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Do Psychotherapists with Different Theoretical Orientations Stereotype or Prejudge Each Other?

Billy P. M. Larsson · Anders G. Broberg · Viktor Kaldo

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Abstract This study investigates a possible threat to the progress of psychotherapy. It aims to detect and compare stereotyped or even prejudiced views among psychotherapists of different theoretical orientations, building on social psychological theory of in-groups and out-groups. Swedish psychotherapists ($n = 416$) of four different orientations (psychodynamic, cognitive, behavioural, or integrative/eclectic) used the valuable elements in psychotherapy questionnaire to rate the importance of various elements in psychotherapy. They also estimated how therapists of other orientations would rate these elements. These estimates were then compared with therapists' actual self-ratings in order to detect patterns of stereotyping or prejudiced views. Psychotherapists exaggerate the differences between their own and other orientations in a stereotyped way, but correctly predict what members of their own orientation (in-group) find important. However, they overestimate how important 'orientation-typical features' are to those of other orientations (out-group), indicating a clear tendency to stereotype. Overall, integrative/eclectic therapists' estimates were less stereotyped than the estimates of therapists of other orientations. A somewhat unexpected finding was that cognitive and behavioural therapists seem more inclined towards stereotyping. The stereotyped views of other theoretical orientations among psychotherapists can be argued to have negative connotations and may thus be seen as prejudices. These prejudices could create irrational and unnecessary obstacles to the development of both the science and the practice of psychotherapy and signal the need for psychotherapists of all orientations to develop a more balanced picture of each other.

Keywords Integrative psychotherapy · Theoretical orientation · Psychotherapist attitudes · Stereotype · Prejudice · In-group out-group

B. P. M. Larsson (✉) · A. G. Broberg
Department of Psychology, University of Gothenburg, Box 500, SE 405 30 Göteborg, Sweden
e-mail: billy.larsson@psy.gu.se

V. Kaldo
Section of Psychiatry, Department of Clinical Neuroscience, Karolinska Institutet, Stockholm, Sweden

One of the most obvious differences between the field of psychotherapy and other fields in the health care system is that psychotherapy is organized in different and somewhat competing theoretical orientations or schools in psychotherapy. Discussion or research about the consequences of this divisive organization is rare. One of the most prominent proponents for integration, John Norcross, has emphasized how this division presents an obstacle to progress within the field of psychotherapy (Dattilio and Norcross 2006; Norcross and Thomas 1988). Ideally, progress within the field of psychotherapy would lead to the development of a common evidence-based science, without clear divisions between the different theoretical schools, similar to that of other research areas in the health care system. If the development towards a common science is desirable, a continuing trans-theoretical dialogue seems necessary (Mahoney et al. 1989). Investigations of possible obstacles to this progress would also be valuable.

Empirical research into psychological group processes between psychotherapists of different theoretical orientations may be useful in these investigations. Social psychology research has shown that people often rely on simplistic views (stereotypes) about other groups (Operatio and Fiske 2001), which can be negative ('Italians are lazy') or positive ('Germans work hard'). Negative stereotypes,

also called prejudices, often arise when people see themselves as belonging to one group (an in-group) that is different to other groups (out-groups) (Dovidio and Gaertner 2006). Because of the different theoretical schools, psychotherapists are likely to identify with an in-group (psychotherapists of their own orientation) that contrasts with specific out-groups (other orientations) and so are likely to have a positive bias towards their in-group and some form of antagonism against the out-group—the classic "us against them" attitude. If so, therapists could be less motivated to favour the development of a common science of psychotherapy.

In an Israeli study of practitioners' views of the three main theoretical orientations—psychoanalytic, eclectic, and behavioural—therapists were asked to rate both their own personality characteristics and those of a 'typical therapist' of the three orientations (Keinan et al. 1989). When the self-ratings of each group were compared to their estimated ratings of typical therapists of their own orientation, psychoanalysts saw themselves as more action-oriented and less insight-oriented than the 'typical analyst,' while the behaviourists saw themselves as more insight-oriented than the 'typical behaviourist'. This shows that therapists stereotype others in their own orientation and see themselves as more flexible. A similar phenomenon was observed when the self-ratings of therapists of one orientation were compared with estimates of this orientation made by practitioners of the other two orientations. Here too the discrepancies indicated that the orientations held stereotypical views of each other.

