

Sustained and Sustaining Continuing Education for Therapists

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Abstract

Thirty-eight therapists who completed a continuing education program of two years duration participated in an evaluation of the effect of that program on the way they conducted therapy and on themselves as individuals. The program differed from most continuing education offerings both in its on-going nature and in its emphasis on an interactive and dynamic use of material rather than a purely didactic presentation. The evaluation resulted in a quantitative and qualitative description of the changes resulting from participation in this program. Participants describe changes relevant to improving the quality of the therapeutic alliance, an increased ability to work effectively with difficult patients, as well as increased self-awareness. This evaluation of the experience of a mature (over 10 years in operation) program is significant at a point where APA is considering a broader conceptualization of continuing education models. These results also point to the importance of thoroughly evaluating the effect of continuing education.

### Sustained and Sustaining Continuing Education for Therapists

The American Psychological Association recently conducted an online interest survey on continuing education options. One option offered a more sustained exposure to material and included the possibility of supervision. This is an interesting initiative that contrasts strongly with the current common model of one-time, very brief, continuing education seminars. The most recent APA Monitor on Psychology (March 2006) included an article on “How psychologists change.” This was a series of personal reflections, but interestingly not one referred to an experience with an APA sponsored continuing education workshop.

These two pieces raise interesting questions. What do we really know about the effect of the current continuing education model? What do we know about why and how therapists change? The lack of an adequate model in this area is evidenced by two further considerations. First, the extensive research on the factors influencing therapy outcomes has had minimal impact on the way we design continuing education. Continuing education programs seldom address the therapeutic alliance other than to note briefly that it is important. Second, these programs even more rarely include supervision, despite ample evidence that the therapeutic alliance is a critical element of change in patients and the supervisory alliance in supervision is an important element of change in therapists.

Most continuing education is currently offered through content based workshops or conferences, most of which consist either of single presentations of varying length, or a collection of briefer presentations. This three hour to several day workshop model implies that most therapy consists of collections of therapeutic techniques that can be improved through exposure to a discrete amount of information. This follows the medical model in which

participants in workshops can learn new procedures or new techniques, or in the use of new medications. In some cases this is appropriate in Psychology. For example, workshops may educate participants on the nuances and appropriate use of new assessment instruments. Here an emphasis on technique is critical. Similarly, workshops focusing on ethical issues and an understanding of psychotropic medications appropriately present important content.

Therapy, however, is more than application of a technique. Relying on the current practice of content based workshops presents two problems: the interpersonal relationship factor that is critical to therapy outcome is not adequately addressed, and the evaluation of these workshops is limited to whether or not the presenters did what they said they were going to do. No follow-up is done to see what effects, if any, the workshop may have had on the participants, or on their therapy and its effectiveness.

The most clearly defined form of content-based therapy training is in presentations of techniques that have been codified in manuals. While manualized therapies have been shown to be effective, some research indicates that improvement may be limited to that group of clients who are highly motivated and embedded in supportive social networks. Clients with less social support and with characterological issues underlying their presenting problem may need interventions that skillfully target the interpersonal source of their adaptive difficulties (Norcross, 2001; Hilliard., Henry, and Strupp, 2000; Sherborne, 1995; Steenbarger, 1994; Horowitz, Rosenberg & Bartholomew 1993). Interestingly, Binder (2004) concludes that there is no evidence of the superiority of manualized therapies. This conclusion is striking because it comes from one of the originators of manualized therapy (with Strupp). In light of such considerations, some researchers have expressed concern that “the skillful, theoretically sophisticated therapist is being replaced by technicians with very limited training and expertise” (Strupp and Anderson, p.

78 in Garfield, 1997). They have found that the most rigid adherence to manualized therapies and techniques is likely to be seen in insecure therapists. The over-reliance on technique thus obscures attention to the ongoing relationship with the patient, focusing instead on relieving the anxiety of the therapist.

Further, research indicates two problems commonly encountered by therapists that are similarly not addressed in continuing education: consistently high rates of patient-initiated premature termination; and few sound studies examining strategies that prevent premature termination (Ogrodniczuk, Joyce, & Piper, 2005; Piper, Joyce, McCallum & Azim, 1998; Baekeland & Lundwall, 1975). At the same time, there have also been several studies suggesting that longer term therapy has an advantage over short term in terms of the maintenance of gains over time (Hansen, 2002; Shapiro, 1995). Clearly it is important to know how to engage a patient, and how to develop and maintain that engagement to achieve therapeutic goals.

