MULTITHEORETICAL ASSESSMENT WITH INTEGRATIVE AND PURE-FORM THERAPISTS: AN EXPLORATORY STUDY

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BY

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To the Dean of the Graduate School:

I am submitting herewith a dissertation written by Nicole R. Roblyer entitled "Multitheoretical Assessment with Integrative and Pure-Form Therapists: An Exploratory Study." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Counseling Psychology.

Jeff E. Harris, Ph.D., Major Professor

We have read this dissertation and recommend its acceptance:

Department Chair

Accepted:

Dean of the Graduate School

DEDICATION

For my mother. You are my best friend and the wind beneath my wings.

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ABSTRACT

NICOLE R. ROBLYER

MULTITHEORETICAL ASSESSMENT WITH INTEGRATIVE AND PURE-FORM THERAPISTS: AN EXPLORATORY STUDY

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The purpose of this study was to investigate the theoretical orientations and practices of therapists using two measures, the Multitheoretical List of Therapeutic Interventions (MULTI; McCarthy & Barber, 2009) and the Multitheoretical Strategies Rating Questionnaire (MSRQ; Roblyer & Harris, 2011). A multivariate analysis of variance and discriminant function analysis was conducted to test for significant differences among integrative and pure-form therapists. In addition, a confirmatory factor analysis was conducted to determine goodness of fit between Brooks-Harris' (2008) Multitheoretical Psychotherapy (MTP) model and MULTI items. The sample consisted of 179 therapists, including both experienced professionals and graduate students, from a variety of therapeutic backgrounds. Eighty percent of the respondents considered themselves to be integrative/eclectic therapists. There was a statistically significant difference between theoretical orientation and therapeutic techniques used, with scores on the Cognitive, Behavioral, DBT, Person-Centered, and Psychodynamic scales of the MULTI being the best at distinguishing between cognitive, behavioral, and cognitive-

behavioral theoretical orientations. There was no statistically significant difference between the repertoire of therapeutic interventions used by integrative and pure-form therapists. Lastly, an adequate model-data fit was found between the conceptual MTP model and MULTI items.

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CHAPTER I

INTRODUCTION

"There is no therapy without theory"

--*Bruce Wampold* (2010, p. 43)

Definition and History of Theoretical Orientation

A practitioner's theoretical orientation is an important factor in the practice of therapy. According to VandenBos (2007), an orientation is "an individual's general approach, ideology, or viewpoint" (p. 657). For psychotherapy in particular, a theory can be seen as "a consistent perspective on human behavior, psychopathology, and the mechanisms of therapeutic change" (Prochaska & Norcross, 2003, p. 5). Thus, theoretical orientation provides therapists with a means of describing their views on human nature and functioning. As such, Brems (2001) reported that theoretical orientation "will enter into [a therapist's] understanding of clients' symptom [*sic*], behaviors, thoughts, affect, and relationships" (p. 205). Furthermore, the theoretical orientation therapists embrace will influence their conceptualization of the problem and best treatment approach to use with clients. Because it serves as the foundation of therapeutic practice, a clear understanding of one's theoretical orientation is vital to the process of conducting therapy. In fact, familiarity with the dominant theoretical schools of thought pertaining to human development and behavior (psychodynamic, humanistic, etc.) is required to

achieve minimal requirements of competency (Brems, 2001). Anchin and Magnavita (2008) described the history of psychotherapy as unfolding in three phases. The first phase is what they called *the beginning of contemporary psychotherapy*, defined by the traditional, overlapping schoolism of psychoanalysis, behavior therapy, humanistic psychology, family systems, cognitive therapy, and biomedical approaches. During this phase, the discipline of psychology had been relatively closed-off to the idea of embracing more than one theoretical orientation at a time (Gold & Stricker, 2006). The second phase, *the psychotherapy integration movement*, is viewed as being a natural outgrowth of the burgeoning therapies that developed during the first phase. The final phase, *unification*, is the one in which we are presently engaged. The unification process involves organizing psychotherapeutic processes and outcomes, and offering metatheoretical frameworks designed to advance the field of psychotherapy, while continuously evaluating and refining theory as it is evolving (Anchin & Magnavita, 2008).