The study of Keinan et al. needs to be replicated, because it failed to investigate many interesting aspects of stereotypes and how well they fit with the group theory of in-groups versus out-groups. For example, are therapists who identify themselves as eclectic or integrative less likely to stereotype other orientations? This should be the case if their in-group identity is not as strong as those of the purer theoretical orientations. The in-group/out-group model would also predict that stereotypes, and definitely prejudices, would be more pronounced in estimates of other orientations than in estimates of one's own. Other unexplored areas are whether stereotyped estimates are related to the therapist's orientation or to other factors, and whether therapists misjudge the importance of common factors within other orientations.

To answer such questions, Swedish psychotherapists are an appropriate population to study because the training programs for psychotherapists are clearly separated by theoretical orientation in Sweden. Three steps are required to become a licensed psychotherapist. First, it is necessary to have a basic training in a psychosocial or medical profession. Second, all psychotherapists have a basic psychotherapy education on a half-time basis for one and a half years. This basic training started 1985 and had an exclusive psychodynamic orientation then since the psychodynamic orientation has been dominant in Sweden. However, beginning in 1987, the Swedish association for behaviour therapy organized basic training with a behavioural orientation, and 1990 it also became possible to get a basic training in psychotherapy with a cognitive orientation. Finally, after 3 years of working with psychotherapy, it is possible to apply for a formal psychotherapist education on a half-time basis for 3 years, leading to a licence as a psychotherapist. For therapists who want to work with adults in individual therapy, this education has one of three orientations; psychodynamic, cognitive, or behavioural. Within each education several sub schools are described, for example in the psychodynamic orientation, Freud, Lacan, object relation theory and self psychology. Historically in Sweden, there is has been a sharp distinction between cognitive and behavioural theoretical orientations—arising from their introductions via two different associations that developed their own training regimes—and only in recent years have those associations begun to cooperate more. All psychotherapists, irrespective of orientation, get some education about other orientations in the basic psychotherapy training. To be licensed as a cognitive psychotherapist, it has been allowed to had the basic education for one and a half years within a psychodynamic orientation, and then a cognitive orientation in the formal training during 3 years to become a cognitive psychotherapists.

This study is part of a research project aimed to elucidate some of the conditions for integration in psychotherapy. A previous study in the project focused on psychotherapists' attitudes towards valuable elements in psychotherapy according to psychodynamic, cognitive, behavioural, or integrative/eclectic therapists (Larsson et al. 2009). The main results of that study showed that therapists of different orientations had very similar opinions about the importance of the therapeutic relationship and other common factors and fairly similar views of the goals of therapy, but that they differed a great deal on which techniques should be used. A second study evaluated the psychometric properties of the valuable elements in psychotherapy questionnaire (VEP-Q) with positive results and found that theoretical orientation was the strongest predictor of ratings on both its psychodynamic therapy (PDT) and cognitive-behavioural (CBT) scales, but had no relation to the scale measuring common factors (Larsson et al. 2010). This newly developed measure and therapist sample is the basis for the current study.

Aims and Hypothesis

The comprehensive aim of this study was to investigate whether psychotherapists can correctly estimate how therapists of different orientations rate the importance of various aspects of practicing psychotherapy, or whether these

ratings reflect stereotyped or even prejudiced perceptions of practitioners of the other orientations, in line with the in-group/out-group phenomena.

Four hypotheses were tested: (1) practitioners from different theoretical orientations misjudge each other in stereotypical ways; (2) therapists are less likely to use stereotypes in their estimations of those within their own orientation (in-group) than of therapists from other orientations (out-groups); (3) the smallest stereotypical misjudgement will be found in the estimates made by integrative/eclectic therapists; and (4) the general tendency to make stereotypical estimates would not differ between psychodynamic, cognitive, and behavioural therapists and would be better predicted by factors other than the therapist's orientation. The issue of whether misjudgements should be seen as stereotypes or prejudices is not tested directly with a specific hypothesis but is discussed in light of the empirical findings.

Methods

Participants

The questionnaire (VEP-Q) was mailed during November 2004 to 931 psychotherapists. A group of 676 therapists constituted a random and representative sample of 15 % of the psychotherapists licensed at that time by the National Board of Health and Welfare. Since the psychodynamic orientation is still so dominant in Sweden, few therapists with cognitive or behavioural orientations were expected in this representative sample. The questionnaire was therefore also sent to 255 licensed cognitive and behavioural therapists, listed by their professional bodies. After two reminders, a total of 760 therapists had responded, for an 82 % response rate over the two samples. To be included in the study, the therapists had to be actively working with adults and regard themselves as practicing within the same orientation they were licensed in, or to define themselves as eclectic. Thus, for example, therapists with a psychodynamic licence who now regarded themselves as cognitive therapists were not included. The final sample consisted of 416 therapists divided into four 'pure' orientations: 161 psychodynamic therapists, 93 cognitive therapists, 95 behavioural therapists, and 67 integrative/eclectic therapists. Background data for these are presented in Table 1; a fuller account of their characteristics and the recruitment process is offered in Larsson et al. (2009).