Regardless of approach used, most of the research indicates that the factor most predictive of positive outcome in therapy is the strength of the therapeutic alliance (e.g. Stein & Lambert, 1995; Baekeland et al, 1975; Piper, Ogrodniczuk, Joyce, McCallum, Rosie, O'Kelly, & Steinberg, 1999; Piper, Azim, Joyce, & McCallum, 1991; Barber, Connolly, Crits-Cristoph, Gladis, & Siqueland, 2000; Aveline, 2005; Horvath & Symonds, 1991; Hilliard, Henry, & Strupp, 2000). Further, therapists' skill in developing a positive therapeutic alliance is not consistently predicted by level of training (Horvath, 2001).

Moreover, evaluation of the impact of the content-based workshop model of continuing education is minimal, so we really don't know the effect on therapists or on therapy. At the end of each workshop, participants are asked to complete an evaluation form geared to the content goals of the presentation. These are sent to the accrediting agency, and little more is heard.

This workshop approach provides educational snapshots with no evaluative follow up in the dimensions deemed important to therapeutic success. This is a problem since research has demonstrated that therapeutic skill does not necessarily increase as a function of increased experience (Beutler, 1997) especially in the absence of regular feedback to therapists (Hannan & Lambert, 2005). We need to know what sorts of continuing education will demonstrably increase therapeutic skill.

This study is an evaluation of a continuing education program. It is significant because the program is ongoing (a model similar to what APA is proposing), focuses on aspects central to the therapeutic alliance, and evaluates change in the therapist and in the way the therapist conducts therapy. The specific program (APA approved) originates in psychodynamic theories and therapy, and was designed and offered by Jill and David Scharff through the International Psychoanalytic Institute (IPI) (see *Tuning the Therapeutic Instrument: Affective Learning of Psychotherapy* by Jill Scharff & David Scharff, 2000). The IPI two year Core Training Program targets established mental health professionals, and has been operating now for over 10 years. Participants commit to two eight-day summer institutes and eight three-day weekends. Reading is required in preparation for each segment. Each segment consists of a series of didactic presentations interspersed with large group processing of the material, and small “affective groups” where the material is made personal in a focused examination of the ongoing interpersonal patterns in the small group; over the course of the two years, each small group meets 64 times. Thus the emotional component of the theory is experienced and worked with as a central part of the training. The theoretical framework is broadly psychodynamic, rooted in Object Relations, though the training explores contemporary work in attachment theory and variants of Object Relations theory, as well as other psychodynamic approaches.

This is not the only program of its kind for experienced therapists. However, it presents a unique opportunity to assess the effect of a mature program that incorporates the implicit goals of the new training initiative being explored by APA. The point of this paper is not to promote psychodynamic training, but to explore the effect of continuing education of an ongoing nature that has some focus on the self-awareness of the therapist and that pays clear attention to the nuances of the therapeutic alliance. It is also an attempt to evaluate a continuing education program in more depth than is the common practice.

The issues examined in the study are: why therapists elected this type of training, which clearly greatly exceeds normal continuing education requirements; when in their careers they seek this training; what effect it has on the way they do therapy; and what part of the training was experienced as producing the greatest change in how they conducted therapy and how they viewed themselves as professionals.

### Method

*Participants:* All participants are graduates of the two year Core Programs in Object Relations Theory and Therapy. Fifty six individuals completed the program in the first eight years of its existence. Questionnaires were sent to all graduates; 38 (68%) returned a completed questionnaire, 7 males and 31 females. Two (females) declined to participate, and 14 did not respond. (Some of the non-responders have moved since completing the program, and their addresses were unknown.)

Participants come from all over the United States, and from Panama (12 from the East coast, 6 from the Midwest, 3 from the South, 7 from the Intermountain West, 3 from the West Coast, and 7 from Panama). The average age of the participants was 50, ranging from 32 to 73

years of age. Prior training included Ph.D. in clinical psychology (10 participants), Ed.D. in Counseling Psychology (3), MSW (11), MS/MA in Psychology (9), and the Panamanian degree, Licenciante (2). The 32 full time therapists had been working full time for an average of seven years, with 11 of them having extensive (average of 7 years) previous part-time experience. Four of the participants maintained a part-time practice, with an average of eight years of experience. The majority were in private practice (n = 21), but others were in public clinics, inpatient settings, or working in some combination of the above.