Definition and History of Psychotherapy Integration

Ayer (1982), a philosopher, described pluralism as "denying that there is a single world, which is waiting to be captured, with a greater or lesser degree of truth, by our narratives, our scientific theories or even our artistic representations" (p. 13). An integrative therapist recognizes that a single world view or psychotherapeutic technique is not "the exclusive truth," even if she or he approaches practice with a single approach or theory (Hollanders, 2007, p. 425). To that end, there are various definitions of

psychotherapy integration. Hollanders (2001) viewed psychotherapy integration as "the process of bringing things together, with the implication of making something whole and new" (p. 32). Norcross (2005) defined integration as "the blending of diverse theoretical orientations and treatment formats" (p. 11). Transcendent of its definition, integrative psychotherapy is based on the concept of pluralism. Pluralism, according to VandenBos (2007), is "the idea that any entity has many aspects and that it may have a variety of causes and meanings" (p. 707).

During the second phase of Anchin and Magnavita's (2008) historical timeline, the initial focus was on exploring the commonalities and differences between the major schools of psychotherapy. As a result, over the past 25 years, the integrative movement has produced an "enormously productive...wave of theoretical and clinical syntheses...among the potpourri of modern-day approaches to psychotherapy" (p. 260). In fact, there is now a whole generation of therapists who have been trained entirely as integrative practitioners, never having identified themselves as otherwise (Lampropoulos, 2006).

Integration was addressed as early as 1932 (Lampropoulos, 2001), when French (1933) compared Pavlov's studies with psychoanalytic concepts (Hollanders, 2007). After that, there was some underground support for integration, but the movement did not really take off until the 1960s, when Jerome Frank and Arnold Lazarus made notable contributions. Frank (1961) was first to introduce the common factors approach and Lazarus (1967) coined the term *technical eclecticism* (Hollanders, 2007). In the 1970s,

Egan (1975) contributed to the integrative movement with his action-oriented eclectic approach to therapy. Wachtel (1977) also contributed to the field with a conceptualization of psychotherapy based on a mixture of psychoanalytic and behavioral principles. According to Hollanders (2007), by the mid-1970s, mental health practitioners were beginning to openly identify their theoretical orientation as eclectic (Garfield & Kurtz, 1974).

The trend toward practitioners identifying themselves as either eclectic or integrative in regard to their theoretical orientation continued in the 1980s and 1990s, and research began to flourish on the topic (Hollanders, 2001). By 1983, The Society for the Exploration of Psychotherapy Integration (SEPI) was formed, and by 2005, international membership included 687 practitioners (Hollanders, 2007). SEPI consists of therapists who have varying agendas in regards to integration. Some are interested in dialoging with therapists from other schools, while others are actively pursuing research with hopes of developing a definitive integrative theory (Lampropoulos, 2006). During the latter part of the 20th century, the international community also began embracing the integrative movement and formed their own organizations related to the endeavor. The British Society for Integrative Psychotherapy was formed in 1987 and evolved into what is now known as the UK Association of Psychotherapy Integration (UKAPI). In addition, the European Association for Integrative Psychotherapy was founded in 1993 (Nuttall, 2008). In the words of Gold and Stricker (2006), "the age of official segregation of the schools of psychotherapy has largely ended" (p. 4).

