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Changing Attitudes Toward Evidence-Based Psychodynamic Psychotherapy

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Many clinicians hold misperceptions about evidence-based practice (EBP), and evidence-based psychodynamic therapy (PDT) in particular. It is important to address these beliefs and attitudes in graduate training and help students to consider evidence-based interventions from a range of theoretical orientations. This study reports on a required 15-week course in evidence-based PDT within two graduate psychology doctoral programs. Eighty-five students completed measures of attitudes toward EBP and PDT prior to the first class and after the final class. Students who identified with different theoretical orientations—integrative, CBT, or PDT—did not differ in attitudes toward EBP, and student attitudes toward EBP remained stable. Students with a precourse CBT orientation viewed PDT less favorably than those with a psychodynamic orientation. Attitudes toward PDT improved significantly across all orientations, but CBT-oriented students reported the largest gains in positive attitudes toward PDT as compared to students with a PDT or integrative orientation. The results support the use of graduate training in evidence-based PDT to improve attitudes toward specific aspects of EBP and PDT. Findings also highlight the mutability of student attitudes and the potential for fostering an integrative approach to EBP that includes PDT. Further research is warranted to examine whether graduate courses in EBP can lead to use of a wider range of therapy interventions with clients.

Keywords: evidence-based, psychodynamic, graduate training, attitude change

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There has been a clear and consistent move toward the use of evidence-based practices (EBPs) in psychotherapy over the past four decades. Evidence-based practice is often described as a three-legged stool that rests on seeking empirical evidence to support the use of specific treatments in combination with clinical judgment and expertise, and client values and preferences. In practice, this often means providing empirically supported treatments (ESTs; e.g., manualized, evidence-based treatments) and incorporating other techniques to adjust to particular client needs, client comorbidities, or previous treatment responses (e.g., Szkodny et al., 2014). Recent research suggests that many therapists are reluctant to implement EBP (Lilienfeld et al., 2013), and that this may be due in part to variations in clinician's training (Pignotti & Thyer, 2009), and less than favorable attitudes regarding the use of certain evidence-based approaches.

Evidence-Based Psychodynamic Practice

Evidence-based practice is not wedded to any one theoretical position or orientation but reflects an approach to knowledge and a strategy for improving the outcomes of treatment that uses research evidence to improve client care (see American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006). In essence, EBP holds that treatments, of whatever theoretical persuasion, need to be based on objective and scientifically credible evidence (Ollendick, 2014). Despite this, there is a widely held view that PDTs are not evidence-based (Becker-Haimes et al., 2019; Hofmann, 2016). Under the EBP umbrella, ESTs are specific, manualized treatments for a specific population/disorder (e.g., Mentalization-Based Treatment for borderline personality disorder) that have demonstrated efficacy in controlled research settings.

Empirically supported treatments are often mistakenly thought to be synonymous with cognitive behavioral therapy (CBT) interventions (Becker-Haimes et al., 2019; Dozois et al., 2014; Luebbe et al., 2007; Shedler, 2018). However, the list of ESTs promoted by APA's Division 12, also includes several psychodynamic treatments (PDTs), such as Short-Term Psychodynamic Therapy for Depression (Luborsky et al., 1995), Panic-Focused Psychodynamic Psychotherapy for Panic Disorder (Milrod et al., 1997), Mentalization-Based Treatment (Bateman, 2006), and Transference-Focused Psychotherapy (Clarkin & Kernberg, 2015) for Borderline Personality Disorder. Among youth, Mentalization-Based Treatment for Adolescents (MBT-A; Rossouw & Fonagy, 2012) for self-injury, Short-Term Psychoanalytical Psychotherapy for adolescent depression (Goodyer et al., 2017), and dyadic psychodynamic interventions for trauma-exposed children, maternal depression, and intimate partner violence have all demonstrated efficacy (Guild et al., 2017; Lieberman et al., 2006). There is ample support for evidence-based PDT for a broad range of psychiatric problems (Fonagy, 2015; Leichsenring et al., 2015; Steinert et al., 2017).

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Several reviews of the empirical literature have shown that PDT is as effective as CBT treatments (Driessen et al., 2015), and possibly even more effective in the long term (Kivlighan et al., 2015). Training of graduate students in psychodynamic interventions, is associated with a positive treatment effect (Hilsenroth et al., 2006), as well as high client and therapist-rated alliance (Hilsenroth et al., 2015). The aforementioned biases against PDT thus form an obstacle to the use of evidence-based PDTs and integration of psychodynamic techniques into EBP, by excluding part of the available evidence-base (Larsson et al., 2009), possibly jeopardizing the credibility of the overall scientific field (Abbass et al., 2017).