Measures

The VEP-Q includes a total of 106 items, divided into five sections. In two sections the therapists were asked to assess their own opinions of different psychotherapeutic issues.

The first of these sections asked about the *mainfocus of therapy*. Therapists were asked which focus they deemed as most important in their own work, given five options: (1) the therapeutic relationship, (2) the patient's thoughts, (3) the patient's feelings, (4) the patient's behaviour, or (5) the connection between the patient's behaviour, thoughts, and feelings (connection focus). Next they were asked to assess which of these foci they thought were considered most important by other therapists, depending on orientation—psychodynamic, cognitive, and behavioural. The reason to allow for two preferences was to increase the variation in the answers, since we expected many to choose the connection focus if only allowed one choice.

In the second section, therapists were asked 17 questions about important aspects of psychotherapy. These questions were not only a result from theoretical and empirical studies, but experienced psychotherapists from different orientations contributed with valuable comments to a pilot version of the questionnaire too. For these questions a Likert-type five-point scale was used (1 = not important at all, 2 = somewhat important, 3 = important, 4 = very important, and 5 = extremely important). After a factor analysis, these 17 items were transformed into the three scales that were used in this article: PDT, CBT, and common factors (CF). The VEP-Q was developed by the authors and the psychometric qualities of these scales have been explored in Larsson et al. (2010). The reliability was good to excellent, with Chronbach's alphas ranging from 0.77 to 0.86, and test–retest between 0.82 and 0.96. The VEP-Q also showed high construct validity in differentiating between therapists of different orientations.

In a subsequent section, therapists were asked to estimate how they thought psychodynamic, cognitive, and behavioural psychotherapists in general would answer each of the previous questions. Each item asked was prefaced with, 'How important do you believe therapists within each orientation find…'. Respondents then gave an answer for each of the three orientations. This design made it possible to compare therapists' estimates of other orientations' opinions with the actual opinions of those other therapists.

Definition of Stereotyped Estimates

A stereotyped estimate is defined as an estimate that exaggerates the theoretically typical features of the orientation being estimated. The scale measuring common factors was not considered in the definition of a stereotyped estimate.

Concerning the CBT scale and the PDT scale, estimates of psychodynamic therapists were considered stereotypical if they were too high (i.e. higher than the actual self-rating) on the PDT scale and too low on the CBT scale. Conversely, estimates of cognitive or behavioural therapists were considered stereotypical if they were too low on the PDT scale and too high on the CBT scale.

Table 1 Background factors of psychotherapists of different orientations

	PDT (max $n = 161$)	CT (max $n = 93$)	BT (max $n = 95$)	I/E (max $n = 67$)	Statistics[a]
Sex					
Female	76 % (122)	80 % (74)	56 % (53)	61 % (41)	$\chi^2(3) = 18.1$; $p < 0.001$
Male	24 % (39)	20 % (9)	44 % (42)	39 % (26)	
Age					
Years, M (SD)	57 (6.9)	53 (6.8)	52 (6.4)	56 (6.7)	F = 14.8; $p < 0.001$
Basic training					
Psychologist	52 % (84)	31 % (29)	82 % (78)	58 % (39)	$\chi^2(12) = 70.9$; $p < 0.001$
Social worker	22 % (35)	23 % (21)	8 % (8)	13 % (9)	
Psychiatrist	9 % (14)	24 % (22)	1 % (1)	10 % (7)	
Nurse/care worker	6 % (10)	17 % (16)	5 % (5)	8 % (5)	
Other	11 % (18)	5 % (5)	3 % (3)	10 % (7)	
Years licensed as a therapist					
Mean (SD)	10 (5.5)	5 (3.5)	9 (6.4)	10 (6.0)	F = 21.2; $p < 0.001$
Most important aspect of training					
Basic professional training	22 % (34)	26 % (24)	32 % (29)	40 % (25)	$\chi^2(9) = 86.9$; $p < 0.001$
Licence as psychotherapist	51 % (79)	40 % (36)	24 % (22)	36 % (23)	
Orientation of education	12 % (19)	20 % (18)	37 % (34)	5 % (3)	
No one element	15 % (23)	14 % (13)	7 % (6)	19 % (12)	
Own orientation more 'applied science' than the others?					
No, all are 'applied science'	92 % (134)	38 % (33)	5 % (5)	84 % (37)	$\chi^2(3) = 200.4$; $p < 0.001$
Yes	8 % (11)	62 % (55)	95 % (87)	16 % (7)	