In the beginning of the 21st century, Corsini (2000) reported that there were 250 theoretical approaches to the practice of psychotherapy. In 2005, Norcross extended this figure even further, suggesting that there are more than 400 therapies from which to choose. This large number of approaches presents a challenge for therapists trying to determine which theoretical orientation is most suitable for use in the practice of psychotherapy. It is not surprising, given the plethora of options available, that we have arrived at a point in history when integrative practice appears to be the norm for a significant number of therapists. Gold and Stricker (2006) stated that "many if not most psychotherapists identify themselves as integrative or eclectic in orientation" (p. 4), a claim that existing research supports. Researchers have consistently shown that one- to two-thirds of clinicians in the United States espouse either an eclectic or integrative theoretical orientation (e.g., Glass, Victor, & Arnkoff, 1993; Hollanders & McLeod, 1999; Norcross, Hedges, & Castle, 2002; Norcross, Karpiak, & Santoro, 2005; Watkins & Watts, 1995).

Since the 1950s, researchers (e.g., Wallach & Strupp, 1964; Wogan & Norcross, 1983) have consistently pointed out the interest in and importance of operationalizing the dimensions of the psychotherapists' behavior and beliefs. Because integrative practice is so prevalent, the need exists to measure the construct of psychotherapy integration. To do so, it is helpful to measure what integrative therapists do in practice and, by extension, describe what an integrative theoretical orientation means. This study was designed to explore the psychometric properties of the Multitheoretical Strategies Rating

Questionnaire (MSRQ; Roblyer & Harris, 2011), which is a tool designed to assess therapists' behavior as it relates to their self-identified theoretical orientation. The MSRQ is based on a model of integrative practice, *Multitheoretical Psychotherapy* (MTP; Brooks-Harris, 2008).

Multitheoretical Psychotherapy

Multitheoretical Psychotherapy (MTP) is a theoretical model of integrative therapy that draws upon the treatment approaches of seven major theoretical traditions of practice: (a) cognitive, (b) behavioral, (c) experiential-humanistic, (d) biopsychosocial, (e) psychodynamic-interpersonal, (f) systemic-constructivist, and (g) multicultural-feminist (Brooks-Harris, 2008). There are several approaches to practicing integrative psychotherapy, including common factors, technical eclecticism, and assimilative integration. Brooks-Harris (2008) describes MTP as "an approach that integrates a multitheoretical framework, technical eclecticism, and advanced helping skills" (p. 38). MTP fits under the umbrella of a multitheoretical framework approach that, according to Brooks-Harris, "describes the relationship between several theories based on their relative emphasis. Frameworks help therapists understand when to utilize a particular approach" (p. 23). Thus, the MTP model is a framework therapists can use to help them choose the best therapeutic approaches and techniques from a multitude of theoretical orientations. MTP's conceptual framework is depicted in Figure 1.

MTP is pluralistic, pragmatic, and idiographic; consequently it is considered to be an integrative approach that rests on pluralistic philosophy (Brooks-Harris, 2008). Based

on this fundamental assumption, Brooks-Harris (2008) offers the rationale that "no single theory of psychotherapy can adequately describe human functioning or therapeutic change" (p. 41). Furthermore, MTP espouses pragmatism, meaning that "the true value of a proposition or a theory is to be found in its practical consequences" (VandenBos, 2007, p. 719). Lastly, MTP is idiographic in nature in that it allows therapists to choose the theoretical orientation and consequent treatment method applicable to the individual needs and preferences of clients (Brooks-Harris, 2008). It is for these reasons that, at least in part, the MTP model is believed to offer therapists an array of strategies from which to draw.

MTP was founded upon five principles of psychotherapy integration (Brooks-Harris, 2008). The first principle, *intentional integration*, suggests that careful planning with adaptability to changing circumstances should guide therapeutic intervention. Second, the principle of *multidimensional integration* encourages therapists to recognize the dynamic interaction of multiple levels of human functioning within and between the cognitive, affective, and behavioral domains. Third, the principle of *multitheoretical integration* refers to the need for therapists to draw upon multiple theories in order to conceptualize clients' problems. The fourth principle, *strategy-based integration*, suggests that therapists use of a variety of strategies taken from different theoretical schools. Lastly, the principle of *relational integration* states that an effective therapeutic relationship be in place and that different styles of relationships can be developed based on clients' individual needs and preferences (Brooks-Harris, 2008).