*Questionnaire development:* The questionnaire was developed following in depth interviews of four graduates of the Core Program chosen by the IPI faculty to represent the spectrum of participants. The interviews were conducted by faculty members, using a core set of common questions focusing on central goals of the training, as well as the graduates' volunteered comments about the training. Themes emerging in the interviews, along with the stated objectives of the educational program, were used to create a questionnaire designed to evaluate relative satisfaction with aspects of the program, as well as the change in the participant's practice as a result of their participation.

Questionnaires were mailed to all graduates of the program. The informed consent form was separate from the questionnaire, and the questionnaires were number coded to preserve the anonymity of respondents. The final questionnaire included demographic questions and structured questions derived from the interviews that were rated on a 5 point scale. Space was provided after every question for optional comments. The structured questions for rating were designed to evaluate specific changes in practice as a result of the program, as well as to determine what parts of the program participants found particularly helpful or not helpful. Most

of the respondents volunteered comments, which are included in the results as a qualitative element.

## Results

Results are presented in the order in which the questions were defined in the introduction to this paper.

### *What attracted people to this intensive form of continuing education?*

Most of the respondents had received graduate training in theories and therapies other than psychodynamic, with only a few ( $n = 7$ ) having received training in dynamic approaches in their graduate work. When they entered the program, 61% of the respondents were not using the methods they were trained in as graduate students; most of them stated they were dissatisfied with the models of their graduate training. They had been exposed to psychodynamic theory and therapy through local workshops, personal therapy, and/or reading and wanted further training in this approach.

### *What was the impact of the two year IPI program on participants' professional development?*

Nearly all respondents were “very glad” (92%) to have participated in the program. Three were “glad.” No one was “unhappy” or “ambivalent” about the training they received. The majority (79%) said it changed the way they conducted therapy. The most frequently cited benefit (76%) was an increased ability to handle difficult patients effectively. They noted being more confident in their work, more clear in their conceptualizations, and more likely to use an awareness of the interpersonal dynamic (including transference and countertransference). Several noted that the approach they learned made their work more interesting and alive. Examples of comments volunteered include:

- I have an increased ability to deal with those clients who attempt to get their needs met in maladaptive, alienating, and sometimes bizarre ways. I am slower to irritation and frustration, and have fewer anxiety provoking episodes.
- The use of myself is now a central tool and has increased my ability to connect and work with patients. They have reported the same to me.
- The training provided me with an entirely different way of being with a patient—truly being with them rather than teaching them.
- Commitment to using oneself seems to me to increase the integrity of the work. I also suspect focus on the relational aspects and being honestly in the room with the patient is better for them than simply focusing on them as a suffering person.

Specific positive effects were noted almost uniformly. Most of the respondents (84%) thought their therapeutic effectiveness had increased as a result of their training. Their perceptions were based on objective measures such as a reduction in premature terminations, a very low rate of clients who left after 1 to 3 visits, and an increased demand for their services. They also noted a more subjective sense of seeing emotional growth and development in their patients. In some cases their perception of increased efficacy was based on patient satisfaction surveys. The majority (74%) felt the training helped them think clearly and specifically, both about assessment issues and specific interventions. A majority (87%) were happy that the training connected them with a larger professional community of support where they could continue to learn; this was an unintended benefit of the program.

*What was learned, and what was the impact?*

*Participants' use of Object Relations concepts before and after training.*

The questionnaire focused on a number of concepts the IPI faculty considered central to the training program. Participants were asked to use a 5 point scale (1 = do not understand, do not use; 5 = central to my work) to rate how much they used the concept before and after training, as well as how much they felt their clinical work was affected by incorporating that concept.

The first group of concepts is common to most approaches to therapy: environmental holding (attention to the physical space), emotional containment, and the therapeutic frame (attention to time boundaries, management of fees, and after-hours phone calls). The average ratings (mean ratings ranged from 3.4 to 3.7) indicated that most participants used these approaches prior to the IPI training, but had changed the way they used them after training. The changes included an increase in their awareness of the role of these “rules” in protecting and supporting the development of the interpersonal relationship, and in their confidence in their use of them (mean after-training ratings ranged from 4.1 to 4.3, where a rating of 4 indicated the participant understood the concept and used it frequently and confidently).