Graduate Teaching in Evidence-Based Practice

Historically, the vast majority of doctoral and social work programs have not required any training in EBP at all (Weissman et al., 2006), which means that many licensed clinicians around the world have received little guidance on how to integrate a range of ESTs into their psychotherapy practice (Aafjes-van Doorn et al., 2018). More recently, education on EBP appears to be gaining popularity (Pidano & Whitcomb, 2012), and the American Psychological Association (APA) now requires graduate programs to provide training in EBP (American Psychological Association Office of Program Accreditation, 2015). In line with the current push for EBP, most clinical educators, therapists, and trainees now identify training in EBP as a priority. Most would agree that in order to produce skilled and well-rounded clinicians and to provide a range of treatment options to clients in the community, it is important to enhance students' knowledge about EBP (Babione, 2010; Bauer, 2007).

Training in EBP in graduate schools has the potential to address biases against ESTs and evidence-based PDT specifically. Knowledge of EBP appears to be associated with more favorable attitudes toward EBP (Bearman et al., 2015; Nakamura et al., 2011). Training in graduate school and the influence of a significant mentor were among the greatest determinants of current practice in a survey of 2,607 providers (Cook et al., 2009). Graduate programs have an opportunity and an ethical obligation to train students in a range of ESTs, including their clinical and theoretical differences and research evidence (Babione, 2010). Students should be exposed to empirical literature on client and therapist characteristics, process variables, and treatment outcomes that cut across theoretical orientations as well as those that are unique to particular approaches (Beck et al., 2014). There is a need for diversity and plurality, with students receiving training and supervision in a range of modalities, including evidence-based PDT (Heatherington et al., 2012). Exposing students to different theories and visions of reality enriches their understanding of clients and ways to treat them, including the possibility of shifting perspectives, thereby encompassing more of the complexity of clients' experiences (Heatherington et al., 2012). Students may then learn to recognize the limits of a particular theoretical model and its associated techniques when applied to particular types of clients and contexts, and make informed clinical treatment decisions (Goldfried et al., 2014). In other words, in order to help the next generation of therapists to become well-rounded, integrative, informed practitioners, graduate training on EBP should include a range of models, including evidence-based PDT (Beck et al., 2014).

At the start of graduate school, initial opinions about the importance of EBP and PDT might be informed by students' preexisting assumptions. For example, a student's allegiance to a particular theoretical orientation (Addis & Krasnow, 2000; Nelson & Steele, 2007; Poznanski & McLennan, 1999), may be influenced by their familiarity with RCTs or other types of research evidence. Moreover, a person with a more rational style—who acquires information through intellectualized judgment or based on logical reasoning—, or identifies with a CBT orientation might be affected by the empirical RCT data because this focus provides a good fit for the kind of information this person would attend to when making decisions. On the other hand, a person who emphasizes intuition—who acquires information based on what one feels to be true even without conscious reasoning—, or those with a psychodynamic orientation may see ESTs as sterile and limiting the freedom to respond to a client's individual characteristics based on intuitive reactions (Seligman et al., 2016; Stewart et al., 2012). University training has been shown to influence and shape theoretical orientation, particularly within a cognitive behavioral paradigm (Poznanski & McLennan, 2003). Additionally, personal therapy has been described as "the epicenter of the educational universe for psychotherapists" (Norcross, 2005, p. 841). The choice to pursue personal therapy is closely linked with theoretical orientation, with psychodynamic practitioners being far more likely to pursue personal therapy than their CBT counterparts (Bike et al., 2009).

Despite the emphasis on the incorporation of the latest of empirical research in the training of clinicians (Cherry et al., 2018; Summers, 2018), very little is known about how to teach graduate students about evidence-based PDT. Currently, there are no well-defined models for teaching evidence-based PDT to psychology graduate students and little is known about how such courses impact attitudes toward EBP and evidence-based PDT.

Aims & Hypotheses

This study sought to explore the impact of graduate courses in evidence-based PDT on students' attitudes toward EBP generally and evidence-based PDTs specifically. The current evaluation builds on the study by Bearman et al. (2015) which focused on students' attitudes toward EBP in the context of a course focused on cognitive behavioral interventions for youth. In order to gain a broader understanding of students' views of EBP before and after these evidence-based PDT courses, we assessed the role of several demographic variables, including personal therapy and theoretical orientation before the course. Based on the previous literature, we expected that: (a) students would differ in their precourse attitudes toward EBP, depending on their theoretical orientation; specifically, CBT-oriented students would have more favorable attitudes toward EBP than PDT or integrative students; (b) students would differ in their precourse attitudes toward PDT, with PDT-oriented students holding more favorable attitudes toward PDT than their CBT or integrative counterparts; (c) all students would report more favorable attitudes toward EBP at the conclusion of the course than at the start; (d) all students would report a more positive assessment of evidence-based PDT at the conclusion of the course than at the start of the course.

