

THESIS

INITIAL DEVELOPMENT OF A MEASURE TO LINK PSYCHOTHERAPY-SEEKING ADULTS
WITH APPROPRIATE THEORETICALLY DERIVED TREATMENT

Submitted by

Nicholas E. Neujahr

School of Social Work

In partial fulfillment of the requirements

For the Degree of Master of Social Work

Colorado State University

Fort Collins, Colorado

Spring 2014

Master's Committee:

Advisor: Nicole I. Cesnales

Emily K. Dakin
Sharon Anderson

Copyright by Nicholas E. Neujahr 2014

All Rights Reserved

ABSTRACT

INITIAL DEVELOPMENT OF A MEASURE TO LINK PSYCHOTHERAPY-SEEKING ADULTS WITH APPROPRIATE THEORETICALLY DERIVED TREATMENT

A multitude of differing theoretical approaches to psychotherapy exist in practice today. Many researchers have attempted to prove the superior effectiveness of one theoretical approach over another, yet most findings point to the overall equal effectiveness of psychotherapy across such theoretical approaches, a phenomenon known as the “do-do bird verdict.” While some investigators continue to focus research efforts on therapists’ approaches to treatment, more emphasis is being placed on clients’ contribution to the therapeutic process. Despite this shift, little research exists that investigates clients’ ability to relate to and incorporate any of the various models of treatment they may potentially encounter in treatment. The development of a measure intended to link psychotherapy-seeking adults with the appropriate theoretically based treatment is described, with an emphasis on clinical application. A panel of nine (n=9) clinical experts was recruited to review 117 items constructed to reflect six major theoretical approaches to psychotherapy. Inter-rater reliability and content validity were determined to determine the 48 strongest items. A cognitive interview was conducted to further determine clarity and understanding of these items, as well as to identify the five strongest items per domain to constitute the 30-item final measure. An outline for developing valid items that constitute the measure is provided, including recruitment and use of a panel of clinical experts to review and revise the instrument for content validity and clarity.

TABLE OF CONTENTS

ABSTRACT	ii
Introduction	1
Literature Review	3
Methods	11
Results	16
Discussion	24
References	27

Introduction

It is estimated that as many as 59 million American adults have received a form of psychotherapy in the last two years (CAMFT, 2004). With the prevalence of services sought, it is not surprising that a variety of different theoretical orientations to mental health treatment have been developed over the decades. In fact, many researchers assert that the number of mutually exclusive therapeutic approaches has increased exponentially in the last 60 years, and will continue to do so (Miller et al., 1997; Bohart, 2000). As approaches to treatment increase, it is increasingly difficult to understand the true differences among the various strategies towards therapeutic change. With all these approaches to treatment in use, there is a high likelihood that many adults who seek psychotherapy will receive treatment that does not thoroughly or accurately match their personal needs. Indeed, therapists receive training that reflects a specific theoretical approach to therapy, become clinical experts in that approach, and expect to be able to use it successfully for a variety of clients and presenting problems (Bohart, 2000). Proponents for the various theoretical approaches to psychotherapy have thus been eager to prove the superiority of their respective therapies. It can be argued that an over-emphasis has been placed on the supposed superiority of one commonly used therapeutic intervention over another. Research has proven inconsistent in demonstrating differences among approaches. While some research indicates modest effects, meta-analyses of other studies demonstrate that all major theoretical approaches to treatment work about equally well – a phenomenon known as the “do-do bird verdict” (Miller, Duncan, & Hubble, 1997; Bohart, 2000).

Responses to the “do-do bird verdict” have called to question the research and practice of psychotherapy. Curry (2009) emphasizes the pragmatics of therapeutic practice, including engagement and motivation of clients for treatment. He proposes innovative approaches to

investigating the effectiveness of different approaches to psychotherapy as well as the execution of such techniques, allowing for “tailoring and improvisation” (pg. 319) throughout these processes that may lead to greater outcomes (Curry, 2009). Angus and Kagan (2007) highlight the importance of alliance building between client and therapist as well as enhancing clients’ sense of agency in therapy as a means to improve outcomes.

Given the well established “do-do bird verdict” finding as well as its notable responses, an innovative approach to investigating the therapeutic process is needed. It is believed that shifting the focus of such research from therapist to client, including their unique self-healing capacities and perspectives on the change process, will contribute to the significance of the therapeutic process for individuals who pursue such services. Similarly, focusing on ways to enhance therapy from the clients’ perspectives may increase the effectiveness of mental health services offered to adults in individual therapeutic arrangements, thus increasing the impact of the fields of psychotherapy and clinical social work.

To this end, our study purpose was to develop and assess the psychometric properties of a proposed measure intended to link therapy-seeking individuals with the appropriate theoretically derived treatment based on assessing attitudes and beliefs about different approaches to therapy. A review of the extant literature regarding investigations of the therapeutic process, including research focusing on therapist variables, client variables, and the relationship between the two, highlights the need for such an instrument.

Literature Review

An analysis of the research in the field of psychotherapy, including current approaches to the evaluation of treatment, demonstrated the need to assess therapy-seeking clients' natural responses to various approaches to treatment. According to Miller, Duncan, and Hubble (1997), the number of psychotherapy models has grown exponentially throughout the last century. Jensen, Bergin, and Greaves (1990) found that no single approach to psychotherapy dominates the mental health field; in fact, the majority of surveyed professional psychotherapists identified an eclectic, or integrated, approach to their practice. With this increase in the amount of psychotherapy models as well as the prevalence of eclecticism in practice, researchers, developers, and clinical adherents to these different models of treatment have been eager to demonstrate the uniqueness of those models, and what they hope to be superior, understanding and effectiveness of their chosen method over the other major approaches to treatment (Miller et al., 1997).

