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Ninety psychotherapy training programmes across the globe: Variations and commonalities in an international context

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Abstract

Objective: Psychotherapist training programmes have arguably a most impactful intervention on the field of psychotherapy, shaping the kinds of therapists their graduates become. Yet, little is known about the structural and organisational similarities and differences of these key learning environments in an international context.

Method: Ninety psychotherapy training programmes in 16 different countries comprised data for a study initiated by members of the SPR Interest Section on Therapist Training and Development (SPRISTAD). Training directors or senior faculty completed the *Training Program Description Form* (TPDF), surveying, for example, organisational setting and size, educational/occupational prerequisites, trainee funding and schedules, educational methods and graduation criteria.

Results: Among otherwise highly diverse programmes, the most consistent finding was commitment to relationship-based experiential learning, including direct supervision of trainees' treatment cases and case discussions with experts and peers. Criteria for selecting applicants focussed mainly on their personal qualities (empathy, self-awareness and good mental health), supplemented by evaluations of relevant intellectual qualities (psychological-mindedness, theoretical interest and intelligence). Training consistently focussed on individual psychotherapy as the dominant treatment modality.

Conclusion: Across countries, essential commonalities among psychotherapy training programmes emerged. Findings suggest there may be common ground for developing therapist training, as knowledge increases on beneficial therapist characteristics and their formation.

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KEYWORDS
evidence-based training, interpersonal skills, psychotherapist development, psychotherapy supervision, therapist characteristics, therapist training programme characteristics

1 | INTRODUCTION

1.1 | Problem

Recent interest in the characteristics of effective psychotherapists (e.g., Heinonen & Nissen-Lie, 2020), and in studying the development of psychotherapists as they progress through training (e.g., Orlinsky et al., 2015), has led, logically and inevitably, to the study of psychotherapy training programmes as well. Callahan and Watkins (2018a, p. 211) argued persuasively that psychotherapy training "is perhaps the most impactful intervention to our field," although varied authors have also noted that training programmes are very hard to study given their heterogeneity, multidimensionality and differences in scope (Callahan & Watkins, 2018a; Knox & Hill, 2021). In actuality, these training programmes, which have been little studied in themselves, constitute formative environments through which therapists-in-training pass as they acquire their professional identities, craft and skills; environments whose organisation, curricula and other characteristics are likely to leave a more or less lasting imprint on them. Yet, virtually no large-scale studies have explored the differences and similarities among the multitude of psychotherapy training programmes in an international context. This paper reports on the highly diverse characteristics of 90 separate training programmes, located largely in Europe but including some in North and South America and Asia, whose main features were described by their directors or senior faculty using a systematic survey called the *Training Program Description Form* (TPDF), which is one of the instruments devised by a group of colleagues to conduct a collaborative, international, longitudinal study of psychotherapist training and development, as members of the Society for Psychotherapy Research Interest Section on Therapist Training and Development (SPRISTAD). This paper documents some of the wide variations and unexpected commonalities that have been found to exist in the characteristics of these 90 psychotherapy training programmes.

1.2 | Background

Unlike long-established traditional professions such as medicine, law and clergy—each of which has a multiplicity of more or less typically organised schools or seminaries—the profession of psychotherapy is still in its earliest stages of becoming a thing in itself, rather than a practice conducted as a subspecialty within other disciplines (e.g., clinical psychology, clinical social work, counselling and, until recent years, psychiatry). Indeed, psychotherapy as a modern form of mental health care is little more than a hundred years old, subsuming a broad gamut of theories and methods, and so it is understandable that training programmes that aim to prepare candidates for professional practice may also include a wide variety of forms and contents. In sum, as Garfield and Bergin (1986, p. 11) commented, "Because there is no single accepted profession of psychotherapy and many different groups offer such services, the training of psychotherapists also shows great diversity."

Key practitioner message

For the development of psychotherapy practice on a global scale, knowledge is needed on how psychotherapists are trained. Yet, virtually no systematic international comparisons have been conducted of therapist training programmes, a gap that the present extensive study begins to close. Results illustrate a widely shared implicit understanding of psychotherapy as an intimate yet asymmetrical interpersonal process within professional boundaries, defining the qualities that are important for the development of practicing therapists. The findings suggest common ground for evidence-based development of therapist training in an international context, as well as shared challenges (e.g., financing of students) crucial for addressing global mental health concerns.

Implications for practise

- Psychotherapists whose practise includes professional training and supervision of trainees can broaden their understanding of the work they do through comparative international studies of training and training programmes.
- Our findings suggest common ground for evidence-based development of therapist training internationally, as well as shared challenges (e.g., financing of students).
- A substantial majority of psychotherapy training programmes used candidate selection criteria (e.g., personal qualities such as empathy and self-awareness) and emphasized experiential learning (e.g., case supervision), which should be considered for adoption where they are not already used.

Implications for policy

- We encourage the active support of programme directors and faculty, as well as mental health institutions and agencies, for collaborative international studies of training, to generate knowledge essential to the growth of psychotherapy as an empirically-based profession.

More recently, Rønnestad and Ladany (2006, p. 261) noted: "Variations among professions, theoretical orientations, training ideologies, and nationalities—and their interactions—contribute to an enormous heterogeneity in duration and content of training. Admission requirements and standards of professional training are diverse. The epistemological foundation for training programs include not only the basic foundations of natural-biological sciences (including a strong emphasis on cognitive science) and the social sciences (including the hermeneutical approach) but also diverse philosophical foundations, including some inspired by Eastern philosophies, which impact curriculum and pedagogical principles guiding training."