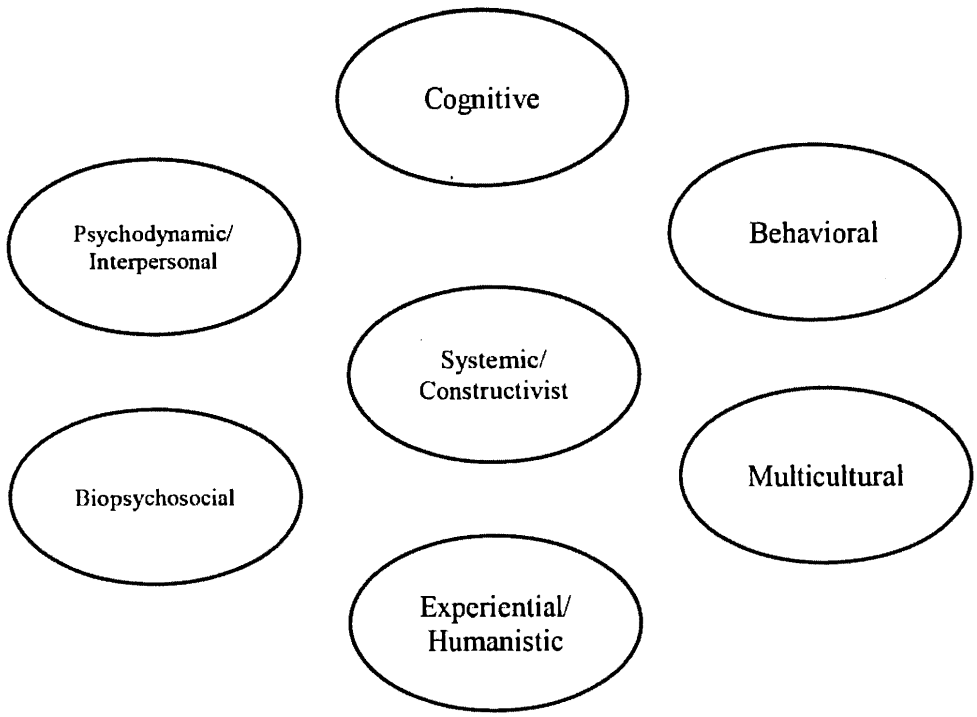

Figure 1. Brooks-Harris' (2008) Multitheoretical Psychotherapy (MTP) framework.

Multitheoretical Strategies Rating Questionnaire

The Multitheoretical Strategies Rating Questionnaire (MSRQ; Roblyer & Harris, 2011) was created for this study and consists of the list of 98 therapeutic techniques, called *key strategies*, developed from a comprehensive array of practices associated with contemporary theories of psychotherapy: (a) cognitive, (b) behavioral, (c) experiential-humanistic, (d) biopsychosocial, (e) psychodynamic-interpersonal, (f) systemic-constructivist, and (g) multicultural-feminist (Brooks-Harris, 2008). Items on the MSRQ

are separated based on these seven theoretical categories. Following is a brief synopsis of the seven dimensions of the MSRQ.

Cognitive. Brooks-Harris' (2008) first dimension is based on cognitive theory. According to Beck and Weisharr (2008), modern cognitive therapy focuses on individuals' information processing mechanisms, or the cognitive, affective, motivational, and behavioral ways in which persons responds to their environment. When cognition is processed effectively, positive change in affective, motivational, and physiological systems will result. In cognitive theory, information processing (taking in and synthesizing information and developing a plan of action accordingly) is seen as crucial to the survival of a species.