It is not surprising, then, that a multitude of research has occurred to provide evidence of the greater effectiveness of one model or intervention over another. However, decades of extensive outcomes research have not found any one theory, model, or approach of psychotherapy to be reliably better or more effective than any other (Lambert & Bergin 1994, as quoted in Miller et. al., 1997; Wampold et al., 1997; Bohart, 2000). From this finding, it has been noted by researchers such as Wampold and colleagues (1997), Bohart (2000), and Miller et al. (1997) that, outside of the occasional study that demonstrates the modest effect of one approach to treatment over another, the overwhelming preponderance of the data indicates that the different therapy models in existence today work about equally well. This alarming finding has been deemed the “do-do bird verdict” (Bohart, 2000).

This finding has caused alarm for many researchers and mental health professionals in the field, and a continued adherence to their respective techniques to treatment has ensued (Miller et al., 1997; Bohart, 2000). Some therapists have implied that, despite evidence of the “do-do bird verdict,” the primary healing force of therapy still reflects specific interventions to produce specific effects (Bohart, 2000). Bohart (2000), citing Fishman (1999), notes that 80% of research on psychotherapy continues to be devoted to specific techniques and procedures, even though research has proven for years that such techniques and procedures do not contribute meaningfully to outcomes in therapy. This has proven to be a critical point in the debate of the specific components that contribute to effective psychotherapy, with considerable division on where to focus research efforts moving forward.

Some research, inevitably, has placed its focus on the therapeutic process, and the therapist in particular, with only limited focus on the clients’ role. Coleman (2007) evaluated the theoretical orientation of clinicians and students towards various major psychotherapy theories using the Theoretical Evaluation Self Test. Even though this study sought to shed light on how therapists use their theoretical orientations in practice (Coleman, 2007), it did not include the client perspective in this evaluation whatsoever. Declining to incorporate client voice in this evaluation of theoretical orientation towards therapy overlooks the client’s perspectives of the therapeutic process, as well as missing any pertinent information as to how or why a client responds well or poorly to a given theory.

Horvath, Marx, and Woudzia (1991) sought to psychometrically evaluate the Counselors’ Intentions List (CIL), a measure assessing therapists’ intentions for their clients in therapy, including the theoretical bias of the therapist. The CIL was also used to evaluate the degree to which clients could understand their therapist’s intentions during therapy. They found that the

outcome of such an approach was limited, with a modest 39% of therapeutic intentions of the therapist being correctly understood by the clients, and no client understanding of therapists' intentions improving over time (Horvath, Marx, & Woudzia, 1991). This study was restricted to intentions generated by the therapist, and did not assess clients' intentions of the therapeutic process, but their reactions to their therapists' generation of intentions. Horvath, Marx, and Woudzia (1991) conducted a subsequent study that had therapists rate each item of the CIL in terms of its estimated frequency in their respective practice as well as the relative importance of the intention to the field in general. While this approach revealed that theoretical influence categories were congruent with the choice of primary theory of the therapist (Horvath, Marx, & Woudzia, 1991), it did not incorporate the clients' views of theoretical preferences or orientations in the therapeutic process, thus overlooking the power they bring to the change process.

Other research has taken similar approaches to evaluating the therapist and their theoretical approaches to treatment. Poznanski and McLennan (1995) focus on therapists' theoretical orientation as a conceptual framework used to understand client therapeutic needs. They emphasize that assessing theoretical orientation of the therapist allows for generating hypotheses about a client's experience and behavior, and formulating a rationale for specific treatment approaches accordingly (Poznanski & McLennan, 1995). Poznanski and McLennan (1995) acknowledge that while "what counselors actually do in a given session might not always reflect the theory to which they adhere" (p. 412) due to various factors, the need remains for therapists to develop and adhere to concrete theoretical approaches to treatment with clients. They emphasize this need because a therapist's theoretical orientation provides an important foundation and perspective for understanding the nature of human struggle and change, case

conceptualization, and therapeutic goals and techniques (Poznanski & McLennan, 1995). The critique includes the psychometric properties and utility of fifteen instruments created to conceptualize and measure therapists' theoretical orientations to practice, with no attention paid to incorporating the clients' understandings or likelihood to benefit from the therapeutic techniques derived from such theoretical orientations.

Other efforts have begun to shift focus towards client variables and their impact on the therapeutic process. Asay and Lambert (1999) report that as much as 40% of improvement in psychotherapy is attributable to client factors and extratherapeutic influences such as client history, severity of symptoms, motivation and ambivalence for therapy, capacity to relate, psychological mindedness, and the ability to identify a focal problem. More recently, Beutler, Forrester, Gallagher-Thompson, Thompson, and Tomlins (2012) have attempted to identify moderating factors in the therapeutic relationship that contribute to outcomes by identifying pairs of client-treatment variables that constituted good matches or fits within therapy. Even though this study incorporated client variables to determine such matches, these variables were determined by "intake impressions" for which clinicians involved in the study completed ratings that were compiled to extract the relevant client dimensions (Beutler et al., 2012). Even though this study found that client variables did, in fact, produce the largest effect size among the various client, treatment, relationship, and matching variables studied (Beutler et al., 2012), they were still directly derived from clinical observations of clients as well as measures used to diagnose clinical issues. Thus, the client factors of interest were not derived from the clients themselves, and client voice and perspective in the therapeutic process were, just as in multiple previous efforts, effectively overlooked.