Evaluating their attention to the specifics of the client-therapist relationship prior to training, participants indicated they had some familiarity with the terms, but had made little or no use of them in actual clinical work (e.g. focused attention on the interpersonal space, transference, countertransference, working in the “here and now” of the relationship, projective and introjective identification and working with their own feelings and associations in the therapy). Ratings of this cluster of concepts was somewhat lower (mean ratings ranged between 2.5 to 3.3) than the mean ratings of the first group of concepts. After-training ratings indicated a substantial increase in participants’ understanding and confident use of these aspects of therapy (mean ratings ranged between 4.0 and 4.6).

Least understood prior to the IPI training was the cluster of intrapersonal dynamics that contribute heavily to the quality of the interpersonal relationship (e.g., states of mind, the internal object world). The dynamic described by concepts are particular to this theoretical orientation, but bear strong relationship to concepts such as attachment style and the internal working model derived from attachment history, both of which contribute strong, unconscious determination to

the quality of interpersonal relationships in the here and now. These constructs were rated as neither familiar nor understood prior to training (mean ratings range from 1.9 to 2.6). After training, participants again indicated a substantial increase in both their understanding and confident and frequent use of these constructs (mean ratings ranged between 3.7 for states of mind, to 4.6)

Thus, prior to training, participants were not as conscious of the interpersonal function of common boundary setting practices in protecting the therapeutic relationship, and even less attentive to interpersonal dynamics in therapeutic assessment and change. The least familiar constructs were those describing the personality structures and dynamics, constructs specific to object relations theory. After training, most participants felt confident in their application of these to their clinical work.

When asked to rate how much their approach to therapy had changed as a result of the training, 8% participants said a moderate amount, 37% felt it had changed a great deal, and 45% indicated they had made major changes. No one indicated that their approach hadn't changed much, or not at all. Some of the comments were as follows:

- It moved me out of intellectualized approaches that were more akin to psychoeducation into an openness and world of depth that continues to surprise me. My patients seem to respond well to the reflective space that is now the focus.
- Putting many analytic concepts into motion with an understanding of what I'm doing while achieving significant results has been quite a monumental achievement, a source of pride, has garnered respect of me by clinicians and academicians.
- I have made changes in my use of myself, my expectations of success, and my understanding of therapeutic failures.
- I certainly understand the concepts better, but more importantly can use them because of my personal affective experience in the core program small group.
- I thought I had been working with projection, here and now, etc., but discovered I had only just started. I feel much more confident. I use the ideas as central although I know I still miss more than I'm aware of.

In general, participants thought they had learned the concepts the Institute considers “core,” and were able to apply them with increased confidence. These core concepts focus on the development of the interpersonal relationship, and the way in which that can illuminate intrapersonal dynamics.

*How did the training change the participants as therapists and as individuals?*

In this section, participants were first asked to indicate, by a rating scale ranging from 0-not relevant to 5-a critical and significant change, how the training changed them as therapists. The largest overall change they indicated was “increased sensitivity to my affective responses as an important part of the therapeutic process” (mean = 4.4), closely followed by “increased ability to use the therapist-patient relationship as an important element in the therapeutic process” and “increased ability to tolerate and think about difficult emotions, and to contain them” (mean = 4.3). Next in order of significance were “increased ability to use the therapist-patient relationship as an important element in assessment” and “increased confidence in my ability as a therapist” (mean for each = 4.0). Other changes rated in the “considerable change” range included “increased aliveness of the therapeutic sessions,” “increased sense of being able to effect change in clients,” and “increased hope about the therapeutic process.” Only two items received ratings below 1 (between not relevant and minimal change): one had to do with the extra effort required being exhausting, and the other was “increased skepticism about the therapeutic enterprise.” These items were included because this kind of therapy is intensely demanding of the therapist’s attention and emotional energy, and because there is general skepticism in parts of the therapeutic community about the effectiveness of psychodynamic therapy.

Participants were also asked about the effect of the training on themselves as persons. Ninety five percent of the respondents indicated that it had increased their sensitivity to their role in relationships, and 97% indicated an increased awareness of the effects of their own internal object world both in their therapeutic relationships and in their personal relationships. Some comments volunteered:

- I feel, from the inside, friendlier, less combative and defensive, less shocking (I used to be quite shocking—I like to shock still, but it is more useful, less destructive). I've been called "loving" more often. I'm funnier, both in my personal world and definitely as a therapist.
- Decreased operation from a paranoid-schizoid position, increased my ego strength. It was a life-altering experience.
- Increased confidence in the validity and use of my reactions.