By the turn of the present century, legal standards for calling oneself a psychotherapist had been enacted only rarely and only in a few places, such as Austria, Finland and Germany (e.g., Van Deurzen, 2001). More recently, Pomerantz and Murphy (2016) noted that, across the world, there still exist diverse legal and statutory regulations influencing psychotherapy training and practice. For example, licensure for independent practice of psychologists providing psychotherapy in the United States has historically been limited to the doctoral degree,[1] while in other countries, licensure for independent practitioners of psychology occurs at master's level,[2] reserving the doctoral degree specifically as a qualification for individuals pursuing careers as researchers and academicians. In some countries (e.g., the United States), regulations have been made by various professional associations to control clinical training and practice (including psychotherapy), although these regulations sometimes have been focussed primarily on limiting the professional titles used by mental health service providers (Van Broeck & Lietaer, 2008). An overview of the current status of psychotherapy laws and regulations in Europe can be found in a publication of the European Association for Psychotherapy (2021).[3]

Research on psychotherapy training, to the extent that it has existed at all, tends to have concentrated on "the teaching and learning of psychotherapeutic skills" (Matarazzo & Patterson, 1986), or on theory-specific "manuals" (e.g., Beck et al., 1979; Strupp & Binder, 1984), or on particular elements of training, such as supervision (Keum & Wang, 2020; Knox & Hill, 2021; Watkins, 2017), rather than on how psychotherapy training has been systematically organised and conducted as a general enterprise. This part of the larger SPRISTAD collaborative study, focussed on training programmes, aims to be more inclusive by taking an international multisite perspective like that called for by Hill and Knox (2013, p. 803) in their review of training and supervision in psychotherapy: "Multisite longitudinal studies need to be conducted, including careful recording of amounts, types, and quality of training and supervision. … By collecting data at multiple sites, researchers would have large samples, and so would have enough power to investigate the effects of sites, types of training, supervisor characteristics, trainee characteristics, and client characteristics."

Following the same empirical and inductive approach, other parts of the SPRISTAD collaborative study also focus extensively on the personal characteristics and learning and clinical experiences of trainees, and on the perspectives of supervisors (Orlinsky et al., 2015). Early pilot studies conducted within single countries have described core aspects of trainees' personal and professional background (Löffler-Stastka et al., 2019; Messina et al., 2019) as well as differences between beginner and advanced trainees in their perception of development as psychotherapists (Messina et al., 2018). Drawing on international data, other recent studies thus far have reported on topics such as trainees' current quality of life (Heinonen et al., 2022), trainees' personal and professional pathways to psychotherapy training (Willutzki et al., 2023), the development of self-acknowledged limitations in the early stage of training (Schröder et al., 2023) and therapeutic work correlates of trainees' currently experienced development (Orlinsky et al., 2023). Ultimately, the SPRISTAD study aims to explore trainee development longitudinally by tracking their experiences as therapists over time, and to determine the various factors that facilitate or hinder their development.

1.3 | Research questions

This study explores the characteristics of the large number of psychotherapy training programmes that are present in the SPRISTAD data collection in order to provide a basic profile and variations across countries. For the purpose of this study, psychotherapy training programmes were defined in terms of three inclusion criteria: (a) the explicit identification of each programme by their clinical directors as training candidates in professional psychotherapy; (b) the training was conducted at a post-master's level of education; and (c) the programme had a minimum training duration of one year. Two groups of research questions comprise the focus of this paper. First, with regard to trainees: (a) How many trainees typically attend the training? (b) Who is eligible to enter training? (c) How are trainees selected? (d) How is training participation financed? And (e) what are the requirements for training completion? Second, we focussed on training programmes' contents: (f) What types of learning activities are included in the programme? (g) Does the programme provide training for work with specific client age groups? (h) Does the programme provide training for work with specific patient problems or diagnoses? (i) Is training offered for practice with minority or ethnic cultural groups? (j) What diagnostic and/or case-formulation methods are typically taught? (k) Which psychotherapy orientations are taught in the programmes? And (l) which psychotherapy modalities are taught in the programmes?

[1] By contrast, other professions that practise psychotherapy in the United States (e.g., social workers, and marriage and family counsellors) may practise independently with a master's degree.

[2] Here too, psychotherapy practice typically requires additional specialised training.

[3] More detailed information is available in the online document referenced below from the European Association for Psychotherapy: "Situation of psychotherapy in various countries" (n.d.).

2 | METHODS

2.1 | Participants and recruitment

Data from a total of 90 training programmes, located in 16 countries, were considered for this study. Participation was voluntary and recruitment relied on convenience sampling through a network of interested SPRISTAD colleagues. Recruitment and data collection of the data presented here were carried out between 2016 and 2021 (in a still ongoing survey). Training programmes worldwide were invited by the SPRISTAD group via personal contact and email to participate in the survey, with the support of local research coordinators. All training programmes gave written informed consent to participate in the SPRISTAD data collection, and they received no payment for participation. The extreme variety of programmes is indicated by the fact that some programmes were based in a university department and others were maintained by associations and societies devoted to a particular theoretical orientation; some comprised diverse trainings housed within a large institution, and others were conducted by small groups of individual practitioners offering training in a specific treatment method or approach.