PDT psychodynamic therapy, *CT* cognitive therapy, *BT* behavioural therapy, *I/E* integrative or eclectic therapy

[a] ANOVA or Chi-square statistics depending on the nature of data

Concerning the question about the main focus of therapy, estimates of psychodynamic therapists were defined as stereotypical if the main focus were judged to be only on emotions, only on the therapeutic relationship or on both. For estimates of behaviour therapists, a main focus on only behaviour or on behaviour and thoughts were seen as stereotypical. Finally, estimating cognitive therapists to have a main focus only on patients' thoughts or on thoughts and behaviour were considered stereotypical. If one of the possible two answers was a main focus on the connection between emotions, thoughts, and behaviour it was never considered stereotypical regardless of what the second answer was.

Index of Stereotypical Misjudgement

To measure the degree to which a therapist tended to make stereotypical misjudgements, an index based on the PDT scale and the CBT scale was calculated. Positive values on this index represent a tendency to make misjudgements in a stereotypical direction, and negative values show a tendency to make estimations in a non-stereotypical direction.

To measure how important a 'general therapist' of a specific orientation *actually* found the PDT and CBT ingredients in psychotherapy, the average of all self-ratings within each orientation was calculated for each scale. These values (found in Table 2) were then used as the benchmark or 'true' opinions of each orientation. Each orientation's *estimates* of how important therapists from other schools would find the PDT and CBT ingredients were similarly calculated by averaging their estimates of each orientation for each respective scale. The differences between these estimated values and the 'true' values were calculated to represent the level of misjudgement in each estimate.

Misjudgements in a stereotypical direction, according to the definitions above, increased the index value, while misjudgements in the opposite direction decreased it. For example, the difference between an estimate of 4.9 for the CBT scale for cognitive therapists in general and the actual average self-rating of all cognitive therapists of 4.33 would be 0.57. Since the estimate overrates how important cognitive therapists actually find the CBT factors, the therapist's stereotyping index would be increased by 0.57. If the same difference in ratings on the CBT scale had been for psychodynamic therapists, on the other hand, the index would instead have been decreased by 0.57, since the misjudgement was *not* in the stereotypical direction.

Each therapist estimated each of the three orientations on two scales (CBT and PDT). However, the stereotyping

Table 2 What is important in psychotherapy? Estimates of therapist attitudes compared to their actual self-ratings

Therapists making the estimate	Therapists being estimated								
	Psychodynamic			Cognitive			Behavioural		
	M (SD)	Effect size[a]	ANOVA statistics	M (SD)	Effect size[a]	ANOVA statistics	M (SD)	Effect size[a]	ANOVA statistics
How important are CBT factors in psychotherapy?									
Psychodynamic	2.92 (0.68)	0.14	F(4, 536) = 48.6; $p < 0.001$	4.40 (0.47)	0.16	F(4, 479) = 16.3; $p < 0.001$	4.65 (0.39)	0.14	F(4, 483) = 1.8; $p = 0.13$
Integrative/eclectic	2.75 (0.84)	−0.35*		4.27 (0.49)	0.10		4.62 (0.37)	0.07	
Cognitive	2.22 (0.66)	−1.18*		4.53 (0.44)	0.42*		4.69 (0.39)	0.23	
Behavioural	1.94 (0.61)	−1.65*		3.92 (0.77)	−0.62*		4.73 (0.37)	0.35	
Actual self-rating[b]	3.02 (0.70)			4.33 (0.51)			4.58 (0.48)		
How important are PDT factors?									
Psychodynamic	4.38 (0.58)	0.54*	F(4, 545) = 19.0; $p < 0.001$	1.93 (0.79)	−1.32*	F(4, 445) = 43.7; $p < 0.001$	1.43 (0.64)	−1.00*	F(4, 477) = 19.9; $p < 0.001$
Integrative/eclectic	4.33 (0.54)	0.53*		2.44 (0.82)	−0.67*		1.60 (0.78)	−0.66*	
Cognitive	4.46 (0.52)	0.75*		3.13 (0.84)	0.12		1.74 (0.72)	−0.48*	
Behavioural	4.63 (0.49)	1.04*		2.84 (0.78)	−0.19		2.09 (0.63)	0.06	
Actual self-rating[b]	4.01 (0.74)			3.00 (0.82)			2.05 (0.62)		
How important are common factors?									
Psychodynamic	4.45 (0.49)	0.08	F(4, 538) = 25.6; $p < 0.001$	3.86 (0.72)	−1.18*	F(4, 474) = 27.6; $p < 0.001$	3.62 (0.80)	−1.11*	F(4, 472) = 24.5; $p < 0.001$
Integrative/eclectic	4.24 (0.60)	−0.29		4.08 (0.64)	−0.86*		3.70 (0.78)	−1.00*	
Cognitive	4.00 (0.68)	−0.68*		4.45 (0.46)	−0.2		3.85 (0.73)	−0.80*	
Behavioural	3.77 (0.73)	−1.03*		4.16 (0.61)	−0.73*		4.32 (0.56)	−0.02	
Actual self-rating[b]	4.41(0.48)			4.54 (0.44)			4.33 (0.50)		