Behavioral. The second dimension contains strategies taken from behavior therapy (Brooks-Harris, 2008). According to Wilson (2008), contemporary behavioral theory consists of three main concepts: (a) applied behavior analysis, (b) the stimulus-response (S-R) model, and (c) social-cognitive theory. Applied behavior analysis is a form of behaviorism in which behavior is seen as being a function of its consequences. The S-R model is based on classical conditioning in which intervening variables mediate behavior. Social-cognitive theory is based on three interacting regulatory systems (external stimuli, external reinforcement, and cognition) that influence behavior. The focus of behavior therapy is on corrective learning experiences and learning new coping skills.

Experiential-Humanistic. The Experiential-Humanistic dimension of Brooks-Harris' (2008) model has roots in Person-Centered, Gestalt, and Emotion-Focused psychotherapy theories. From a person-centered perspective, people are viewed as having an innate desire to self-actualize and heal themselves. Therapists play an important role in therapy, acting as non-directive agents. The necessary ingredients for this brand of therapy are unconditional positive regard and empathy, with the quality of the therapeutic relationship being paramount (Raskin, Rogers, & Witty, 2008). Gestalt theory is a holistic perspective that takes into account contextual reality. The focus of therapy is clients' awareness of their experience in the moment (Yontef & Jacobs, 2008). According to Greenberg (2004), "emotion is seen as foundational in the construction of the self and is a key determinant of self-organization" (p. 3). The goals of Emotion-Focused therapy are to promote emotional awareness, emotion regulation, and emotional transformation.

Biopsychosocial. The fourth dimension of the MSRQ (Roblyer & Harris, 2011) is based on Engel's (1977) biopsychosocial model of medicine, which describes disease as being influenced by somatic, mental, and systemic factors. Disease and medical care are seen as interrelated processes, therefore therapists need to consider clients' social, psychological, and biological context when conceptualizing dysfunction and providing therapy. A biopsychosocial approach also takes into consideration the importance of the client-therapist relationship in the healing process, since it has been shown that a positive doctor-patient relationship can produce positive outcomes (Siegel, 1986).

Psychodynamic-Interpersonal. The fifth dimension of the MSRQ (Roblyer & Harris, 2011) contains treatment strategies based in psychodynamic and interpersonal theories. Psychodynamic psychotherapy is a modern form of psychoanalytic treatment with roots in psychoanalytic theory. Central to the psychodynamic approach are four principles: (a) Unconscious conflict causes problems in living, (b) transference causes problems in current relationships, (c) early problems resurface in later functioning, and (d) the therapeutic relationship serves as a foundation of treatment (Luborsky, O'Reilly-Landry, & Arlow, 1998). Change happens when clients open up to self-discovery; discovers patterns of relating and perceiving that hinder functioning; reconciles influences from the past; and finds new, more effective ways of coping. Contemporary interpersonal theory is based on three assumptions: (a) problems are interpersonal in nature, (b) familial experience is the most important source of learning about ourselves and others, and (c) the therapist-client relationship is the means by which problems can be resolved (Teyber, 1992).

Systemic-Constructivist. Another dimension of the MSRQ (Roblyer & Harris, 2011) is rooted in systemic principles. Systems theory contends that "individuals can only be understood within the social context in which they exist" (Prochaska & Norcross, 2003, p. 374). The underlying assumptions of systems therapy are: (a) Multiple viewpoints of what constitutes reality exist, (b) there are multiple causalities for most events, (c) the entire system should be the focus of scrutiny, and (d) the therapist should search for systemic connections and meanings (Prochaska & Norcross).

In constructivist theory, therapy is seen as a personal science in which clients actively formulate, refine and revise hypotheses about, and elaborate on, their experience. Clients are seen as narrators of their experience, and therapy is seen as a way to explore how personal stories may be reconstructed. The goal of therapy is to promote meaning-making and personal development (Neimeyer, 1995).