The data represent a convenience sample, the delineation of whose "sample characteristics," customarily reported here, is deferred to the Results section, since the main aim and topic of this paper is precisely the presentation of our sample's characteristics. Given the relative heterogeneity of our sample programmes, inferences based on similarities among them may be more informative than those based on their differences. We also note that this study relies on information provided by the directors or senior faculty of training programmes and thus may sometimes give an idealised picture. Moreover, it is only descriptive and does not evaluate the training or its elements. Other parts of the SPRISTAD study examine these programmes from the perspective of their trainees, exploring their experiences of training elements and which are more or less helpful in fostering their professional development (Orlinsky et al., 2015).

2.2 | Instruments: Training program description form

The TPDF was designed to provide a systematic description of psychotherapy training programme characteristics, including both quantitative and qualitative items, with initial versions available in English, Spanish and French (reporters in most countries were comfortable using English). Items on the TPDF were divided into 10 sections, asking, in turn, about: (1) the name, location, public/private and academic/non-academic setting, and provision of initial/advanced training, as well as the name and position of the reporting colleague; (2) the number of full-time and part-time faculty and affiliated supervisors; (3) the educational and occupational backgrounds required of applicants, the criteria for and locus of decision-making on admissions; (4) the number of applicants, acceptances and current programme trainees, whether in part-time or full-time study, and the number expected to complete the programme this year; (5) the typical annual cost of training and the sources of funding available to trainees; (6) the most important programme activities for trainees in their first, second and final year (if programmes exceeded 2 years), and the amounts of time devoted by trainees to those activities; (7) the programme content, including specific academic subjects and modes of instruction (e.g., case demonstrations); (8) experiential learning opportunities (e.g., role-play with peers, sensitivity training and practice with real therapy patients), including supervisory feedback and guided self-reflection (e.g., self-experience groups and personal therapy); (9) training to work with specific client types of problems and pathologies, use of diagnostic procedures, treatment modalities (e.g., individual therapy, couple or marital therapy, family therapy and group therapy) and therapeutic methods (e.g., psychodynamic, cognitive-behavioural and humanistic); and (10) requirements for programme completion and professional qualification.

2.3 | Data analysis

The statistical analysis was mainly descriptive and partly classifying or categorising. Measures of central tendency (mean, median) and variation (standard deviations, range) were used to characterise numerical distributions, and frequency tables to describe nominal distributions. Significance tests are rarely reported as specific hypotheses were not tested. For multivariate, multidimensional characteristics (e.g., theoretical orientations), factor analysis was used for data reduction. All analyses were computed with SPSS for Mac (version 28.0).

3 | RESULTS

3.1 | Location and organisational characteristics

Table 1 summarises the geographical distribution (left column) and some of the main organisational characteristics (right column) of the 90 training programmes, including programme sponsorship, size, duration and orientation.

3.1.1 | Location

Programmes were located in 16 countries, with five or more programmes in seven of the countries: Finland ($n = 17$),[4] Austria ($n = 16$),

[4] The large number of training programmes represented in Finland was facilitated by all psychotherapeutic trainings being organised under, or in collaboration with, Finnish universities (Heinonen et al., 2017). In Austria, parallel to the present study, a survey had started to foster psychotherapy research in training institutes for reasons of quality assurance and to build up a practice-oriented research network (Wieser et al., 2015).

TABLE 1 Training programmes: Location and organisational characteristics.

National setting	*N*	%	Programme sponsorship	*N*	%
Argentina	2	2.2	Private organisation	46	51.1
Austria	16	17.8	Public institution	25	27.8
Chile	3	3.3	Joint private and public	19	21.1
Finland	17	18.9	Total	90	100.0
France	5	5.6			
Germany	10	11.1	**Faculty size (full and part time)**	*N*	%
Ireland	1	1.1	Very small (1–4 persons)	5	5.7
Italy	11	12.2	Small (5–8 persons)	15	17.0
Lithuania	1	1.1	Moderate (9–15 persons)	28	31.8
Norway	1	1.1	Intermediate (16–25 persons)	18	20.5
P.R. China	1	1.1	Large (26–40 persons)	14	15.9
Romania	1	1.1	Very large (>40 persons)	8	9.1
Sweden	2	2.2	Total	88	100.0
Switzerland	9	10.0	*M* = 22.5; *Med* = 15; *SD* = 29.7; range = 2–250.		
UK	8	8.9			
United States[a]	2	2.2			
Total	90	100.0	**Programme duration**	*N*	%
			At least 2 years	90	100.0
Programme Locale[b]	*N*	%	More than 2 years	84	93.3
Metropolis	20	22.2			
Large city	38	42.2	**Required orientation categories[c]**	*N*	%
Small city	17	18.9	Analytic/psychodynamic	44	48.9
Large town	7	7.8	Cognitive-behavioural	40	44.4
Smaller town	6	6.7	Humanistic	36	40.0
Village/rural	2	2.2	Systemic	32	35.6
Total	90	100.0	Body/expressive	23	25.6

[a] Underrepresentation of training programmes from the United States is due, in part, to most SPRISTAD collaborators being located elsewhere, and that US training programmes largely represent distinct professions and are burdened with documentation paperwork required by the accrediting bodies of their professional organisations.

[b] Metro (≥2.5 million); large city (1 to <2.5 million); small city (300,000 to <1 million); large town (100,000 to <300,000); smaller town (10,000 to <100,000); village/rural (<10,000).

[c] "*Analytic/Psychodynamic*" can include PD therapy, Freudian, Jungian, object relations, or self-psychology psychoanalysis, interpersonal therapy; "*Cognitive-Behavioral*" can include CBT, cognitive therapy, behavior modification; "*Humanistic*" can include Gestalt therapy, client/person-centered therapy, existential therapy, experiential emotion-focused therapy; "*Systemic*" can include solution-focused therapy, systemic family systems therapy; "*Body/Expressive*" can include movement/dance therapy, psychodrama, bodywork therapy.