* $p < 0.01$ (Dunnett's post hoc test within the ANOVA, using the actual self-rating as comparison group)

[a] Cohen's d for each estimate compared to the actual self-rating

[b] The actual self-rating of the therapists being estimated

index only considers estimates of *other* orientations than one's own, so except for the integrative/eclectic therapists, each therapist's index was calculated from four (two orientations × two scales) stereotypical or non-stereotypical misjudgements.

Because of the closeness between the cognitive and behavioural orientations, and their representation together on the scale of CBT factors, there was a risk that each therapist, in estimating for them separately, would have two estimates of the combined cognitive/behavioural school counted compared with only one estimate of the psychodynamic school. To avoid this, the *mean* of these two estimates were used to represent one single estimate of the CBT orientation as a whole. This correction would not have been necessary had another orientation more closely related to PDT (for example psychoanalysis) been included, but as this was not the case, we decided to apply the correction.

Statistical Analyses

ANOVAs were used to find any overall difference between estimates of what others find important in therapy (the VEP-Q scales) and actual self-ratings. Dunnett's post hoc test was then used to compare each of the four estimates with the actual self-ratings, and Cohen's d was also calculated to show the strength of these differences. Chi square tests were used to analyze data from the questions about focus in psychotherapy. To compare the different orientations on the index measuring overall stereotyped misjudgements, ANCOVAs were used (controlling for some background variables) together with Sidak post hoc tests. A two-step hierarchical regression was used to compare theoretical orientation (coded as dummy variables before being entered in the second step of the regression; see "Results" section for a closer description) to other factors on their impact on stereotyped misjudgements. A conservative alpha level of 0.01 was used. The samples were deemed large enough to achieve sufficient statistical power.

Results

Overview of Estimates Compared to Actual Self-Ratings

Table 2 shows how therapists from different orientations believe psychodynamic, cognitive, and behavioural therapists in general would rate the importance of the three different VEP-Q scales, compared to their actual self-ratings.

To compare the estimates of what therapists of different orientations believe should be the main focus in therapy to their actual self-ratings a number of Chi square tests were performed as presented in Table 3.

Do Practitioners from Different Theoretical Orientations Misjudge Each Other in Stereotypical Ways?

In 20 of the 27 out-group comparisons shown in Table 2, there was a statistically significant misjudgement (stereotypical or not) of how important a therapist of a particular orientation would believe a certain factor to be in psychotherapy. The most correct judgments were of how important behavioural therapists believe the CBT factors to be, and none of these estimates deviated statistically from the actual self-ratings. Of the 18 out-group estimates made for the CBT and PDT scales, 11 were significantly misjudged, and of these all except one could be defined as stereotyping. The one exception was that behavioural therapists actually underestimated the importance of the CBT scale to cognitive therapists.

Table 3 shows that compared to the self-ratings in the last row, the estimates of other therapists' predicted main focus in therapy were often highly stereotyped. Of all nine out-group comparisons, eight were significantly stereotyped, most with strong effects as shown by Phi correlations ranging from 0.37 to 0.74. Taken together, the empirical findings do support the first hypothesis.

Are Estimations of Other Therapists Within One's Own Orientation (In-Group) Less Stereotyped than Estimations of Therapists of Other Orientations (Out-Group)?

Table 2 shows that when therapists estimate what therapists of their own orientation find important, the overall deviation from the actual self-ratings is markedly lower than when the estimation is done by therapists of other orientations. Out of nine estimations, psychodynamic therapists significantly overestimated their psychodynamic colleagues' ratings on the PDT scale, and cognitive therapists overestimated other cognitive therapists' ratings on the CBT scale. Both of these were stereotyped misjudgements; however, the effect sizes were rather small. Overall, the average effect sizes of the misjudgements were 0.21 for the in-group estimates and 0.70 for the out-group estimates.