With this multitude of studies conducted that focus on therapist theoretical orientation and therapist-derived perspectives of the therapeutic process, a trend has arisen in the research literature that criticizes such an approach, pointing the field in the direction of emphasizing clients' attributes and processes. Duncan and Miller (2000) observe that the client has been "woefully left out" (pg. 170) of the therapeutic process and its accompanying research efforts. The literature that integrates clinical research and application, Duncan and Miller (2000) assert, has paid little attention not only to the client's inherent abilities, but also their own preferences for treatment and integration efforts. Unfortunately, a search of the current literature in databases such as Web of Science and PsycINFO since Duncan and Miller's original assertion reveals little progress towards incorporating direct client perspective in the therapeutic change process. This presents a significant limitation in identifying the literature that can support and direct the development of a measure intended to incorporate client perspective in the change process. As has been demonstrated in this literature review, much existing research has focused almost exclusively on the therapist's frame of reference; it is apparent that a major focus in the psychotherapy field revolves around the therapist's use and synthesis of the various models that exist. This approach, Duncan and Miller (2000) argue, ignores the importance of the client's "wisdom, perspective, resourcefulness, and expertise on their own life" (pg. 174). An approach involving the "client's theory of change" (pg. 174) is proposed, in which the client's perspective and understanding of their lives and what is necessary for change is honored as a proactive initiative that requires the conduct of therapy within the client's ideas and circumstances (Duncan & Miller, 2000). This idea is reflected in some research that has focused on what prompts or motivates one to seek help (Prochaska, Norcross, & DiClemente, 2013). As such, the infamous and limiting "do-do bird verdict" can be overcome by shifting therapeutic focus away

from differing models based on theoretical orientation of the therapist and onto the client's regenerative abilities. Therapies work equally well because the client's propensities toward change ultimately transcend any differences between models (Duncan & Miller, 2000). Because the therapeutic alliance has repeatedly been shown to be one of the best predictors of favorable outcomes for clients (Batchelor & Horvath, 1999), Duncan and Miller (2000) posit that the simple act of assessing a client's views and perspectives about their personal change process and collaboratively planning their treatment accordingly should significantly impact treatment outcome.

This reinvention of the approach to studying the psychotherapy process is continued by other research designs. Elliott (2008) evaluated the various facets of studying clients' experiences of therapy. He emphasizes a multi-dimensional model of evaluating the therapy process, including the perspective from which the relevant clinical information derives (client vs. traditional therapist perspectives) as well as the person the research focuses on, which is shifting from the therapist to the client. (Elliott, 2008). Elliott (2008) asserts that innovated ways of examining client experiences such as this are central to advancing theoretical understandings of the change process in therapy. This reflects earlier assertions of the value of utilizing theory of human nature and change as an important tool to understand presenting problems, case conceptualizations, and beliefs about the change process (Poznanski & McLennan, 1995). In particular, knowledge about key overlooked aspects of client in-session experience, including their understandings and use of different techniques in personal change, can be used to help therapists work more effectively with their clients.

According to Elliott (2008), two elements of research on client processes are largely ignored: clients' understandings of the context of important therapeutic processes and their

assessments of the quality of their own or their therapists' responses. Citing his earlier meta-analysis on therapeutic process (Elliott & James, 1989), Elliott (2008) highlights one relevant domain of client experience that has been perceived by clients to be helpful in therapy: client self-expression. Many of the current issues regarding the psychotherapy process could be addressed by creating a measure that, through assessing and incorporating clients' unique processes such as beliefs about change and self-expression, will contribute to greater outcomes for such clients in therapy.

Another notable milestone that facilitates the critical shift from therapist to client involves research by Lundgren, Luoma, Dahl, and Melin (2012) that seeks to develop and evaluate an instrument intended to identify and measure client values and client-perceived barriers to goal attainment in the therapeutic process. Participants were instructed to place an X on a graphic that resembles a bullseye, with the X representing the extent to which the client's current behaviors were congruent with their values and goals they wish to achieve (Lundgren, Luoma, Dahl, & Melin, 2012). Participants whose perceptions of values were incorporated in treatment by the therapist showed highly significant positive changes in their values attainment scores when compared with clients in supportive therapy treatment alone (Lundgren, Luoma, Dahl, & Melin, 2012). This finding represents a significant step towards assessing clients' understanding of their own needs and processes in therapy, while providing compelling support for the need to assess clients' personal views before and during therapy as a means of attaining positive outcomes. Additionally, a psychometric evaluation of this instrument indicated significant test-retest reliability and validity with other measures (Lundgren, Luoma, Dahl, & Melin, 2012), which reflects the ability to develop such a measure that can have true utility in clinical work as well as research on psychotherapeutic process for clients.

Emphasis is being placed on evidence-based practice in the fields of psychotherapy, psychiatry, and social work (Simon & Perlis, 2010). Evidence-based practice is a process that incorporates current best evidence, clinical expertise, and client preferences, when possible (Shlonsky & Gibbs, 2004). This literature review demonstrates the lack of client voice in the initial assessment of the change process, an essential element of true evidence-based practice as emphasized by Shlonsky & Gibbs (2004). Accordingly, the instrument developed in this study can contribute to the process of achieving evidence-based practice by effectively incorporating client perspective about the process of change and their understanding of effective therapy.

A review of the current research on psychotherapy shows that much attention has been paid to the therapist, as well as certain elements that the client brings to the therapeutic arrangement. We argue that the client-centered elements in research and clinical assessment have been lacking to this point. The development of a rapid assessment instrument will incorporate clients' natural inclinations towards various major models or approaches to psychotherapy. Although beyond the scope of this thesis, the goal is to develop a streamlined measure to administer to adults when they seek individual therapeutic services, with the purpose of providing valuable information to the practitioner or treatment team to be used in planning and implementing effective treatment for that individual.