Italy (*n* = 11), Germany (*n* = 10), Switzerland (*n* = 9), the UK (*n* = 8) and France (*n* = 5). These programmes are not necessarily representative of either the number or type of psychotherapy training in their respective countries, except as far as they conform to applicable national laws (if any) regarding psychotherapy training and practice. However, given the prevalence of European countries shown in Table 1, at least the training programmes that identify primarily with clinical psychology as a gateway profession to psychotherapy practice likely correspond to the third educational path identified by Lunt and Hall (2016, p. 162) as typical of Europe and Latin America: "the extended first degree (between 4 and 6 years), leading to local titles…" which are "usually at a generic level with specialization [i.e., psychotherapy training] occurring after the license." This does not necessarily apply to training programmes grounded in other disciplines than in psychology (e.g., medicine and social work) or in other countries (e.g., China).

Nearly two-thirds (64%) were located in major urban settings with populations of 1 million or more, while only a few (8.9%) were technically in small town or rural settings (with some like Evanston in the United States being part of the Chicago metro area, or Küsnacht in Switzerland being close to Zürich). This distribution clearly reflects the well-known concentration of psychotherapists in urban

areas and probably reinforces that concentration by attracting graduates who may arrive from elsewhere but often remain in the local professional communities where they trained and established collegial networks.

3.1.2 | Organisation

Close to half (51%) of the training programmes were constituted as private organisations, often as independent professional groups sharing a commitment to specific types of psychotherapy (e.g., Gestalt), but sometimes as subgroups within "private" universities (e.g., Sigmund Freud University in Vienna and Columbia University in New York City). Over a fourth (28%) of the training programmes are, or are part of, public institutions (e.g., University of Oslo in Norway or Dublin University in Ireland). Finally, about a fifth (21%) of the programmes represent some form of joint undertaking or partnership between private organisations and public institutions (e.g., the Metanoia Institute and Middlesex University in London).

3.1.3 | Size

Training programmes varied enormously with respect to the reported size of their faculty, with a median of 15 (Table 1, right column) but ranging from a minimum of 2 (both in Austria, one CBT and the other "depth psychology") to as many as 180 (a public university-based programme in Norway with 30 full-time equivalent faculty for clinical training, along with a large proportion of its general faculty to implement its scientist–practitioner model). Overall, about half of the programmes were "moderate" (9–15 staff) or "intermediate" (16–25 staff) in size, counting *both* full-time and part-time faculty—but as many as 43 (or 49%) of 88 programmes responding reported having *no full-time* faculty members, operating only with part-time faculties.

3.1.4 | Duration

Although the SPRISTAD study required that programmes last only a minimum of 1 year, in fact, the duration of training all 90 of the programmes was at least 2 years, and in most (93%), it extended for three or more years (Table 1, right column).

3.1.5 | Orientation

The varied theoretical orientations of these training programmes, which trainees were required to study, were grouped into categories from a long list of therapeutic methods using exploratory factor analysis as a data reduction procedure (principal component extraction with eigenvalues ≥1 and Varimax rotation). This yielded five broad categories in which one or more specific methods were taught as programme requirements (Table 1, note 2): "Analytic/Psychodynamic," "Cognitive-Behavioral," "Humanistic," "Systemic" and "Body/Expressive." These categories primarily reflect the way methods are combined in programmes, not necessarily their theoretical or historical roots. Also, many programmes required trainees to study methods from more than one theoretical category (e.g., "Analytic/Psychodynamic" and "Humanistic"), and several programmes were explicitly "integrative" in approach (e.g., in Austria, Finland, Ireland, the UK and the United States).

3.2 | Programme admissions: Requirements and numbers

Table 2 presents the educational and occupational backgrounds that each programme has as prerequisites for trainee applications, the number of applicants, admissions and current student body, the sources of funding available to trainees and their study schedules.

3.2.1 | Education

Nearly two-thirds (63%) of the 90 training programmes required that applicants have attained a university-level of academic work (e.g., master's equivalent)—including all programmes in Germany—and another quarter (24%) required prior completion of undergraduate college studies. Thus, most (88%) of the professional programmes viewed their training as tertiary-level education. Of the 11 rare exceptions, nine accepted applicants with secondary-level education: six in Austria, due to its unusual legal provisions for the profession; one in Norway at a major university selected rigorously for top grades and involved a 6-year programme that brings graduates to at least a master's-equivalent level; and one in the UK leads to a bachelor's-level degree. Only two of the 90 programmes, one in Austria and one in the UK, required only primary schooling of applicants, evidently preferring to select applicants by other than academic prerequisites.

3.2.2 | Occupation

Almost three-quarters (72%) of the programmes indicated that prior qualification in some occupation was also a prerequisite for applicants. Psychology was the area of prior experience accepted by a clear majority (64%), followed by medicine (49%), psychiatry (38%) and social work (37%). Somewhat less frequently mentioned were education (32%), nursing (31%) and clergy or chaplaincy (30%). Curiously, introductory-level training in psychotherapy and counselling was least often cited (18% and 12%, respectively). Of the 62 programmes that specified an occupational prerequisite, 51 (82%) accepted two or more, and many (48%) accepted five or more. However, the single largest group (nearly 30%) consisted of programmes that indicated no previous occupational background was required for applicants.