Method

Participants

All participants were psychology doctoral students (n = 85) enrolled in either a school-clinical child psychology combined

doctoral program (n = 35 third year students) or an adult clinical psychology doctoral program (n = 50 first year students), both APA accredited. All students were enrolled in a required course on evidence-based PDT taught within their program. These graduate student trainees were an average age of 26.86 (SD = 4.68, Range = 22–49), the majority of students where White (n = 69; 81.2%) and female (n = 70; 82.4%). About half of all students reported being in personal therapy themselves. At the beginning of the course, the majority of students described themselves as integrative, with the remainder identifying with a cognitive behavioral or psychodynamic orientation. The characteristics of the students are shown in Supplemental Table 1. This study was approved by Yeshiva University's Institutional Review Board: Western IRB. Prior to the start of the course and at the conclusion of the course, all enrolled students were asked to complete an online survey. Although the study occurred in the context of a required, evaluative course, it was clearly communicated that study participation was voluntary.

Course Description

Although the content and format of the evidence-based PDT courses were very similar, the course taught within the School-Clinical Child Psychology Doctoral Program, emphasized treatments for children and adolescents, whereas the course taught within the Clinical Psychology Doctoral Program, emphasized treatments for adults. The courses were taught at the same graduate school and both courses were taught by full-time tenure track faculty members. Both courses included 15 2-hr in-person classes and were designed to introduce students to psychodynamic intervention strategies that have scientific support. The first hour of each class was used for didactic teaching, and the second hour of each class was used for interactive discussion and student presentations of the assigned materials. The series of 15 classes focused on the EBP guidelines, EST requirements, the most recent meta-analyses and reviews of PDT outcome studies, as well as a theoretical and clinical introduction of several manualized evidence-based treatment approaches, including ISTDP (ISTDP; Abbass, 2015), Transference-focused Psychotherapy (TFP; Clarkin & Kernberg, 2015), Supportive Expressive Therapy (SET; Luborsky, 1984), as well as longer-term psychoanalysis (Leuzinger-Bohleber et al., 2020). Both courses included weekly readings of peer-reviewed empirical articles highlighting issues related to the use, dissemination, and integration of PDT interventions in clinical work. Additional class presentations on the conceptualization of a treatment case, required students to integrate research findings, clinical and theoretical aspects. The assigned readings and the preparations for the class presentations were expected to take around three hours each week. The syllabi of these PDT courses are provided upon request.

Measures

Student Characteristics

Several individual items were administered in order to assess gender, age, ethnicity, highest completed degree, personal therapy, and a multiple choice item on self-described theoretical orientation ("How would you describe your theoretical orientation?": cognitive, behavioral, psychodynamic, psychoanalytic, integrative, or other). The rest of the online survey included standardized measures on attitudes toward EBP, PDT, and beliefs about the curative factors in therapy.

Attitudes Toward EBP

The Modified Practice Attitudes Scale (MPAS; Borntrager et al., 2009), a self-report measure of attitudes toward evidence-based practices, was used to assess attitudes toward EBP. We used the revised five-item MPAS, which has been validated across cultures (Park et al., 2018) and includes only reverse coded items from the original eight-item MPAS (Dorsey et al., 2017; Park et al., 2018). Responses are rated on a 5-point Likert scale, ranging from *not at all* (0) to *a very great extent* (4), to indicate agreement with statements regarding evidence-based practices such as, "Evidence-based treatments do not allow me to tailor my therapy to each client's individual needs." The five-item MPAS has good reliability and acceptable internal consistency (Dorsey et al., 2017; Park et al., 2018). In the present study, the internal consistency was comparable (Cronbach's α = .76 for precourse and postcourse).

Attitudes Toward PDT

Building on Buckman and Barker (2010) operationalization of preferences for therapeutic orientations during training, we assessed attitudes toward PDT with the Therapeutic Orientation and Experiences Survey (TOES; Buckman & Barker, 2010) and the Counsellor Theoretical Position Scale (CTPS; Poznanski & McLennan, 1999). The TOES is a 28-item self-report measure of a therapist's openness to different theoretical orientations (CBT, PDT, and family systems). In line with the research questions in this study, the subsequent TOES analyses are based on the PDT subscale scores. The TOES-PDT includes three questions: (a) "To what extent do you identify with the basic principles of PDT?," (b) "To what extent does PDT appeal to you personally?," and (c) "How much do you envisage using PDT when qualified?" Participants respond to each question on a 5-point Likert scale ranging from *not at all* (1) to *very much* (5). Internal consistency was acceptable in this sample (Cronbach α precourse = .74; postcourse = .70).