Methods

Item Development

The issue of determining which theoretically informed approaches to include for this study proves complex. Recent research on therapists' selection of theoretical orientation incorporates approaches such as Psychodynamic, Cognitive-Behavioral Therapy, and Humanistic Therapy, but does not explicitly state *why* these specific techniques were included (Ogunfowora & Drapeau, 2008). Other research focusing on therapists' use of techniques focuses more on broad-based approaches that are trans-theoretical, such as insight-oriented and affect-focused techniques (Haran, 2009). Strom (1994) surveyed 155 social workers in private practice for their chosen theoretical orientation they utilize with clients by providing a list of commonly used theories in practice. Respondents indicated most commonly using Psychodynamic and Cognitive-Behavioral Therapy (Strom, 1994). Many respondents wrote in additional theories including Solution-Focused Therapy, Existential Therapy, and Interpersonal Therapy, suggesting that many theoretical approaches to treatments were gaining traction (Strom, 1994). Strom (1994) also found that clinical social workers use an average of 4.2 theoretical bases in their practice, a finding which suggests the need to develop a method of determining when to use which theories with which clients.

The National Institute of Mental Health (NIMH) emphasizes that there are many differing approaches to therapy for individual adults, but does not explicitly mention which models are most commonly used. Instead, the NIMH outlines only a select few, such as Cognitive Behavioral Therapy, Interpersonal Therapy, and Psychodynamic Therapy (NIMH, 2013). These approaches are also stressed in social work higher education for direct clinical practice, along with other theoretically distinct models such as Existential techniques, Post-modern

constructivist techniques, and Motivational Interviewing (Payne, 2005; Walsh, 2010). Therefore, in order to maintain a theoretically broad base while incorporating commonly used approaches in therapy, the measure includes items constructed to reflect six models and approaches to treatment in use today, including Cognitive-Behavioral Therapy, Postmodern techniques like Solution-Focused Therapy and Narrative Therapy, Interpersonal Therapy, Psychodynamic Therapy, Existential and Humanistic Therapy, and Motivational Interviewing.

A pool of 30 items for each of the six theoretical domains was initially generated by the author and a committee member based on texts and instructional curricula currently in use to train therapists and clinical social workers. The items were written to reflect major tenets of each of the theoretical domains in a way that the intended population may endorse. One example for CBT is: "I believe how I think about myself may impact how I feel." The 30 items for each of the theoretical domains were reviewed by this author and the thesis committee, and reduced to the 20 strongest items, except for the Psychodynamic domain, which included 17 items, for review by the expert panelists. A Likert-type scale was employed and includes a response category of five options: 0 "Not at all", 1 "A little bit", 2 "Somewhat", 3 "Quite a bit, and 4 "Very much." Originally, a set of 20 questions was asked of each of the six domains, except for the Psychodynamic domain, which had 17 questions. Panelists were provided definitions for each domain

. The definition provided for CBT is:

Cognitive-behavioral therapy combines two therapeutic models (behavioral, derived from learning theories, and cognitive, derived from perception and information processing theories) into one comprehensive treatment modality (Payne, 2005).

Behavioral approaches emphasize principles of respondent, operant, and social learning. Cognitive approaches, in turn, build on social learning theory by emphasizing how cognitions mediate learning, behavior, and emotions. (Thyer & Myers, 1997)

The definition provided for IPT is:

Interpersonal Therapy combines elements of psychodynamic and cognitive-behavioral therapies into an approach that focuses on the client's use of defenses, underlying thought patterns that influence evaluation of the self and others, and the client/practitioner relationship as a model for other relationships. (Walsh, 2010)

The definition provided for Psychodynamic is:

Psychodynamic therapy emphasizes unconscious aspects of the internal experience, the use of defense mechanisms as a protection against anxiety, and the role of early relationships in personality development. This clinical approach places great significance on the relationship between worker and client, including dynamics of transference and countertransference. (Walsh, 2006)

The definition provided for the Existential/Humanistic domain is:

Existential and humanistic therapies are strength-based approaches that are concerned with human dignity, growth, self-determination, and potential. These approaches address human needs related to love, meaning, creativity, and connectedness with other people and the universe (Payne, 2006; Robbins, Chatterjee, & Canda, 2006). They also emphasize the importance of empathy, genuineness, and unconditional positive regard on the part of the worker. (Payne, 2006)

The definition given to panelists for Social Constructionism is:

Social constructionism holds that people's views of themselves and the social world are subjective, rather than absolute, and develop through their interactions with others. Based on this foundation in social constructivism, narrative therapy involves using clients' language to 'deconstruct' or analyze problematic underlying views of self and the world, and then to 'reconstruct' or develop more positive alternative narratives. Also based on social constructionism, solution-focused therapy involves quickly shifting clients' language, interpretations, and relationship patterns away from problems and towards solutions to these problems. (Walsh, 2006)

Finally, the definition provided for Motivational Interviewing is:

People often experience resistance, ambivalence, or lack of motivation about addressing problems in their lives. Motivational interviewing uses a collaborative client/worker relationship to resolve ambivalence or resistance about addressing problems, enhance motivation to change, and promote client self-efficacy so the client perceives that change is possible. (Miller & Rollnick, 2002; Walsh, 2006)

Participant Recruitment

Expert Panelists. For this study, potential participants were eligible for inclusion as expert panelists if they have completed a master's or doctoral degree in social work, family and marriage therapy, clinical psychology, or counseling psychology. Individuals were eligible for

inclusion only if they are licensed practitioners in their respective degree field, and currently working as individual psychotherapists. All 19 training staff at a local university counseling center that meet these criteria were approached to participate as expert review panelists. Names and email addresses of these training staff are available on the agency website and were used to contact staff members for potential participation in the research. This clinical training staff were approached because they represent the aforementioned variety of disciplines and licenses as well as theoretical backgrounds. Because they are identified as clinical training staff, they are especially appropriate for assessing items for this instrument development.