TABLE 2 Programme admissions: requirements and numbers.

	N	%
Educational entry level		
Secondary or less	11	12.2
Post-secondary (e.g., college)	22	24.4
Post-graduate (e.g., masters)	57	63.3
Total	90	100.0
Occupational backgrounds		
A prior qualification is required	65	72.2
If so, which are accepted?		
Psychology	58	64.4
Medicine	44	48.9
Psychiatry	34	37.8
Social work	33	36.7
Teacher/educator	29	32.2
Nursing	28	31.1
Clergy/chaplain	27	30.0
First-level psychotherapy training	16	17.8
Counselling	11	12.2
Sources of trainee funding		
Private funds or loans	52	57.8
Trainee's clinical practice	41	45.6
Workplace grants	23	25.6
Government grants	19	21.1
Programme fellowships	12	13.3
Teaching/teaching assistant	7	7.8
Applicants last year		
Very few (<10)	10	11.1
Few (10–24)	23	25.6
Moderate (25–49)	32	35.6
Intermediate (50–79)	11	12.2
Many (80–149)	8	8.9
Very many (150+)	6	6.7
Total	90	100.0
% Accepted last year		
Selective (≤33%)	9	10.2
Fairly selective (34%–50%)	15	17.0
Fairly open (51%–75%)	29	33.0
Quite open (76%–90%)	21	23.9
Very open (>90%)	14	15.9
Total	90	100.0
Number of trainees[a]		
Very small (1–12)	9	10.0
Small (13–25)	21	23.3
Moderate (26–50)	23	25.6
Fairly large (51–90)	16	17.8
Large (91–199)	11	12.2
Very large (>200)	10	11.1
Total	90	100.0
Training schedule		
Part-time study	69	76.7
Full-time study	12	13.3
Part-time or full-time study	7	7.8
Alternate part- and full-time	2	2.2

[a]*M* = 90.4; Med = 42; *SD* = 159.9; range = 4–1092

3.2.3 | Applicants

The number of applicants to programmes in the previous year varied enormously, ranging from 0 for two programmes to an incredible 2200 for an outlier about four times the size of the next largest (i.e., the distinctive and very large programme at the University of Oslo). In fact, the median number of applicants per programme was 30, and 90% of the programmes had 100 or fewer applicants. As shown in Table 2 (right column), 61% of the programmes had relatively "few" (10–24) or a "moderate" (25–49) number of applicants. Perhaps more interesting are variations in the acceptance rates of various programmes, which ranged from 0% (one programme that rejected its two applicants) to 100% (nine programmes that accepted all applicants). The median acceptance rate for the 88 programmes that reported data was 71% (*M* = 66%, *SD* = 24%). As categorised in Table 2, most (57%) of the programmes were rated as "fairly open" (51–75% accepted) or "quite open" (76–90% accepted). However, most programmes clearly were not rejecting many of the applicants that met the educational/occupational prerequisites noted above. Norcross et al. (2010) obtained interestingly comparable results in the United States in a survey of directors of APA-accredited doctoral programmes in clinical psychology.

3.2.4 | Trainees

The median number of trainees per programme was 42 (*M* = 90, *SD* = 160), but the range extended from lows of 4 and 6 (both located in Zürich) to a high of 720 (Gestalt School in Paris, 91% accepted), 750 (University of Oslo, 6% accepted) and 1092 (Sigmund Freud University in Vienna, 83% accepted). Interestingly, the programme with the largest number of applicants and second largest number of trainees (i.e., Oslo) had an extremely selective acceptance rate, whereas the others accepted nearly all applicants. Again, as categorised in Table 2, the student bodies rated as "small" (13–25 trainees) or "moderate" (26–50 trainees) together comprised a majority (59%) of programmes.

3.2.5 | Funding

Sources of funding for trainees also varied across programmes, but for the most part were the responsibility of trainees themselves. As noted in Table 2, trainees in 58% of the programmes had to rely at least partly on their own private funds or loans they took, and if already

qualified to treat clients (e.g., under supervision), 46% also drew on money they earned through clinical practice. Trainees in a few programmes had access to workplace grants (26%) or government grants (21%), and even fewer could rely on programme fellowships (13%) or work as teaching assistants (8%). This tended to vary by country, as some provided significant government support (Norway, 100%; UK, 63%; France, 60%) or workplace grants (e.g., Sweden, Norway, Lithuania and China at 100%). Norcross et al. (2010) also found training funding to vary significantly across types of clinical doctoral programmes in the United States. Given the great need for mental healthcare providers almost everywhere, it is a bit surprising (and rather sad) that trainees are forced in many places to fund their own training. Financial burden has been identified as a significant source of poor life quality in our trainee sample (Heinonen et al., 2022), which, in turn, has been shown to negatively influence their experienced development as psychotherapists (Orlinsky, Willutzki, et al., 2022). Doran et al. (2016) also identified trainee financial debt as a significant source of stress. Moreover, the need to admit candidates who can pay for their training may be a covert source of bias in some programmes' selection process.

3.2.6 | Schedule

Finally, Table 2 (bottom) shows that most trainees (77%) tend to participate in their training programmes on a part-time basis, possibly reflecting both their need to work in order to fund their training and support themselves, and the large part-time involvement of faculty in many programmes (who may themselves rely primarily on their clinical practice for income). Among the 13% who tend to engage in full-time study, many were training at well-known academic institutions (e.g., Heidelberg University in Germany, Oslo University in Norway, Columbia University in the United States or University College London in the UK).