Multicultural. The final dimension of the MSRQ (Roblyer & Harris, 2011) is based on several concepts taken from multicultural and feminist theories. In multicultural therapy, clients are understood within the context of their social environment and stage of identity development and acculturation (Ivey & Brooks-Harris, 2005). The goal of multicultural therapy is to use modalities and goals consistent with the life experiences and cultural values of clients. A balance of individualism and collectivism is important in the assessment, conceptualization, and treatment of diverse clients (Sue & Torino, 2005). Feminism values diversity and promotes an increased awareness of the ways race, class, and religion influence women's issues. Feminist therapists believe that "the personal is political," which means that problems in living are affected by the social and political climate in which they are embedded (Enns, 1997). In feminist therapy, an egalitarian relationship between clients and therapists is valued. Clients are viewed as being their own best expert in regard to their problems in living. With the assumption that no therapy is value-free, therapists are expected to monitor their personal values to ensure that they do not adversely impact clients. The main goals of feminist therapy are to encourage

social activism and promote equality for men and women in regard to gender roles and socioeconomic status (Enns).

Conclusion

Anchin and Magnavita (2008) asserted that we are currently in the third phase of the evolution of psychotherapy, described as a movement toward psychotherapy unification. This phase involves organizing and making meaning of the vast array of variables associated with the effective practice of psychotherapeutic intervention. The third phase also involves promoting various metatheoretical frameworks designed to advance the practice of psychotherapy. The scope of this research, which explores the latent structure of Brooks-Harris' (2008) MTP model, is a direct outgrowth of this current phase in the evolution of psychotherapy integration.

Definition of Terms

For the purposes of this study, certain terms are operationally defined as follows.

- *Theoretical Orientation*: Therapists' consistently-held perspective on human behavior, psychopathology and mechanism of therapeutic change (Norcross, 1985). These perspectives will specifically be delineated as: (a) cognitive, (b) behavioral, (c) experiential-humanistic, (d) biopsychosocial, (e) psychodynamic-interpersonal, (f) systemic-constructivist, (g) multicultural-feminist, (h) integrative/eclectic (Brooks-Harris, 2008), and (i) other.
- *Pure-Form Therapist*: Therapists' whose self-identified, primary theoretical

orientation consists of one of seven theoretical traditions identified by Brooks-Harris (2008): (a) cognitive, (b) behavioral, (c) experiential-humanistic, (d) biopsychosocial, (e) psychodynamic-interpersonal, (f) systemic-constructivist, and (g) multicultural-feminist. Most pure-form therapists prefer to use one chosen theory rather than a combination of theories.

- *Integrative/Eclectic Therapist:* Therapists who identify their theoretical orientation to be one that embraces ideas from more than one theoretical tradition (Brooks-Harris, 2008).
- *Key Strategies*: Twelve to 16 interventions from each of the seven theoretical traditions that are representative of interventions used in this form of psychotherapy (Brooks-Harris, 2008).

CHAPTER II

LITERATURE REVIEW

This literature review will discuss numerous early and contemporary measures of theoretical orientation. There are different ways of measuring theoretical orientation, including rating scales designed to be used for the coding of in-session occurrences, self-ascription, and adherence questionnaires (Guinee, 2000). However, because the Multitheoretical Strategies Rating Questionnaire (MSRQ; Brooks-Harris, 2008) is a self-report questionnaire, only other self-report measures or techniques will be explored in this review. Eight early measures that will be described lack psychometric validation, while six early measures need further validation or a change in structure. Only one measure, the Therapists' Orientation Questionnaire (TOQ; Sundland & Barker, 1962) has adequate validity and reliability established. Six newer measures have varying degrees of psychometric validation. In addition to describing existing measures, this literature review will describe studies involving specific variables (i.e., experience level, profession, and gender of the participants) as they relate to the behavior and theoretical orientations of practitioners.

Instrument Development

Developing an instrument that measures psychological constructs is a complex endeavor. DeVellis (2003) offered an eight-step approach to scale development: (a) determine what you want to measure, (b) generate an item pool, (c) determine the format

for measurement (i.e., what type of scale and response format should be used), (d) have the items reviewed by experts, (e) consider including validation items in the item pool, (f) administer items to a pilot sample, (g) evaluate the items, and (h) optimize the scale length. Once these basic guidelines have been met, factor analytic procedures are performed to test whether the resulting items adequately reflect the latent aspects of the construct the instrument was designed to measure.