The CTPS (Poznanski & McLennan, 1999) consists of 40 items related to views about therapy on a Likert scale ranging from *strongly disagree* (1) to *strongly agree* (7). The CTPS includes to subscales. The Rational-Intuitive (R-I) dimension describes a preferred style of knowing or acquiring information through either rational judgment based on logical reasoning or intuitive processes. In contrast, the Objective-Subjective (O-S) dimension refers to a preference for acquiring data through observable, objective measurements or through subjective, introspective, and experientially acquired knowledge. These two CTPS subscales assess the degree to which the respondent endorses therapeutic principles that tend to align with psychodynamic and cognitive-behavioral approaches to therapy. For example, rational items include, "I usually take an active role" and "People can learn effective coping skills without necessarily having to go into the depths of their private experience." Conversely, subjective items include, "Unconscious motivation is a very important aspect of human behavior" and "Self-knowledge deepens our understanding of life." Sample items for the objective pole on the objective-subjective subscale include, "Emotional stability is a product of one's logical and consistent thinking" and "Any claimed mental process can be translated into a statement describing

observable behavior." The CTPS has demonstrated criterion validity, with the scales effectively distinguishing between practitioners of different therapies (Poznanski & McLennan, 1999). The two subscales have good internal consistency with coefficients for the O-S and R-I subscales reported as 0.87 and 0.81, respectively. In this sample internal consistency was .83 for the precourse R-I dimension and .81 for O-S. Postcourse internal consistency was .86 and .80, respectively.

Data Analysis

Since the sample consisted of students from two different graduate programs, we compared the two groups on relevant study variables with a series of independent samples *t*-tests. Because student characteristics such as age, personal therapy, and orientation have been found to predict differences in attitudes toward EBP (e.g., Nakamura et al., 2011), we investigated whether these variables were related to student attitudes toward EBP. To determine if precourse attitudes differed for students with different age, attendance of personal therapy yes/no, or identified theoretic orientation (CBT, PDT or integrative), we conducted correlations, independent samples *t*-tests, and one-way ANOVAs, respectively. Paired samples *t*-tests were used to assess changes in attitude over time and one-way ANOVA was used to compare changes across theoretical orientations.

Results

Preliminary Analyses

There were no significant differences in demographics; gender, $\chi^2(2, n = 85) = 1.90, p = .39$, Cramer's $V = 1.49$, age, $t(83) = -.891$, $p = .38$, 95% CI [−.63, .24], Cohen's $d = -.20$, ethnicity, $\chi^2(6, n = 85) = 4.54$, $p = .61$, Cramer's $V = .23$, and personal therapy, $\chi^2(1, n = 85) = .57$, $p = .45$, Cramer's $V = .082$, between students in the School-Clinical Child Combined Doctoral Program ($n = 35$) and the adult Clinical Psychology Doctoral Program ($n = 50$). No differences were identified between the two programs on precourse attitudes toward evidence-based treatments, MPAS; $t(83) = 1.130$, $p = .26$, 95% CI [−.11, 41], Cohen's $d = 2.5$ or toward PDT, TOES; $t(81.16) = 1.130$, $p = .06$, 95% CI [−.84, .02], Cohen's $d = -.44$, CTPS-RI; $t(83) = 1.37$, $p = .17$, 95% CI [−1.67, 9.11], Cohen's $d = .30$, CTPS-OS; $t(83) = -.57$, $p = .57$, 95% CI [−.7.06, 3.92], Cohen's $d = .13$. Therefore, the data was analyzed for the group of 85 graduate students as a whole.