3.3 | Selection process

The data contained in Table 3 allow one to further explore the trainee selection process as conducted by the 90 training programmes in our sample to date. The training directors or senior faculty who completed the TPDF were presented with a series of potential answers following the question, "What criteria for evaluating applicants are used in your programme?"

Some of the options listed in Table 3 refer to the sources of information about applicants that programmes might consult to assess the trainees (e.g., interviews or letters of reference); some refer to the actual criteria that programmes use in forming judgements (e.g., applicants' personal qualities or intellectual abilities); and others might refer somewhat ambiguously to both (e.g., grades from previous studies, which may be consulted but may not be salient in forming judgement, or may be both). Some of the ambiguity can be resolved if one considers the relative rank by percentage of programmes in each category.

TABLE 3 Applicant selection: Information sources and assessment criteria.

	N	%
Sources of information used in assessing applicants		
Interviews with programme faculty or staff	81	90.0
Grades from previous studies[a]	38	42.2
References from personal contacts	27	30.0
References from employers or supervisors	23	25.6
Professional society affiliation with or registration by an accrediting group	20	22.2
Standardised test scores (e.g., Graduate Record Exam)[a]	15	16.7
Possible criteria applied in assessing applicants		
Personal qualities (empathy, self-awareness, good mental health)	75	83.3
Intellectual qualities (intelligence, theoretical interest, psychological-minded)	67	74.4
Previous experience with relevant client groups	46	51.1
Grades from previous studies[a]	38	42.2
Standardised test scores (e.g., Graduate Record Exam)[a]	15	16.7

[a]"Grades from previous studies" and "standardised test scores" may be consulted as admission-relevant data and/or used as criteria for acceptance.

3.3.1 | Sources

Looking first at the sources of information on which programmes rely (Table 3, top tier), one notes a strikingly consistent preference among 90% of the programmes for direct interviews of applicants by programme faculty or staff. As Callahan & Watkins (2018b, p. 221) noted, "From a program perspective, interviewing provides an opportunity for a more holistic consideration of the applicant's aptitude for major components of doctoral training: curriculum, practicum, and research." No other source of information is as widely endorsed. In addition, the grades applicants attained in their previous studies, consulted by 42% of programmes, at least offer some evidence about the likelihood of the trainee successfully completing a course of study. Even fewer programmes seem to rely on references from the applicant's personal contacts (30%), past or current employer or supervisor (26%) or affiliation with a professional society (22%). Least of all do programmes seem to rely on an applicant's standardised test scores (17%), in contrast to most psychology departments in the United States (Callahan & Watkins, 2018b).

3.3.2 | Criteria

With respect to the criteria that programmes use in evaluating applicants (Table 3, lower tier), there is nearly as striking a consistency among 83% of programmes in specifying the applicant's

personal qualities (i.e., empathy, self-awareness and good mental health) that presumably are judged through interviews with programme faculty or staff. The applicant's intellectual qualities (i.e., intelligence, theoretical interest and psychological-mindedness) are another judgement criterion stipulated by as many as three-quarters (74%) of the programmes. Both of these common criteria emphasise the individual characteristics of the applicant. To a lesser extent, prior experience with relevant client groups is cited as a criterion by about half (51%) of the training programmes, such that a programme focussed on the treatment of children and families (for example), or on group treatment, might prefer applicants with a relevant background for that work. Academic criteria such as grades from previous studies and standardised test scores ranked fifth and sixth among six potential selection criteria, respectively. Unlike many other fields of advanced study, individual and personal factors are more salient than academics in the selection and training of psychotherapists, even though most training programmes require a significant level of academic training as prerequisites for applicants.

3.4 | Training modalities and methods

Questions in the TPDF ask, in some detail, about the content and methods of training programmes, which cannot be fully treated in this paper but will be presented elsewhere (Hartmann et al., in progress). However, a brief overview of some features will add to the meaningfulness of the present paper.

3.4.1 | Modalities

For example, Table 4 shows which treatment modalities are required subjects, optional studies or not available among the 90 training programmes. These data make clear that most (86%) programmes share a requirement that trainees prepare to provide individual psychotherapy with adults. As a requirement or option, this is absent from only 12% of the programmes, which presumably focus exclusively on alternative treatment modalities (e.g., couple or family therapy). Furthermore, nearly three-quarters (73%) of the programmes also concentrate on relatively long-term treatment (defined as lasting >6 months), and over half (57%) of the programmes also require study of brief or short-term therapy (defined as lasting <12 sessions). Beyond what may be described as this core content of psychotherapy training—that is, for long- or short-term individual psychotherapy with adults—treatment modalities fall into relatively specialised areas. Relatively common as required or optional trainings are group psychotherapy (40% required and 23% optional) and couple/marital psychotherapy (37% required and 26% optional). Only about one-third of the programmes surveyed required that trainees prepare for individual psychotherapy with children (34%), family therapy (34%) or parent–child therapy (30%)—suggesting their relatively specialised nature in the realm of mental health treatments.

3.4.2 | Methods

Table 5 shows that most programmes require (87%) or offer optional (4%) practice with real therapy patients and require trainees have their treatment cases supervised by experienced therapists (98%), discuss their cases jointly with trainee colleagues (96%) and get feedback on their performance from trainers and supervisors (94%). Other more or less similar methods are also very common: feedback on performance by other trainees, participation in sensitivity-training groups and role-play with peers, individual self-reflection (e.g., via work diaries) and attendance at case demonstrations—all methods that were required by 80% or more of the programmes. Thus, despite all the variations in size, sponsorship and location of training programmes, there appears to be a remarkable consistency in the training methods that they use, although we do not know as yet how they are implemented in specific contexts.