Once an instrument's factor structure has been determined, various reliability and validity tests can be performed (DeVellis, 2003). Internal consistency can be studied by testing the relationship each test item has with the other test items. It is imperative that items within each subscale correlate highly with one another in order for the subscale to be deemed reliable. Coefficients valued at .90 and above are considered to indicate good reliability, coefficients valued at .80 and above are considered an indicator of moderate reliability, and coefficients valued at .70 and below are considered to indicate low reliability. Test-retest reliability can also be established by administering the measure to the same sample two or more times. Another test of reliability involves giving two alternate forms of a measure to the same sample. Or, item responses on half of a test can be compared to item responses on the other half of the same test (split-half reliability method). Lastly, inter-rater reliability can be determined by comparing the responses of the sample's participants to responses of independent raters (Groth-Marnat, 1997).

There are three types of validity associated with scale construction: (a) content validity, (b) criterion-related validity, and (c) construct validity (DeVellis, 2003). Testing

for content validity involves investigating whether or not a set of scale items adequately reflects an entire content domain. This process can be accomplished by having experts review the items to make sure there are no other possible items that could measure what the researcher is trying to measure. Criterion-related validity analysis concerns whether or not a measure is related to another variable of the construct that is being measured and whether or not the test predicts performance of any kind. Construct validity describes the extent to which a scale measures what it purports to measure. Investigating this type of validity involves looking at the correlations and correlational patterns (i.e., directions) that exist between variables that are believed to measure a given construct (DeVellis, 2003). Validity coefficients can range from 0, which indicates a low level of validity, to 1, which indicates a high level of validity.

Existing Measures

Early Measures Without Psychometric Validation

There are eight measures that were developed between 1950 and 1993 that lack adequate psychometric validation. These measures are described in detail in the following section.

Fiedler's Questionnaire. Fiedler (1950b) is among the earliest researchers who studied therapists' theoretical orientations. He developed a questionnaire, which I have labeled Fiedler's Questionnaire (FiQ), consisting of 75 statements describing elements of an ideal therapeutic relationship. The questionnaire was designed to be used by judges for rating therapy sessions within the parameters of the Q-sort methodology (Stephenson,

1953), "which permits correlation between persons on the basis of traits...akin to inverse factor analysis" (Fiedler, 1950a; p. 240). The statements of the FiQ are categorized under three headings: (a) Communication, (b) Emotional Distance, and (c) Status. The Communication statements deal with the extent and quality of communication present in a therapy session. The Emotional Distance category contains statements describing the extent to which therapists draw away from or tend to be too close to patients. The Status heading categorizes the extent to which therapists feel very inferior or superior to their patient. The FiQ is different from the MSRQ (Roblyer & Harris, 2011) because the FiQ items were derived from concepts believed to be important in creating an ideal therapeutic relationship, regardless of theoretical orientation. The MSRQ items, on the other hand, are techniques taken from specific theoretical schools that are believed to be vital to the practice of that particular school. The FiQ lacks psychometric validation.

Fey's Questionnaire. Fey's Questionnaire (FQ; Fey, 1958) consists of 30 questions. The first 27 questions assess the extent to which the respondents practice various behaviors with clients, on a scale from 1 (*yes*, *always*, or *routinely*) to 5 (*no* or *never*). The final three questions assess how many years the participants have been practicing therapy and how many items were marked a "3" on the scale versus how many items were marked "1" or "5." Four factors emerged from the data Fey (1958) obtained by conducting a factor analysis. Factor I items describe a distinct division of professional versus social roles of therapists. The items within Factor II focus on a traditional, rational approach to health problems. Factor III describes a broad-based, resourceful, and

supportive approach to therapy. Factor IV emphasizes an "artful, almost expedient virtuosity in dealing with...patients from moment to moment" (Fey, 1958, p. 408). The FQ needs psychometric validation as no reliability or validity data were provided. Subscale intercorrelations range from .10 to .50. The FQ is different than the MSRQ (Roblyer & Harris, 2011) in that the FQ asks participants to respond to issues that often arise in treatment instead of endorsing a specific therapeutic technique. Fey's (1958) research is severely limited in scope. He surveyed only 36 therapists from a Midwestern college town with a Rogerian, Analytic, or Eclectic theoretical orientation. The Rogerian group consisted of mostly inexperienced therapists and the Analytic group was small.