Thus the strongest and most widespread effect of the training was an increased ability to fine-tune the therapeutic or working alliance, using that as part of the therapy. Much of the change had to do with increased sensitivity to themselves and what they brought, consciously or unconsciously, to their interpersonal interactions.

*What about the training was most helpful to learning and applying these core concepts?*

The IPI training contains many elements. Those elements were rated (0 - not effective to 5 - extremely effective. The small affective groups (structure and purpose are elaborated in the next section) were rated as most important (mean = 4.6), followed by lectures (mean = 4.0), assigned readings (mean = 3.9), large group discussions (mean = 3.8) and plenary meetings (mean = 2.7).

For most of the respondents, involvement in this focused form of continuing education did not stop after the two year core program, which can be seen as another indicator of the perceived value of the program. The majority (87%) elected to obtain supervision from faculty, and rated that very positively (mean = 4.75). A number (71%) became involved in personal

therapy, and saw that as similarly very helpful to extremely important (mean = 4.6). Over half continued to be involved in a variety of programs offered through IPI (e.g. 71% are involved in study groups, 39% in Master Lecture Videoconferences, 76% attend weekend conferences from time to time, 32% have added participation in the Couples and Family Institute offered by IPI).

The use of the affective group process is central to the didactic philosophy of the Institute. While the participants found the traditional continuing education components (reading, lecture, and discussion) useful, they consistently rated the small affective groups most highly as contributing to their ability to master and use the material. It is also noteworthy that so many went on to request supervision, personal therapy, and to view their learning process as continuing after the end of the two year program.

*What made this program different?*

The use of an affective model of learning is one of the distinguishing features of IPI. Participants meet in small groups to discuss the material that has been read or presented, and at the same time to examine their emotional responses to it. As each participant attempts to do this, a group process develops, in which the concepts being studied can be seen to affect both the behavior and the emotional responses of the group. Each small group is led by an experienced faculty member and remains intact throughout the 2 year experience, and has a total of at least 64 on hour sessions together. The majority of respondents (84%) found this approach to be different from any other training they had been involved in previously. When asked what made it different, participants indicated that the small group process: facilitated the integration of the conceptual and theoretical material with affective content (97%); brought the concepts to life as they were experienced in the group relationships (92%); required learning on a deeply personal level rather than on just an intellectual and technical level (89%); involved working in the small

group with people who are focused on understanding the material in their lives as well as in the life of the group (89%); and provided containment that allowed participants to take in new material and be changed by it (84%). In effect, the affective group experience provided participants with practice using the concepts. This increased understanding and made it more likely that they would be immediately incorporated into therapeutic practice. At the same time, the small group experience enhanced self-awareness in a context that encouraged curiosity; participants not only learned how to work with the concepts, but also how to use those concepts in understanding themselves in relationships. Additionally, the faculty facilitator modeled how one might technically and experientially deal with such material. Comments volunteered include the following:

- The consistency of the theory, with the personal emotions of the therapist, make what is being learned real.
- It definitely led to a shift inside me that led to my positive growth.
- It was similar to gestalt training which was in a group process, and my academic training which used a group process model. So all the areas listed I had experienced before, but the on-going structure and organization made it more alive and provided learning in a deeper way.
- It allowed me to explore my own emotional responses and provided concepts with which to better understand them.
- It has deepened my understanding of OR concepts and techniques in such a way that my practice has been both enlivened and enlightened. I've especially benefited from the affective model, its focus on the use of the therapist's self, and its emphasis on the current transference-countertransference matrix between analyst and analysand.

#### Discussion:

This study had three goals: to look at an alternative model of continuing education in terms of its ability to change therapeutic practice; to see if participants felt that the focus on the interpersonal relationship, or therapeutic alliance, improved the quality of the therapy they offered; and to do an evaluation that identified both the areas of change in therapeutic practice and the elements that most contributed to those changes.

There are obvious limitations to the study. This form of continuing education was clearly sought by a group of highly motivated therapists who had been working in the field for a time, and who found themselves less than satisfied with approaches taught in their graduate training. They may or may not be unusual. They actively committed to this form of training; both the expense and the hours involved go far beyond what is required by state licensing boards. Once involved, most of these therapists undertook more engagement, primarily through supervision, but also in ongoing forms of exposure to the material. The reports of gains are based on the subjective sense of the respondents, with the most “objective” measures being the dropout rate and length of therapy; there was no evaluation of patient reports of therapeutic alliance, or of patient improvement. While these qualify the results, they do not invalidate them.