Given the nature of the scales and the existing literature on these measures, the observed MPAS score precourse ($M = 2.33$, $SD = .60$) was relatively low. The observed TOES-PDT score ($M = 3.68$, $SD = .99$) and the CTPS Rational scores ($M = 58.69$, $SD = 12.36$) in our sample were in line with other publications on student samples, whereas the CTPS Objective scores in our sample ($M = 75.24$, $SD = 12.47$) were relatively high. There were no differences in the precourse attitude variables by student gender: MPAS; $\chi^2(38, n = 85) = 29.76$, $p = .83$, Cramer's $V = .42$, or TOES; $\chi^2(22, n = 85) = 16.25$, $p = .80$, Cramer's $V = .31$, CTPS-RI; $\chi^2(78, n = 85) = 60.28$, $p = .93$, Cramer's $V = .60$, CTPS-OS; $\chi^2(74, n = 85) = 122.89$, $p = .99$, Cramer's $V = .85$. There was also no difference for these variables based on students' ethnicity: MPAS; $\chi^2(114, n = 85) = 97{,}63$, $p = .86$, Cramer's $V = .44$, or TOES; $\chi^2(66, n = 85) = 83.52$, $p = .07$, Cramer's $V = .41$, CTPS-RI; $\chi^2(234, n = 85) = 189.25$, $p = .99$, Cramer's $V = .61$, CTPS-OS; $\chi^2(222, n = 85) = 216{,}20$, $p = .69$, Cramer's $V = .65$. Student age was also unrelated to precourse attitudes toward EBP, $r(83) = .20$, $p = .07$, 95% CI [−.06, 1.94], and PDT TOES-PDT; $r(83) = -.16$, $p = .14$, 95% CI [−.38, .05], CTPS-RI; $r(83) = .19$, $p = .09$, 95% CI [−.03, .40], CTPS-SO; $r(83) = -.09$, $p = .40$, 95% CI [−.31, .13]. Students' who attended personal therapy did not significantly differ from students who did not attend personal therapy in their reported attitudes toward EBP at the beginning, $t(83) = -.48$, Cohen's $d = -.10$, $p = .63$, 95% CI [−.32, .20]. However, students who were currently in personal therapy ($n = 42$) had more positive attitudes toward PDT, as measured on the TOES-PDT, $t(83) = 2.41$, $p = .018$, 95% CI [.09, 92], Cohen's $d = .52$, and the CTPS-RI, with scores more toward the intuitive end of the rational-intuitive continuum compared to, $t(83) = -1.60$, $p < .05$, 95% CI [−11.89, −1.58], Cohen's $d = -.56$. No significant difference on the CTPS-OS was found, $t(83) = -1.75$, Cohen's $d = -.38$, 95% CI [−9.99, .63] $p = .084$. Subsequently, personal therapy was included in analyses of attitudes toward PDT. Precourse attitudes toward EBP were negatively correlated with attitudes toward PDT on the TOES-PDT, $r(83) = -.34$, $p = .001$, 95% CI [−.55, 1.14], and positively correlated with rational tenets of psychotherapy associated with CBT, on the CTPS-RI, $r(83) = .45$, $p < .001$, 95% CI [.26, .65], and objective tenets of on the CTPS-OS, $r(83) = .25$, $p = .021$, 95% CI [.04, .46], (see Supplemental Table 2).

Precourse Attitudes Toward EBP and PDT and the Role of Theoretical Orientation

Contrary to expectations, there were no significant differences in precourse attitudes toward evidence-based practice between students of differing theoretical orientations, $F(2, 82) = 2.58$, $p = .08$, $\eta^2 = .06$. When exploring the precourse attitudes by precourse theoretical orientation, students' attitudes toward PDT, as measured by TOES-PDT precourse, were significantly different depending on precourse orientation, $F(2, 82) = 17.08$, $p < .001$, $\eta^2 = .29$). PDT identified students showed the highest scores ($M = 4.31$, $SD = .90$), compared to the CBT-oriented students ($M = 2.79$, $SD = .94$), and the integrative students ($M = 3.88$, $SD = .78$). Posthoc Tukey HSD comparisons showed that PDT students differed significantly from CBT students, $p < .001$, 95% CI [.83, 2.21], but not from the integrative students, $p = .21$, 95% CI [−.18, 1.04].

The CTPS-RI continuum also reflected differences by student orientation precourse, $F(2, 82) = 9.85$, $p < .001$, $\eta^2 = .19$, with CBT-oriented students being significantly less intuitive and more rational than PDT-oriented, $p < .001$, 95% CI [−26.27, −7.77] or integrative students, $p < .01$, 95% CI [1.41, 15.35] and integrative student being less intuitive than the PDT students, $p = .03$, 95% CI [−16.75, −.53]. In other words, CBT-oriented students preferred acquiring information through rational judgment based on logic more than those who were not CBT-oriented at the start of the course, and integrative students preferred this rational approach more than the PDT students. Similarly, students' scores on the CTPS-OS continuum showed a difference across theoretical orientation precourse $F(2, 82) = 5.09$, $p < .008$, $\eta^2 = .11$, with PDT students emphasizing significantly more subjective information than the objectively focused CBT students, $p < .01$, 95% CI [−22.85, −3.24]. There were no differences between integrative students and CBT or PDT students on this measure, $p = .19$, 95% CI [−12.47, 1.87] and $p = .21$, 95% CI [−2.37, 14.30], respectively.