The recruited expert panelists received an email explaining the rationale for the study, including a statement about potential risks or benefits for participating. The email emphasized that participation is optional and anonymity will be maintained; they were notified in the email that electing to complete the review implied consent to be included in the study. The recruited expert panelists were charged with evaluating representativeness and clarity of all 117 proposed items on a web-based survey. To do so, they were first asked to call upon their clinical training and expertise to rate how well an item represented the provided content domain, on a scale of 1 to 5. Once panelists reviewed all items for representativeness, they were instructed to review all of the same items for clarity on the same 1 to 5 scale.

Specific analyses determine representativeness and clarity, and ultimately the overall soundness, of the items in order to select the strongest items from each domain to include in the next phase of the instrument development. Abell, Springer, and Kamata (2009) suggest inter-rater reliability as a way of establishing to what degree different raters follow the same procedures, interpret responses in similar ways, or use techniques that elicit similar information.

Additionally, measures of content validity establish how well item content reflects the definition of the target constructs (Abell, Springer, & Kamata, 2009).

Cognitive Interviews. An additional process is utilized in the design of this instrument to further determine clarity and generate suggestions for the narrowing down of the final items. Cognitive Interviewing is often used in the development of survey questionnaires to determine response error and issues of misunderstanding (Willis, 1999). This process intentionally focuses on the cognitive processes that respondents use to answer survey questions (Willis, 1999). For this phase of the research, twenty therapists were contacted from a list of local practicing professionals generated from psychologytoday.com and narrowed down based on self-reported treatment orientation. Therapists were invited via email to participate in the “Think-aloud” method of Cognitive Interviewing posited by Willis (1999). Consent to participate was read and explained before beginning. This process involved asking the participant to literally think out loud as they are read each of the proposed items for the instrument. Typically in Cognitive Interviewing and Think-aloud, respondents answer as though they are the subject of the questionnaire. This research adapted the process to prompt the participating therapist to think aloud for each item for their impression of its clarity and representativeness, as well as how they would anticipate their clientele to respond to each of the questions. Feedback from the completed cognitive interview will be incorporated to make final selections of the individual items to maximize clarity, representativeness, conciseness, and understanding of the included items.

Results

Expert Review

A panel of 9 total experts completed the entire review of the newly generated instrument. Abell, Springer, and Kamata (2009) suggest an ideal panel size of 6 to 10 panelists for rapid instrument development. Table 1 shows the demographic data of the expert panelists.

Table 1

Expert Panelist Demographic Data (N = 9)

Characteristic	N	%
Highest education		
Master's Degree	2	22.2
Doctorate Degree	7	77.8
Type of professional licensure		
Licensed Clinical Social Worker	2	22.2
Licensed Psychologist	7	77.8

The majority of expert panelists were licensed psychologists with doctorate degrees with more than 15 years of reported post-graduate clinical experience ($M = 15.88$, $SD = 9.72$).

Respondents were also asked to indicate all of the six domains they use in their practice. Table 2 shows the number of expert panelists who indicated using each of the theories in their clinical practice.

Table 2

Type of theoretically derived approaches to therapy used in clinical practice (N = 9)

Domains used in practice	N	%
Cognitive Behavioral	7	77.8
Interpersonal	8	88.9
Psychodynamic	2	22.2
Humanistic/Existential	8	88.9
Social Constructionism	2	22.2
Motivational Interviewing	6	66.7

The majority of respondents indicated using Interpersonal Therapy and Humanistic/Existential approaches, followed by Cognitive Behavioral and Motivational Interviewing. The fewest respondents indicated using Social Constructionism and Psychodynamic approaches in therapy.

Respondents were also asked to rate their level of competence in each of the six domains on a 5 point Likert-type scale identical to the scale used to rate all items for the measure. Table 3 displays these findings.

Table 3

Expert panel average level of competence in each theory (N = 9)

Level of competence	<i>M</i>
CBT	3.89
IPT	4.11
Psychodynamic	3.11
Humanistic/Existential	4.44
Social Constructionism	2.56
Motivational Interviewing	3.44

The highest average level of competence was reported for Humanistic/Existential, followed by Interpersonal Therapy, Cognitive Behavioral Therapy, Motivational Interviewing, and Psychodynamic. Social Constructionism was reported as the lowest mean level of competence out of the six theoretical domains.

Inter-rater reliability. To calculate inter-rater reliability for representativeness of the theories, the total number of items rated a 4 (“quite a bit”) or a 5 (“very much”) for representativeness by the panelists was divided by the number of items on the scale. For the entire pool of 117 questions, inter-rater reliability was .80 ($94/117 = .80$). Inter-rater reliability was also determined for each of the six individual domains: .75 for CBT, .75 for IPT, .53 for Psychodynamic, 1.00 for Existential/Humanistic, .85 for Social Constructionism, and .90 for

Motivational Interviewing. Suggested value for inter-rater agreement ranges from .70 to .80 (Grant & Davis, 1997). The entire pool of questions, as well as five of the six domains, demonstrated adequate inter-rater reliability. Only the psychodynamic domain demonstrated less than the suggested adequate level of .80, with a value of .53 indicating moderate inter-rater reliability (Abell et al., 2009).