The results clearly indicate that the participants changed the way they worked in therapy. Further, they changed as individuals and as therapists. Some of the concepts presented in the training were not new to them, particularly those related to the structural elements of therapy (e.g. use of time, payment issues). While they knew and used them as a set of rules, they had not thought of them in terms of how they can be used more consciously to affect the therapeutic relationship. So, the therapists changed the way they used old concepts. They also learned new concepts, and reported being able to use most of them comfortably. The most important vehicle of change was not the presentation of material in reading or lecture; it was the experience of the material in the small affective groups. This element seems to have given them the lived understanding that allowed them to move the training into their practice. Importantly, all participants were pleased that they had undertaken this training.

Other measures of the importance of this training to the therapists include the indicators of their desire to continue their association with the institute. A majority of the participants was

sufficiently committed to incorporating what they learned that they sought supervision both during and following the Core Program. Most of the participants found ways to continue learning through the contacts they established, through continuing participation in ongoing seminars of various sorts, and through personal therapy. Not only was it a truly sustained and continuing educational experience, it appears to have become a continuing and truly sustaining experience that is maintained. This should be effective in preventing therapist burnout, a significant issue for many experienced therapists.

The focus on the interpersonal relationships, partly in the didactic aspects, but most particularly in the affective groups, had a strong effect on the participants. The program encouraged intense focus on self-understanding, and attention to relationships in the here and now. Each participant was provided feedback in how others experienced him/her, as well as ample opportunity to reflect on his or her interpersonal and intrapersonal life in the group setting. Comments volunteered, as well as the pattern of responses, suggest that participants gained in self-awareness. Participants felt they had changed as individuals, becoming more sensitive to their impact on others, more able to understand their own internal dynamics and how those dynamics affect who they are in relationship. They used what they learned to develop deep and comfortable therapeutic alliances with their patients, an important element of successful therapy. They indicated an increased ability to stay with the painful affect that difficult clients bring and produce in others, and to remain empathetic and analytic in the face of this intensity. These therapists were challenged to take responsibility for their contribution to therapeutic relationships, which should result in improved therapeutic alliances.

The deepened understanding of themselves and their impact on others increased their confidence in themselves as therapists. The conceptual material allowed them to remain open

and curious about difficult moments in therapy, rather than resorting to an educational mode that might allay their own anxiety. They commented that they thought they were able to work more effectively and confidently with difficult patients and difficult emotional material. This kind of curious, focused attention to the nuances of the therapeutic relationship should also provide the ongoing feedback to the therapist about what is occurring, and provide it in a fairly natural context. This kind of feedback has been suggested as a critical element in increasing the effectiveness of a therapist's work (Miller, Duncan, Sorrell, and Brown, 2005). It would be seem at least as effective to attend to this feedback in an ongoing and focused way as to do periodic assessments using a standardized questionnaire (which is what those authors propose, a kind of manualized evaluation).

A number of the participants noted that their patients noticed the difference. An interesting indicator of this is found in the very low proportion of patients who terminate prematurely. Most of the participants indicated that roughly 90% of those who come for a first appointment stayed engaged in therapy over an extended period of time. While the practice statistics of this group might not excite managed care, the majority of respondents indicated that most of their patients engaged in long term therapy, with the short-term engagement that is posed as the norm being unusual.

Finally, while response rates were respectable (68%), but not perfect, this in-depth evaluation gives more information about what works and why, what changes were made and how. The results of this survey do not simply evaluate whether or not the participants learned a set of concepts; they also indicate whether or not the participants use the concepts in their current therapy, and whether or not they feel that changing the way they work has changed the effectiveness of their therapy, and of themselves as therapists. Participants said they changed the

way they worked, and found their therapy to be more effective. While such an intensive and extended educational experience and follow up cannot be offered for all forms of continuing education for therapists, perhaps it should be done on occasion. It might be interesting to perform follow-up evaluations on the current short term continuing education programs to see what changes, if any, result from participation.

The implication of this study is that there should be options for intensive mid-career training for therapists, and that continuing education requirements should be flexible enough to allow such concentrated training to be followed by periods of less involvement in continuing education. Perhaps the “snapshot” brief workshops should be seen as introductions to possible intensive, ongoing options. Supervision focusing on the therapeutic alliance seems to be effective as a form of continuing education. APA appears to be moving in the direction of offering more sustained (and perhaps sustaining) continuing education opportunities with supervision, and these results support that direction.

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