3.5 | Programme completion

3.5.1 | Graduation

Requirements and rates for programme completion complement the similar data reported for programme admissions. Parallel to variations in the size of their student bodies, the top tier of Table 6 shows a wide variation among programmes in numbers of trainees expected to complete training during the current year, although the correlation between number of trainees and graduates was only $r = 0.40$. The numbers ranged from 0 (only among the "very small" programmes) up to 200, with a median of 11 ($M = 19$, $SD = 32$). Graduation rates (number expected to graduate divided by number of programme trainees) also ranged widely, 0% to 100%, with a median of 15% and mean of 20% (i.e., about what might be expected as average in a 5-year-long programme).

3.5.2 | Requirements

The TPDF asked programme directors about specific requirements for graduation such as number of cases treated under supervision, hours of supervision, experience of personal psychotherapy and a scholarly or research thesis or clinical paper. The frequency of programmes with such requirements and the numbers reported for them are shown in the middle tier of Table 6. Almost all (94%) programmes required a minimum number of hours in supervision in order to graduate, again with a very wide range (12–600) but a median of 150 and mean of 162 ($SD = 106$). About

TABLE 4 Treatment modalities taught.

Modalities	Required		Optional		Not offered	
	N	%	*N*	%	*N*	%
Individual psychotherapy with adults	77	85.6	2	2.2	11	12.2
Long-term psychotherapy (>6 months)	66	73.3	6	6.7	18	20.0
Brief/short-term psychotherapy (<12 sessions)	51	56.7	15	16.7	24	26.7
Group psychotherapy	36	40.0	21	23.3	33	36.7
Couple/marital psychotherapy	33	36.7	23	25.6	34	37.8
Individual psychotherapy with children	31	34.4	17	18.9	42	46.7
Family therapy	31	34.4	16	17.8	43	47.8
Parent–child therapy	27	30.0	22	24.4	41	45.6

TABLE 5 Training methods.

Methods	Required		Optional		Not offered	
	N	%	*N*	%	*N*	%
Case supervision with experienced therapists	87	96.7	1	1.1	2	2.2
Case discussions by trainees/candidates	86	95.6	1	1.1	3	3.3
Feedback on performance by trainer/supervisor	85	94.4	1	1.1	4	4.4
Practice with real therapy patients	78	86.7	4	4.4	8	8.9
Feedback on performance by other trainees	76	84.4	10	11.1	4	4.4
Sensitivity training group experience	76	84.4	2	2.2	11	12.2
Individual self-reflection	75	83.3	9	10.0	6	6.7
Role-play with programme peers	75	83.3	8	8.9	7	7.8
Case presentations by trainer	72	80.0	13	14.4	5	5.6
Live demonstration by programme trainer(s)	70	77.8	13	14.4	7	7.8
Personal therapy	67	74.4	14	15.6	9	10.0
"Self-experience" or "Balint" group	62	68.9	9	10.0	19	21.1
Use of technology (e.g., viewing videos)	61	67.8	24	26.7	5	5.6
Practice with simulated patients (actors)	37	41.1	6	6.7	47	52.2

four-fifths (80%–81%) of programmes also specified that trainees complete a minimum (but widely varying) number of supervised treatment cases ($M = 75$, $Med = 6$) and number of hours of personal therapy ($M = 190$, $Med = 150$). The same proportion (81%) required that trainees produce a thesis or final paper demonstrating intellectual proficiency and clinical competence in their practice.

However, these were not the only requirements for programme completion reported by training directors. Nearly four-fifths (79%) said other requirements also existed; and, when asked for specifics, half (50%) mentioned a final written and/or oral examination; a fifth (20%) indicated that trainees had to receive further treatment experience (e.g., in the form of a supervised internship); and a third (34%) listed a variety of other requirements (e.g., attendance at special seminars).

3.5.3 | Qualification

The bottom tier of Table 6 shows answers to two questions about programme completion that were included in the TPDF. The first was "Do graduates of the programme receive an academic degree or certification?"—and most (87%) training directors said "Yes." These included academic awards such as bachelor's (2), master's (12) and doctoral degrees (3); certificates indicating professional recognition of specialist achievement; and grants of governmental accreditation, qualification for licensing examination or licensing for practice.

Programme directors were also asked, "Is additional post-graduate experience or training required for graduates to be formally certified or licensed as independent practitioners?" and most (92%) indicated that no further training or achievements were required for graduates

TABLE 6 Programme completion, graduation requirements and practice qualification.

	Programmes involved		Numbers reported			
	N	%	*M*	*SD*	Med	Range
Programme completion						
Number expected to graduate this year	89	98.9	18.8	32.3	11	0[a]–200
Graduation rate (% of trainees)	85	94.4	20%	24%	15%	0[b]–100.0%
Graduation requirements						
Number of treatment cases supervised	72	80.0	74.5[b]	180.8[b]	6[b]	1–600[b]
Number of hours in supervision	85	94.4	161.5[c]	105.7[c]	150[c]	12–600[c]
Number of hours in personal therapy	73	81.1	189.7[d]	154.7[d]	150[d]	20–800[d]
Research thesis or final clinical paper	73	81.1	–	–	–	–
Additional requirements (as specified) …	71	78.9				
Final examination (written or oral)	45	50.0				
Further treatment experience (e.g., internship)	18	20.2				
Something else	30	33.7				
Qualification						
Graduates receive an academic degree or certificate	78	86.7				
No further experience or training required for independent practice	83	92.2				

[a]No expected graduates only from "Very small" programmes (1–12 trainees).