Inter-rater reliability was also calculated for items rated for clarity. Just as the ratings for representativeness, the total number of items rated a 4 (“quite a bit”) or a 5 (“very much”) for clarity of items was divided by the number of items. For the entire pool of rated questions, inter-rater reliability for clarity was .81 ($95/117 = .81$). Inter-rater reliability was .85 for CBT, .85 for IPT, .59 for Psychodynamic, .80 for Existential/Humanistic, .75 for Social Constructionism, and 1.00 for Motivational Interviewing. As with the inter-rater reliability values for representativeness, only the Psychodynamic domain displayed moderate clarity.

Content validity index. To determine the content validity of the instrument, the number of experts who score items as representative with either a 4 (“quite a bit”) or a 5 (“very much”) was divided by the total number of panelists (Grant & Davis, 1997). Ideally, a content validity index of .80 or more is desired (Grant & Davis, 1997). For this study, the content validity index for the total pool of items is .82 ($95/117 = .8149$). The content validity is .80 for CBT, .82 for IPT, .69 for Psychodynamic, .92 for Existential/Humanistic, .83 for Social Constructionism, and .83 for Motivational Interviewing.

Analyzing mean representativeness scores and content validity of individual items based on expert panel review informed the process of decreasing the number of items to the eight most representative and valid items per domain to be reviewed in the cognitive interview. For each of the domains, items were ordered by the most representative and clear based on expert panel

review. The eight items per domain that demonstrated the highest values of both representativeness and clarity relative to the rest of the items in the domain were selected for the Cognitive Interview. Table 4 displays mean representativeness scores (MRS) for the eight items per domain with the highest scores and content validity index (CVI) for each of the 48 items used for the Cognitive Interview to finalize the five items per domain to be included in the 30-item final measure.

Table 4

Mean representativeness scores (MRS) and content validity index (CVI) of items for cognitive interview

Item	MRS	CVI
Cognitive-Behavioral		
My beliefs about myself affect my behavior.	4.78	1.00
I believe that changing how I think will change how I feel.	4.44	.89
If I learn new ways of behaving in my life, I will feel differently.	4.56	1.00
I would be open to doing homework assignments outside of counseling to practice the new skills I'm learning.	4.67	.89
I believe how I think about myself may impact how I feel.	4.67	.89
It's helpful to get feedback on a new behavior I am practicing.	4.56	1.00
I believe I need help with changing the way I behave.	4.44	1.00
It would be helpful for me to think about behaviors that I would like to change in concrete and measurable ways.	4.89	1.00
Interpersonal		
I would like to explore different ways of interacting with others in my life.	4.78	1.00
I hope to improve the quality of relationships in my life.	4.67	1.00
I believe that many of my problems have to do with relationships in my life.	4.67	1.00
I believe that my struggles are rooted in my interactions with		

people in my life.	4.67	.89
I would like to explore the relationship between how I interact with others and my satisfaction with my life.	4.56	1.00
I would benefit from exploring how interactions with others impact me emotionally.	4.56	.89
I believe my current relationships impact my quality of life.	4.56	1.00
I would benefit from feedback about how I am perceived when Interacting with others.	4.78	1.00

Psychodynamic

I believe understanding my past is important to understanding my current problems.	4.67	.89
My early childhood played a significant role in developing my personality.	4.56	.89
I am interested in exploring the role of my early relationships in my current difficulties.	4.56	1.00
In order for me to feel better in the present, I need to understand my past.	4.33	.78
A lot of my current problems relate to my childhood.	4.33	.89
Exploring my childhood will be important to helping me feel better.	4.33	.89
I would like to gain insight into how my past relationships impact my present relationships.	4.11	.67
It will be helpful for me to understand parts of my mind that I am currently unaware of.	4.33	.89

Existential/Humanistic

I want to consider ways of making meaning for my life.	4.89	1.00
I would like my counselor to interact genuinely with me.	4.78	1.00
I would like to explore the purpose for my life.	4.67	1.00
I would like to find meaning for the things that have happened in my life.	4.67	1.00
A goal for my therapy is achieving my highest personal potential.	4.56	1.00
I would like my counselor to be warm and empathic in relating to me.	4.56	1.00
I believe that people must find their own unique meaning in life.	4.44	1.00
I would like to explore the ways I block my own growth.	4.33	1.00

Social Constructionism

The language I use impacts how I view the world.	4.75	1.00
I want to find concrete solutions to my problems.	4.63	1.00
I would like to move quickly from talking about my problems to focusing on solving them.	4.63	1.00
I like to explain myself through the stories of my life.	4.50	.86
I would like to identify other possible interpretations of my life story.	4.50	1.00
I think it will be more helpful to focus on solutions to my problems than on the problems themselves.	4.38	.86
It would help me to question some of my assumptions about my world.	4.38	1.00
I view my life as a story I create.	4.38	.86

Motivational Interviewing

It would help me to explore advantages and disadvantages to making certain changes in my life.	4.78	1.00
I have conflicting thoughts about whether I need to make changes in my life.	4.67	.89
If I am really honest with myself, I can recognize that I have behaviors I should change.	4.67	1.00
I need to feel ready to make positive changes in my life.	4.67	1.00
I'm not sure whether I am ready to make changes in my life.	4.56	.89
I recognize that on some level, I have behaviors I am hesitant to change.	4.56	1.00
I want to feel more capable of making positive changes.	4.33	.89
In order to make positive changes in my life, I need to feel prepared to do so.	4.44	1.00