Table 3 shows that the three Phi correlations (0.04, 0.07, and 0.15) for in-group estimates of the main focus of therapy were all non-significant and much lower than for the out-group estimates. Thus, the data also support hypothesis two.

Are the Smallest Stereotypical Misjudgements Found Among Integrative/Eclectic Therapists?

For integrative/eclectic therapists, the out-group effect sizes in Table 2 show that they are less stereotypical in their estimates than psychodynamic therapists in all estimates and cognitive or behavioural therapists in estimates

Table 3 What should be the main focus in psychotherapy? Estimates of therapist attitudes compared to their actual self-ratings

Therapists making the estimate	Therapists being estimated						
	Stereotypical?	Psychodynamic		Cognitive		Behavioural	
		n (%)	Phi	*n* (%)	Phi	*n* (%)	Phi
Psychodynamic	Yes	38(27)	0.15	57(43)	0.45*	83(59)	0.58*
	No	104(73)		75(57)		58(41)	
Cognitive	Yes	75(90)	0.74*	1(1)	0.04	35(40)	0.47*
	No	8(10)		85(99)		52(60)	
Behavioural	Yes	69(80)	0.65*	23(29)	0.37*	4(4)	0.07
	No	17(20)		57(71)		84(96)	
Eclectic	Yes	13(30)	0.17	12(29)	0.41*	20(44)	0.56*
	No	30(70)		29(71)		25(56)	
Actual self-ratings	Yes	21(15)		2(2)		2(2)	
	No	124(85)		86(98)		91(98)	

The number of stereotyped estimates (according to definitions described in the "Methods" section) compared to the number of therapists who actually rate themselves in a stereotypical way. All analyses are 2 × 2 Chi square tests (with Phi correlations) always using the actual self-ratings shown in italics in the last row as the comparison group

* Chi square with $p < 0.01$

of psychodynamic therapists. However, when cognitive and behavioural therapists estimate each other, they are often more accurate than integrative/eclectic therapists. The same basic pattern is found for estimates regarding the main focus of therapy in Table 3. Taken together with findings presented in the section below, these results support hypothesis three that integrative/eclectic therapists are generally less inclined to stereotyping than others.

Do Psychodynamic, Cognitive, and Behavioural Therapists Tend Equally Towards Stereotyping, and are Factors Other than Theoretical Orientation Stronger Predictors of Stereotyped Estimates?

The index for stereotyped estimates calculated from the CBT and PDT subscales of the VEP-Q was compared among the four different orientations in an ANCOVA using age and years since being licensed as covariates. The overall test results were significant ($F[3, 365] = 12.0$; $p < 0.001$), and theoretical orientation explained 9.0 % of the variance (partial Eta squared) in the index. Post-hoc tests showed that cognitive and behavioural therapists scored significantly higher on the index than did psychodynamic and eclectic therapists (all p-values <0.01). Integrative/eclectic therapists had the lowest scores, but not significantly lower than psychodynamic therapists. The largest difference was between cognitive and integrative/eclectic therapists with an effect size of 0.84 (Cohen's d) and the smallest (non-significant) difference was found between cognitive and behavioural therapists (Cohen's d = 0.19).

To test whether theoretical orientation was a stronger predictor of stereotyped estimates than other factors, a two-step hierarchical regression was performed. First, 16 possible predictor variables from the VEP-Q were screened, excluding the factors with non-significant correlation with stereotyped estimates (gender, basic professional training, preferred number of therapeutic orientations in the future, being a supervisor, years licensed as a therapist, number of treated clients, and opinions regarding which philosophy of science is best suited to psychotherapy and its status as a form of art or as an applied science).

Age, willingness to refer clients to a therapist of another orientation, perceived importance of a therapist's orientation, and specific importance of theoretical orientation to therapy outcome were all significantly correlated (r = 0.10–0.14) to stereotyped estimates, but because they showed a large overlap with the three chosen variables presented below and did not add to the total amount of variance explained, they were excluded from the final regression analysis.

Three variables (see Table 1 for descriptive data) were included in the final regression: (1) number of years with a licence, (2) believing that one's own theoretical orientation matters more than being a psychotherapist or the basic professional training one has, and (3) believing that one's own orientation is better characterized as an applied science than others. When added in the first step of the hierarchical regression, they together explained 11.1 % of the variance ($F[3, 319] = 13.30$; $p < 0.001$).