Change in Attitudes Toward EBP and PDT

A paired samples *t*-test was conducted to evaluate changes over the 15-week period. Although overall student attitudes toward EBP improved slightly, this change was not statistically significant, $t(84) = -1.75$, $p = .08$, 95% CI [−.28, .02], Cohen's $d = -.19$. There was no difference in change achieved on the MPAS (postcourse MPAS—precourse MPAS) across the different orientations, $F(2, 82) = .64$, $p = .53$, $\eta^2 = .015$. Looking at individual items on the MPAS (see Supplemental Table 3), the only item with a statistically significant difference was, Item 4) "I dislike using evidence-based treatments because they are too inflexible," with students less likely to agree with this statement at the end of the course, $t(84) = -2.87$, $p = .005$, 95% CI [.10, .58], Cohen's $d = .31$. The other items did not show significant change pre–post course; Item 1; $t(84) = -1.05$, $p = .30$, 95% CI [−.11, .38], Cohen's $d = .11$, Item 2; $t(84) = 1.69$, $p = .10$, 95% CI [−.46, .04], Cohen's $d = -.18$, Item 3; $t(84) = -2.01$, $p = .05$, 95% CI [.00, .49], Cohen's $d = .22$. Item 5; $t(84) = -1.17$, $p = .25$, 95% CI [−.11, .41], Cohen's $d = .13$.

To examine change in attitudes toward PDT, we calculated change scores on each of the three measures that assessed this variable. A change score (postcourse—precourse) was created for the TOES-PDT, CTPS-OS, and CTPS-RI. Paired samples *t*-tests were used to assess change in attitudes toward PDT at the end of the course (Supplemental Table 4). A significant change was found on all three measures: TOES-PDT; $t(84) = 3.54$, $p = .001$, 95% CI [−.45, −.13], Cohen's $d = -.19$, CTPS-RI; $t(84) = 8.00$, $p = .001$, 95% CI [6.67, 11.09], Cohen's $d = .86$. CTPS-OS; $t(84) = 3.40$, $p = .001$, 95% CI [1.49, 5.71], Cohen's $d = .37$.

To better understand these differences, a one-way ANOVA was conducted to identify changes among students of different theoretical orientations (Supplemental Table 5). There was a significant difference in the change score for attitudes toward PDT (postcourse TOES-PDT score—precourse TOES-PDT score), $F(2, 82) = 4.95$ $p = .009$, $\eta^2 = .11$, and no significant differences on the CTPS scales measuring attitudes toward PDT, CTPS RI; $F(2, 82) = 2.85$, $p = .06$, $\eta^2 = .07$, CTPS OS: $F(2, 82) = .14$, $p = .87$ $\eta^2 = .003$. Posthoc comparisons using the Tukey HSD test indicated that the TOES-PDT change score for students who identified a CBT orientation before the course was significantly different than the change for students who held a psychodynamic, $p = .02$, 95% CI [.09, 1.26], or integrative orientation, $p = .02$, 95% CI [.07, .95]. Given that students who attended personal therapy reported more positive attitudes toward PDT before the course, we also performed independent samples *t*-tests to examine changes in attitudes toward PDT among students in therapy compared to those who were not in therapy. There was no significant effect of personal therapy on change in attitudes toward PDT on any of the three measure: TOES-PDT; $t(83) = .20$, $p = .84$, 95% CI [−.29, .36], Cohen's $d = .04$, CTPS-RI; $t(83) = 1.2$, $p = .23$, 95% CI [−1.73, 7.09], Cohen's $d = .26$; $t(83) = -1.18$, $p = .24$, 95% CI [−6.71, 1.7], Cohen's $d = -.26$.

Discussion

The purpose of this study was to examine changes in graduate students' attitudes toward evidence-based practice (EBP) and psychodynamic psychotherapy (PDT) after a 15-week course focused on evidence-based PDT, and to examine the role of students' identified theoretical orientation. We found that, after the course, students had slightly more favorable attitudes toward EBP; however, this change was not statistically significant, and attitudes toward EBP generally stayed moderately positive. There were no significant differences in change in attitudes toward EBP across students from different precourse theoretical orientations.

With regard to attitudes toward PDT, students reported significantly more favorable attitudes toward PDT at the end of the course. Precourse differences among students of different orientations were shown on all three attitude measures, in that PDT-oriented students were more positive toward PDT than students who self-identified as CBT-oriented or integrative. Students with a precourse CBT orientation had larger increases in their positive attitudes toward PDT on this measure than their psychodynamic or integrative counterparts. There were no differences for theoretical orientation on the other two measures of attitudes change toward PDT. Overall, these findings suggest that the attitudes toward PDT, within the context of evidence-based practice, are mutable and can change over the course of a 15-week graduate course.

