 2013.