Cognitive Interview. One cognitive interview was conducted with a licensed clinical social worker who has worked in community mental health for four years and is currently in private practice for the last three years. The interviewee self-reported using all six theoretical domains in practice. One interview was conducted, as the vast majority of therapists did not respond to the invitation to participate. As stated before, all items were read aloud to the

interviewee to process verbally her understanding of the item, as well as how individual adults seeking therapy may understand them. The interviewee provided feedback on each of the eight items for all six domains. Examples of feedback that served to exclude items include some items reflecting self-awareness of clients that comes after the initial assessment for therapy, some items being too broad in their scope, and other items being anticipated to be strongly endorsed by most or all respondents. Alternatively, positive feedback was given about other items that lead to their inclusion in the final measure. Examples include using more strengths-based language, as well as being strong overall determiners of the nature of problems clients are facing. This feedback informed the processes of narrowing down the items to five final items per domain, to comprise 30 total items for the measure, provided in Table 5. The order of the items in Table 5 deliberately rotates through the six theoretical domains as the final order of questions respondents would complete.

Table 5

Final Items used for Measure based on Expert Panel Review and Cognitive Interview

-
1. My beliefs about myself affect my behavior.
 2. I would like to explore different ways of interacting with others in my life.
 3. I believe understanding my past is important to understanding my current problems.
 4. I would like my counselor to interact genuinely with me.
 5. I want to find concrete solutions to my problems.
 6. It would help me to explore advantages and disadvantages to making certain changes in my life.
 7. I believe that changing how I think will change how I feel.
 8. I hope to improve the quality of relationships in my life.
 9. I am interested in exploring the role of my early relationships in my current difficulties.
 10. I would like to explore the purpose for my life.
 11. I would like to move quickly from talking about my problems to focusing on solving them.
 12. I have conflicting thoughts about whether I need to make changes in my life.
 13. If I learn new ways of behaving in my life, I will feel differently.
 14. I believe that many of my problems have to do with relationships in my life.
 15. In order for me to feel better in the present, I need to understand my past.
 16. A goal for my therapy is achieving my highest personal potential.
 17. I like to explain myself through the stories of my life.
 18. If I am really honest with myself, I can recognize that I have behaviors I should change.
 19. I would be open to doing homework assignments outside of counseling to practice the new skills I am learning.
 20. I believe my current relationships impact my quality of life.
 21. A lot of my current problems relate to my childhood.
 22. I believe that people must find their own unique meaning in life.
 23. I would like to identify other possible interpretations of my life story.
 24. I'm not sure whether I am ready to make changes in my life.
 25. It would be helpful for me to think about behaviors that I would like to change in concrete and measurable ways.
 26. I would benefit from feedback about how I am perceived when interacting with others.
 27. It will be helpful for me to understand parts of my mind that I am currently unaware of.
 28. I would like to explore the ways I block my own growth.
 29. I think it will be more helpful to focus on solutions to my problems than on the problems themselves.
 30. In order to make positive changes in my life, I need to feel prepared to do so.
-

Discussion

This final, 30 item measure reviewed first by expert panelists and subsequently by a cognitive interviewee signifies the termination of the scope of this thesis. Although beyond the scope of this current project, future direction of this research will involve collecting data with this instrument for the intended population of therapy-seeking adults to conduct confirmatory factor analysis of the six theoretical domains, as well as determine psychometric reliability and validity. Ultimately, this instrument may be used in an experimental design in which consenting participants will be randomly assigned to one of three groups: a control group of participants who do not complete the instrument and are provided treatment as usual, another control group who completes the instrument and are provided treatment as usual, and an experimental group that completes the instrument and is matched to provided psychotherapy according to their results. The hypothesis of this design will state that those participants who complete the measure and are matched to treatment accordingly will demonstrate greater outcomes at completion of treatment than either of the control groups.

One limitation of the proposed experimental design, as well as the use of this instrument in general, is the impact of extratherapeutic factors in clients' lives on the therapeutic process. This instrument focuses exclusively on clients' beliefs and ideas about change in therapy, and does not take into account other elements of the clients' experiences, such as access of external resources, into this procedure. The proposed experimental design would need to intentionally control for these extratherapeutic factors when determining the psychometric properties and ultimate utility of this measure.

Certain limitations arose in the execution of this study. Out of the 19 total licensed clinicians recruited to participate as expert panelists, 9 individuals completed the review, which

represents a 47.39% response rate. Similarly, 20 community therapists were invited to participate via email as cognitive interviewees. Out of these 20, only one therapist was willing to complete the cognitive interview. While the feedback provided was helpful in finalizing the instrument, it nevertheless represented one clinician's perspective on the items. The final items for inclusion in the 30-item measure might be different had more clinicians participated in either phase of the review.

Another limitation involves the number of items reviewed by expert panelists. These participations were asked to rate a total of 117 items two times. It is likely that many respondents experienced fatigue during this task, which may have impacted how they reviewed the items. A similar issue may have occurred during the cognitive interview, as this participant was asked to think aloud with a total of 48 items. Future endeavors in instrument development may take caution in overwhelming reviewers with a high volume of items.

While expert panelists reported a high mean of post-graduate years of clinical practice (15.88), the average self-reported expertise in some domains was low, as was the extent of use of some domains in practice. On a five-point Likert scale, the mean expertise in Social Constructionism was 2.56, in Psychodynamic was 3.11, and in Motivational Interviewing was 3.44. Likewise, only two of the nine expert panelists reported using approaches from social constructionism and psychodynamic therapy in their practice. This is also apparent in the relatively low inter-rater reliability and content validity of the psychodynamic domain. Accordingly, the items selected from these domains might not be the most representative or valid. Future research may make greater efforts to recruit therapists who equally represent a high level of expertise in all six theoretical domains in order to account for this issue.