The absence of change in attitudes toward EBP may be understood in different ways. First, students began the course with moderately favorable attitudes toward EBP, therefore statistically significant change on this measure (MPAS) might have been relatively hard to achieve. However, Bearman et al. (2015) did demonstrate greater increases in attitudes as a result of a similar course in EBP focused on cognitive behavioral interventions for youth. Notably, although the MPAS is described as designed to "assess therapists' attitudes toward evidence-based practices" (Borntrager et al., 2009, p. 678), the measure specifically reference "evidence-based treatments" which seems to refer to specific manualized empirically supported treatments (ESTs) rather than the 3-legged stool of EBP. The evidence-based PDT courses in this study emphasized all three legs of the evidence-based practice stool—research evidence, clinical judgment, and client-specific needs—in equal measure. It is thus possible that the additional emphasis on therapist and client perspectives, provided the students with a more nuanced and critical stance toward ESTs alone. Moreover, change on individual MPAS items in this study was significant for the item, "I dislike using evidence-based treatments because they are too inflexible," with students less likely to agree with this statement at the end of the course. The wording of this item makes it difficult to determine whether students (a) simply had more favorable attitudes toward ESTs or (b) saw EBP as more flexible than they had at the beginning of the course. Another measure, such as the Evidence Based Practice Attitudes Scale (EBPAS-36 or 50; Aarons et al., 2012; Rye et al., 2017), might be useful in future studies as it offers scores on multiple factors including openness to trying new manualized treatments and the extent to which the respondent perceives evidence-based treatments as clinically useful.

Most notable for the field of psychotherapy training is the degree of change among students who began the course with a primarily CBT orientation on the primary measure of attitudes toward PDT. This group reported the largest shift in attitudes, in the positive direction, toward PDT at the end of the course. This may be because they started the course with less favorable attitudes toward evidence-based PDT, thus providing more room for change. However, the fact that significant and meaningful change occurred for these students is encouraging in terms of the mutability of attitudes toward theoretical approaches and the potential for the incorporation of multiple perspectives.

Participants in this study also reported shifts on both subscales of the CTPS, regardless of precourse theoretical orientation, indicating a shift toward therapeutic principles that align with PDT. The shifts on the continuum identified on these two subscales also highlight the value of integration through the privileging of rational, *and* intuitive, objective, *and* subjective aspects of psychotherapy. The data in this study suggests that students were able to move slightly toward the intuitive and subjective poles of these scales. Learning about integration might be important especially because students' often experience difficulty with tolerating ambiguity and not belonging to a particular theoretical community (Aafjes-van Doorn et al., 2018).

It is not uncommon for therapists to incorporate techniques and perspectives outside of their own psychotherapy orientation (Thoma & Cecero, 2009) and there is some evidence that therapists who hold a flexible stance and are open to greater integration produce better treatment alliance and outcomes for clients (Boswell et al., 2019; Goldman et al., 2013, 2018). In other words, clients who present with symptomatology for which several ESTs exist (e.g., cognitive-behavioral therapy and short-term dynamic therapy for Anxiety disorders) might benefit from techniques from these different modalities in facilitating the change process (Glock et al., 2018).

Admittedly, teaching graduate students about EBP, and evidence-based PDT specifically, is not an easy task. First, despite agreeing with its principles, many graduate students tend to hold misconceptions about EBP (Luebbe et al., 2007). Graduate students tend to be unfamiliar with literature or manuals for empirically supported treatments (Karekla et al., 2004). Many clinicians have had minimal exposure to manualized treatments during their graduate training (Bearman et al., 2015; Lilienfeld et al., 2013), and even fewer have experience with evidence-based PDT. This study provides encouraging evidence that a course covering common theories and manuals of empirically-supported psychodynamic treatments, treatment outcome research, and issues related to evidence-based PDT can improve trainee attitudes, potentially paving the way for greater psychotherapy integration.

Strengths, Limitations, and Directions for Future Research

This study adds to the very small literature base about change in attitudes toward EBP and PDT as a result of graduate training. However, several limitations can be noted. First, without a comparison group, we cannot be certain that the change in attitudes occurred as a result of the course material. Students were also simultaneously enrolled in other clinical and theoretical courses. It would be useful to compare a broad course on evidence-based practice that included multiple treatment approaches with the course described in the present study, focused on evidence-based PDT.

Second, this was a relatively small and White sample obtained across only two graduate programs. Similar to the importance of the client's diversity, multiculturalism, and intersectionality in EBP, assessment of the students' culture and diversity and their preconceptions about "evidence" will likely enhance the external validity of the findings.