[b]Based on data provided by 67 of 72 programmes requiring this.

[c]Based on data provided by 84 of 85 programmes requiring this.

[d]Based on data provided by 72 of 73 programmes requiring this.

to qualify for independent practice as psychotherapists. However, it is quite possible that many trainees had already reached that level of professional practice, given that 40% of the directors indicated their programmes provided only "advanced" professional training, and many programmes required prior qualification in therapy practice-related areas such as psychology, medicine or psychiatry (Table 2).

4 | CONCLUSIONS

4.1 | Summation and interpretation

As expected, the 90 psychotherapy training programmes differed widely among themselves in terms of their formal characteristics, such as sponsorship, size, nationality and theoretical focus. However, despite these many variations, some aspects were remarkably consistent. Most programmes reported that their preferred sources of information about applicants were individual and direct, involving interviews with faculty or staff, rather than indirect (e.g., letters of reference) or standardised (e.g., academic grades). That may not be feasible for programmes with large numbers of applicants, although they might preselect a smaller number of candidates to be interviewed using other criteria (e.g., grades and references). A few programmes (about 8%) even host "introductory" groups where applicants' social and interpersonal skills can be directly observed.

The selection criteria described by programme directors likewise focussed most consistently (in 83% of programmes) on the personal

qualities of applicants (empathy, self-awareness and good mental health), supplemented (in 74% of programmes) by evaluations of applicants' relevant intellectual qualities (psychological-mindedness and theoretical interest as well as intelligence). Prior academic achievements, which figure prominently as gateways for many other professions, are not among the leading criteria for selecting psychotherapy trainees.

Undoubtedly, the most striking consistency among otherwise highly diverse programmes is a commitment to experiential learning as distinct from mainly academic or cognitively oriented instruction. Whatever their other differences, almost all (94% to 97%) programmes include direct supervision of trainees' treatment cases by experienced therapists, together with discussion of cases with experts and peers, comprising what can be described as the "common core" of psychotherapy training. These core methods are widely supplemented with sensitivity-group experience and individual self-reflection methods in many (84%) of the programmes. Theories are taught in every training programme, and discussion of cases would not be possible without them; but theory in that context would normally focus on understanding the nature of the cases presented and the processes involved in their treatment, rather than on abstract concepts and their interrelations.

If there is a common focus in terms of modalities and methods, that is clearly on individual psychotherapy with adults (86% of programmes), often in the context of relatively long-term treatment (73% of programmes), but, in many (57%), also in brief or short-term treatment. Preparation of trainees for sustained engagement in therapeutic relationships with individual adult patients, with all the interpersonal and self-reflective skills needed to conduct those helpfully, represents the backbone of psychotherapeutic education.

The explanation for these commonalities among programmes that aim to train professional psychotherapists, and to further enhance their skills in "advanced" trainings, has to reflect the generic nature of psychotherapy as an intimate yet asymmetrical interpersonal process, held and controlled within the boundaries of a professional relationship carried on mainly for the patient's or client's personal benefit, and only for the "impersonal" occupational/economic benefit of the therapist. The ability to do this successfully requires a level of interpersonal sensitivity and self-discipline far beyond the average population norm. Trainees are typically selected who show above-average talents, and training typically focusses on the refinement of these talents to a level that ideally makes them safe and effective when applied in practice (e.g., Norcross & Lambert, 2019). Inevitably, that ideal is only approximated more or less closely and may be missed by some who were accepted into and completed training programmes (e.g., Baldwin & Imel, 2013; Johns et al., 2019; Orlinsky, Hartmann, et al., 2022). Still, the essential commonalities among psychotherapy training programmes appear to be more significant than their many differences, due to the nature of psychotherapy itself and the typical modality in which it is practiced.

4.2 | Limitations and future directions

The current sample of psychotherapy training programmes in the SPRISTAD study not only has the strengths of size and internal variability, far exceeding what has been encompassed by prior research, but also has the serious limitation of its unbalanced representation of some countries (e.g., Finland) and underrepresentation of others (e.g., the United States). Caution is thus needed with respect to generalising our findings beyond the observations presented, and to hold as likely that many observed differences between programmes may reflect differences between, and local conditions within, the countries and professional organisations thus far studied. At the same time, observation of broad similarities across these divergent factors tends to enhance their persuasiveness. Nevertheless, future efforts should be directed to the recruitment of training programmes from diverse areas that were not represented in the current sample. Other future directions for the investigation of training and training programmes within the SPRISTAD collaborative study will compare trainees' descriptions of their training programmes with those offered in the TPDF by training directors, and examine trainees' evaluations of their programmes' varied features as particularly helpful, or hindering, or wished-for but absent.

AUTHOR CONTRIBUTIONS

David E. Orlinsky: Conceptualization; writing – original draft; data curation; methodology; formal analysis; project administration; investigation. **Irene Messina:** Writing – original draft; conceptualization; investigation. **Armin Hartmann:** Methodology; investigation. **Ulrike Willutzki:** Investigation; data curation; project administration; conceptualization. **Erkki Heinonen:** Investigation; project administration. **Michael Helge Rønnestad:** Investigation. **Henriette Löffler-Stastka:** Investigation. **Thomas Schröder:** Investigation; conceptualization.

CONFLICT OF INTEREST STATEMENT

None declared.

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