Despite the limitations, the implications for such an approach to planning and implementation of therapy are notable. Assessing a client's ideas of change and strategies they believe they will respond to reflects the important social work value of self-determination. Likewise, incorporating client values and expectations is an essential component of true evidence-based practice (Shlonsky & Gibbs, 2004). Matching clients to therapeutic techniques they have determined they will respond to should contribute to greater effectiveness in outcome and reduce the time used in therapy to explore options of treatment. This, in turn, should contribute to cost-effectiveness, as clients will spend less time in treatment and receive techniques they have elected to be appealing to them. Ultimately, receiving individualized treatment as the result of this measure will empower clients to recognize and honor their uniqueness as individuals, and seek effective strategies in meeting their needs in other life endeavors.

References

- Abell, N., Springer, D. W., & Kamata, A. (2009). *Developing and validating rapid assessment instruments*. New York, NY: Oxford University Press.
- Angus, L. & Kagan, F. (2007). Empathic relational bonds and personal agency in psychotherapy: Implications for psychotherapy supervision, practice, and research. *Psychotherapy: Theory, Research, Practice, Training*, 44(4), 371-377.
- Asay, T. P. & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In Hubble, M. A., Duncan, B. L., & Miller, S. D. (Eds.) , *The Heart and Soul of Change: What Works In Therapy* (23-55). Washington, D.C.: American Psychological Association.
- Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 133-179). Washington, DC: American Psychological Association.
- Bergin, A. E. & Garfield, S. L. (1994). Overview, trends, and future issues. *Handbook of Psychotherapy and Behavior Change* (4th ed., pp. 821-830). New York: Wiley.
- Beutler, L. E., Forrester, B., Gallegher-Thompson, D., Thompson, L., & Tomlins, J. B. (2012). Common, specific, and treatment fit variables in psychotherapy outcome. *Journal of Psychotherapy Integration*, 22(3), 255-281.
- Bohart, A. C. (2000). The client is the most important common factor: Clients' self-healing capacities and psychotherapy. *Journal of Psychotherapy Integration*, 10(2), 127-149.
- California Association of Marriage and Family Therapists. (2004). Therapy in

America 2004 polls shows: Mental health treatment goes mainstream.

Retrieved from:

<http://www.camft.org/ScriptContent/CAMFTarticles/Misc/TherapyInAmerica.htm>

Curry, J. F. (2009). Research psychotherapy: Aspirin or music? *Clinical Psychological Science and Practice, 16*, 318-322.

Coleman, D. T. (2007). The theoretical evaluation self test (TEST): A scale of therapist Theoretical orientation for clinical research and education. ProQuest Dissertations and Theses.

Duncan, B. L. & Miller, S. D. (2000). The client's theory of change: Consulting the client in the integrative process. *Journal of Psychotherapy Integration, 10*(2), 169-187.

Elliott, R. (2008). Research on client experiences of therapy: Introduction to the special section. *Psychotherapy Research, 18*(3), 239-242.

Fishman, D. B. (1999). *The case for pragmatic psychology*. New York: New York University Press.

Grant, J. S. & Davis, L. L. (1997). Selection and use of content experts for instrument development. *Research in Nursing & Health, 20*, 269-274.

Haran, T. (2009). Personality and defense style as predictors of therapy orientation preference. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 70*(11-B), 7209.

Horvath, A. O., Marx, R. W., & Woudzia, J. (1991). Development and preliminary validation of the counselors' intentions list. *Psychological Assessment: A Journal of Consulting and Clinical Psychology 3*(3), 469-477.

- Jensen, J. P., Bergin, A. E., & Greaves, D. W. (1990). The meaning of eclecticism: New Survey and analysis of components. *Professional Psychology: Research and Practice* 21(2), 124-130.
- Lundgren, T., Luoma, J. B., Dahl, J. & Melin, L. (2012). The bull's-eye values survey: A psychometric evaluation. *Cognitive and Behavioral Practice*, Elsevier.
- Ogunfowora, B. & Drapeau, M. (2008). A study of the relationship between personality traits and theoretical orientation preferences. *Counselling and Psychotherapy Research*, 8(3), 151-159.
- Payne, M. (2005). *Modern Social Work Theory*. Chicago, IL: Lyceum Books Inc.
- Presser, S. & Blair, J. (1994). Survey pretesting – do different methods produce different results? *Sociological Methodology*, 24, 73-104.
- Poznanski, J. J. & McLennan, J. (1995). Conceptualizing and measuring counselors' theoretical orientation. *Journal of Counseling Psychology*, 42(4), 411-422.
- Prochaska, J. O., Norcross, J. C., & DiClemente, C. C. (2013). Applying the stages of change. In G. P. Koocher, J. C. Norcross, & B. A. Greene. (Eds.), *Psychologists' desk reference* (pp. 176-181). New York, NY: Oxford University Press.
- Shlonsky, A. & Gibbs, L. (2004). Will the real evidence-based practice please stand up? Teaching the process of evidence-based practice to the helping professions. *Brief Treatment and Crisis Intervention*, 4(2), 137-153.
- Simon, G. E. & Perlis, R. H. (2010). Personalized medicine for depression: Can we match patients with treatments? *American Journal of Psychiatry*, 167, 1445-1555.
- Walsh, J. (2010). *Theories for direct social work practice*. Belmont, CA: Wadsworth Cengage Learning.

Willis, G. B. (1999). Proceedings from Meeting of the American Statistical Association: *Reducing Survey Error through Research on the Cognitive and Decision Processes in Surveys*. Rockville, MD: Research Triangle Institute.