In step two, theoretical orientation was added in the form of three dichotomous dummy variables according to a

method for including categorical variables in linear regression (Field 2005). This increased the explanatory power significantly (F[3, 319] = 3.95; $p < 0.01$) to a total of 14.3 % of the variance. The standardized coefficients for the dummy variables cannot be interpreted comprehensively, but the beta-values for the three other predictors moved to 0.01 for more years with a licence (n.s.), 0.11 for believing the theoretical orientation to be most important ($p < 0.05$), and 0.25 for the belief that one's own orientation is better characterized as applied science than others ($0 < 0.01$).

The data presented in this section do not support the hypothesis that therapists of all orientations show an equal tendency to be stereotypical in their estimations of others. Instead, they suggest that behavioural and cognitive therapists are generally more likely to stereotype than psychodynamic and integrative/eclectic therapists. However, data do support the prediction that factors other than theoretical orientation may play a large role in stereotyped misjudgements.

Discussion

The aim of this study was to examine the existence and extent of stereotypes and prejudices among different schools of psychotherapy. Large misjudgements were regularly found when therapists estimated the beliefs and attitudes of therapists belonging to orientations other than their own. Psychotherapists were shown to hold stereotyped views of practitioners of other orientations and to exaggerate the differences between their own orientation and others. These results are in line with the results of Keinan et al. (1989), and point to the possibility that the division of the field of psychotherapy into different theoretical schools is at least partly upheld by in-group/out-group mechanisms well known from social psychology (Brewer 2007).

The existence of in-group/out-group mechanisms is further strengthened by the finding that psychotherapists estimated the attitudes of therapists of their own theoretical orientation much more accurately. The few significant in-group misjudgements that were found were very small compared to out-group estimations. These results moderate the results of Keinan et al. (1989), where larger within-groups effects were found. The hypothesis that integrative/eclectic therapists tend towards less stereotyping in their estimates overall were confirmed. This disconfirms the previous findings of Keinan et al. (1989) that eclectic therapists were just as inclined towards stereotyping as psychoanalytic and behavioural therapists.

One unexpected and interesting finding did occur in our analysis. We had predicted that there would be no differences between orientations other than integrative/eclectic therapists being less inclined to stereotype (which they were), but the index used to measure an individual's tendency to make stereotypical estimates showed that cognitive and behavioural therapists were more inclined to stereotype than other therapists. To find a possible explanation for this, the specific analysis of factors influencing stereotyping becomes much more important. Two factors other than theoretical orientation predicted stereotypic estimates: (1) identifying the orientation of the therapist as more important than other factors, and (2) the belief that one's own orientation is better characterized as an applied science than other orientations. These factors are, in fact, statistically stronger predictors of stereotyped estimates than orientation per se. Both of these factors, however, and especially (2), are strongly related to the CBT orientations, as shown in Table 1. These could then be the key characteristics in explaining why CBT therapists seem more inclined towards stereotyping. It is not unreasonable to assume that a stronger belief in the importance of the theoretical orientation (also found in other variables presented in Larsson et al. 2009) goes hand in hand with a more pronounced in-group/out-group view of other orientations. Because scientific evaluation of therapy is highly valued within the CBT community, it is likely that this fosters stereotyped views of other orientations deemed to be less empirically based.

Another observation that supports the existence of in-group/out-group processes within the field of psychotherapy is that therapists seem to regard psychotherapy within their own orientation as more multifaceted than psychotherapy in the other orientations. Two arguments support this. The first is that all orientations regard the common factors as more important than they believe the other orientations do. The second is that therapists also thought that their own orientation often had a more complex focus in psychotherapy (a connection focus together with a focus on the therapeutic relationship) than other orientations had. Since both of these aspects (common factors and complex foci) describe a more complex viewpoint and a less single-minded focus on techniques, it could imply that therapists in all theoretical orientations view their own orientation as a more advanced form of psychotherapy, and other orientations as somewhat less complex forms of psychotherapy.

The psychotherapists' views of other orientations found in this study have been described as stereotypes, which can be either negative or positive. Just estimating how important a certain aspect of psychotherapy is for another orientation does not fully explore whether this reflects a positive or negative view of that orientation. However, two arguments support defining our findings more strongly as prejudices, i.e. negative stereotypes of out-groups (Brewer 2007; Stroebe and Insko 1989). The first argument derives from our findings related to the scale measuring common

factors (CF scale).The theoretically neutral status of the CF scale was shown in a previous study (Larsson et al. 2010), in which all orientations had very similar and very high ratings. Since all therapists find these common factors important, it is reasonable to argue that a therapist who assumes that another therapist finds these common factors less important likely holds a negative opinion of that other therapist. This is not as clear for misjudgements on the CBT and the PDT scales, which might reflect the belief that a therapist of any one orientation should actually focus on the typical features of that orientation, regardless of their importance to one's own, but the low estimates on the theoretically neutral CF scale increase the likelihood that the misjudgements reflect prejudices rather than stereotypes.