Third, the reliance on three dichotomous theoretical orientations—CBT, PDT, and integrative—was necessarily oversimplified. There is a need for the development of more nuanced measures of theoretical orientation that privileges various types of psychotherapy integration. In addition, it would be beneficial to develop a measure of attitudes toward evidence-based psychodynamic psychotherapy given that many professionals mistakenly equate EBP and ESTs with cognitive-behavioral treatments (Dozois et al., 2014). Relatedly, the theoretical orientation of the students' personal therapy might be a meaningful factor to consider in future studies.

Moreover, a mixed methods design, that incorporates interviews like the ones described by Safi et al. (2017) in their studies on how therapists' development professionally, would add a great deal to our understanding of changes in attitudes toward EBP and PDT. Future research would also benefit from follow-up measurements to examine if graduate training in a evidence-based PDT leads to change in attitudes (Beidas & Kendall, 2010) or if it also leads to changes in practice behavior (e.g., Nelson & Steele, 2007).

Furthermore, the reported findings might currently be limited in their generalizability because doctoral programs that offer courses on evidence-based PDTs might not be representative of all APA accredited graduate programs. Few graduate programs are requiring or offering courses on evidence-based PDT, possibly because the faculty have strong allegiances to CBT approaches, or they do not have faculty members who have the expertise to offer such courses (Heatherington et al., 2012).

Implications for Clinical Training

The process of EBP requires constant synthesizing of relevant research on different evidence-based treatments (Beck et al., 2014), individual characteristics of clients, and clinical theory and experience (Forman et al., 2016). It is erroneous to assume that one orientation is more compatible with basic science than another, the current data notwithstanding. The challenge, of course, is to be true to the intent of graduate training; to actually expose students to science, teach them how to understand and engage in it, and to help them to integrate emerging scientific findings into their practices (Heatherington et al., 2012).

What little is known about classroom-based instruction of psychology doctoral students suggests that it has the potential to change attitudes toward EBP (Bearman et al., 2015). In many respects, training in EBP has the potential to unify the field, if students are trained with similar expectations regarding how to synthesize multiple sources of information. It is important for us to teach EBP, not as promoting a view of decision-making that is deterministic, but to emphasize "intentional practice" that reflects what they know is most likely to be helpful, a process that is integral to ethical therapy practice (Allan, 2019).

Didactic training in EBP at graduate schools is not enough. Lecture courses must be supported by high quality supervision, clinical training experiences, and behavioral rehearsal for interpersonal and intrapersonal skills, such as in deliberate practice. Arguably, the didactic teaching of EBP is too focused on the first leg of the three-legged EBP stool (empirical evidence, clinical experience, and client characteristics) even though these are implicitly given equal weight (at least in the APA definition). It might be more beneficial to students, and ultimately to their future clients, to develop more graduate training in the process of psychotherapy integration, more explicitly. One therapeutic orientation cannot and will not be adequate for all clients, problems, and experiences and rigidly adhering to a particular treatment protocol is not or even negatively related to treatment outcome (Webb et al., 2010).

Therefore, rather than teaching evidence-based CBT (Bearman et al., 2015) or evidence-based PDT, we should focus our teaching efforts on EBP more generally and guide future clinicians in carefully integrating evidence-based interventions from varied orientations to produce beneficial treatment outcomes. It might be important to remember that what we teach our students is not "the truth" but simply an approach to clinical practice, that values the contemporary scientific evidence and research developments in the field (Goldfried, 2020). Arguably, besides providing factual knowledge about different types of EBPs, the goal of any graduate training program should be to help students develop a positive attitude toward evidence-based practices from a range of theoretical orientations.

摘要

许多临床医生对循证实践(EBP)存在误解,特别是循证精神动力取向心理治疗。在研究生培训中提出这些信念和态度,以及帮助学生从一系列理论取向来考虑循证干预都是很重要的。本研究报告了要求进行15周的循证PDT课程的两个心理学博士研究项目。85名学生在第一节课之前和最后一节课之后完成了对EBP和PDT的态度的测量。那些认同不同理论取向—整合取向、CBT或PDT—的学生对于EBP的态度没有差异,学生对EBP的态度是稳定的。参加CBT取向预备课程的学生对PDT的评价不如精神动力取向的学生。对PDT的态度在所有取向中都有显著改善,但是,与PDT或整合取向的学生相比,CBT取向的学生报告了对PDT的积极态度的最大收益。结果支持使用循证基础的研究生培训,以改善对EBP和PDT特定方面的态度。调查结果还强调了学生态度的可变性,以及培养包括PDT在内的EBP的整合方法的潜力。有必要进行进一步研究,以检验EBP的研究生课程是否可使治疗干预更广泛地应用于患者。

关键词:循证的,精神动力学,研究生培训,态度改变

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