The second argument follows the same line of reasoning. We know from previous research (Larsson et al. 2009) that therapists of all orientations have a positive view of a 'connection and relation focus' in therapy, which can be defined as both theoretically neutral and more complex than a more narrow focus on only thoughts or behaviours, for example. The findings that therapists underestimate how important these aspects are in orientations other than their own can thus be interpreted as a negatively exaggerated view (prejudice), rather than a pure misjudgement.

Prejudices were originally conceptualized as irrational and pathological, but later came to be regarded as a normal psychological phenomenon (Hodson et al. 2009). Because prejudice is a normal psychological phenomenon, therefore, it should come as no surprise that psychotherapists appear to follow the same pattern of acquiring prejudices as other people. Psychotherapists need to have a nuanced picture of humans in general including themselves, because assessing people is a part of the job. Obviously, however, this does not prevent them from establishing prejudiced attitudes towards psychotherapists in groups other than their own.

To our knowledge, the social psychology in-group/out-group explanation has not been used before in the context of psychotherapy schools. The theory of territorial instinct has, however, been proposed (Dattilio and Norcross 2006).We suggest that the group psychology explanation is preferable to the theory of territorial instinct because it is a well-known psychological concept, while the instinct theory tries to use a concept from biology appropriate for describing animals protection of their territory for food, and then transform it to psychotherapy integration by meaning a sphere or field of scholarship. The in-group/out-group phenomenon can also better explain why integrative/eclectic therapists are less inclined to prejudice because they do not have a strong identification with a specific in-group.

The division of therapists into different schools could create an irrational and prejudiced-based obstacle to psychotherapists' ability to see similarities with therapists of orientations other than their own; knowing this, however, might inspire the orientations to discuss whether it is necessary and desirable to preserve the various schools or whether it would be more valuable to look for common ground. Research indicates, for example, that different orientations are more similar in their practice of psychotherapy than theory would predict (Ablon and Jones 1998; Goldfried et al. 1998; Thompson-Brenner and Westen 2005). Furthermore, research about common factors in psychotherapy suggests that these factors are more important than specific techniques are (Norcross 2011). However, as long as there are different therapeutic schools, the representatives of different orientations will still have a tendency to search for differences rather than to look for similarities between their own group and other orientations.

The main limitations of this study are: it is mono-cultural and includes only Swedish therapists; the correlational design prevents causal interpretations; and stereotyped estimates are difficult to define and measure theoretically and operationally. Concerning the last point, the index that was used to measure stereotyped estimates includes a possible confounder. As explained in the methods section, the mean of the estimates of cognitive and behavioural therapists was used as one value representing an estimate of CBT. A reanalysis carried out without this procedure found that psychodynamic therapists were the most likely to stereotype; however, integrative/eclectics were still the least likely. Although we find this merging of estimates of cognitive and behavioural well motivated to avoid a statistical artefact, it might be too simplistic. The conclusion that CBT therapists tend more towards stereotyping than other therapists should therefore be treated with caution. Furthermore, since data was collected for this study, the Swedish Association for Cognitive Psychotherapy and the Swedish Association for Behaviour Therapy have begun to cooperate more, possibly resulting in a more nuanced picture of each other.

Finally, although we controlled for some important possible confounders there can be other such factors, for example how the psychotherapist relates and adjusts to a client's preference for a certain style.

We recommend that future research take a closer look at how stereotypes and prejudices develop over time through education and clinical work related to psychotherapy, perhaps by using Kegan's stage theory, whose usefulness for psychotherapy research has been proposed by Eriksen (Eriksen 2008). It is also important to study the actual consequences of prejudice among therapists and to evaluate different ways to change exaggerated negative attitudes towards other theoretical orientations.

We hope this study will contribute to the clinical field by demonstrating how therapists exaggerate differences between theoretical orientations and by encouraging debate

about how the field of psychotherapy ought to be organized in the future, based more on valid perceptions and arguments than on stereotypes and prejudices. We urge all psychotherapists, the next time you are involved with psychotherapists of an orientation other than your own, please remember that they are not as different from you as you may think.

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