Analytic-Impersonal-Directive Scale. Like the MSRQ (Roblyer & Harris, 2011), the Analytic-Impersonal-Directive Scale (AID; McNair & Lorr, 1964) measures psychotherapists' treatment techniques. The AID consists of three independent dimensions of therapeutic techniques: a psychoanalytic treatment approach (Factor A), the therapists' affective response to patients (impersonal vs. warm-Factor I), and a directive, active approach to treatment (Factor D). Based on a cluster analysis using data from 265 psychotherapists, McNair and Lorr (1964) confirmed their hypotheses that the three factors (psychoanalytic, impersonal vs. personal, and directive) adequately characterize therapeutic technique. Therapists who obtain high scores on Factor A tend to view psychopathology as resulting from childhood experiences; use interpretations; analyze dreams, resistance, and transference; encourage free association; and emphasize childhood experiences and unconscious motives. High-scoring therapists on Factor I

endorse a detached approach to therapy. They believe training and therapeutic technique affect a positive therapeutic outcome and they do not reveal emotions. Low scorers tend to verbalize their feelings, call patients by their first name, decorate their office with personal items, and believe that the therapeutic relationship is most important to a positive therapeutic outcome. High scores on Factor D indicate therapists who set goals and make treatment plans. They value social adjustment as a therapeutic goal and consider a thorough case history and diagnosis to be essential. They vary their role depending on the nature of the case. Low scores on Factor D are indicative of less directive therapists who are more inactive during the interview, letting patients determine the goals of treatment. Although the three scales are independent estimates of each factor, the Kuder-Ross internal consistency estimates were fair, suggesting a need to better define each of the variables comprised in each scale.

The dimension of the AID Scale (McNair & Lorr, 1964) most similar to the MSRQ's (Roblyer & Harris, 2011) Psychodynamic-Interpersonal scale is Factor A, a psychoanalytic treatment approach. Based on a cluster analysis, Factor A consists of the following therapeutic strategies: (a) analysis of resistance, (b) discussion of childhood events, (c) free association, (d) interpretation of dreams, (e) change depending on finding the cause of a behavior, (f) placing a limited value of importance on the concept of "unconscious," (g) interpretation of mannerisms and slips of tongue, (h) change depending on understanding childhood, (i) interpretation of unconscious motives, and (j) analysis of transference. Analogous MSRQ Psychodynamic-Interpersonal key strategies

include: (a) encouraging free association, (b) honoring resistance, (c) exploring childhood experiences, and (d) interpreting dreams. The MSRQ Psychodynamic-Interpersonal scale has a total of 16 items, but the remainder of the key strategies not listed above measure variables associated with psychodynamic and interpersonal theories that either did not exist or were not popular during the time that McNair and Lorr's (1964) study was undertaken.

Usual Therapeutic Practices Scale. The Usual Therapeutic Practices scale (UTP), developed by Wallach and Strupp (1964), is a 17-item measure consisting of four factors: (a) Maintaining personal distance (Factor I), (b) Preference for intensive therapy (Factor II), (c) Keeping verbal interventions at a minimum (Factor III), and (d) Psychotherapy as art (Factor IV). Respondents rate their agreement with items on a 6-point Likert scale. The concept Factor I describes is therapists' preference for keeping their private life quiet by not answering personal questions in therapy. Factor II is concerned with therapists' preference to deal with psychoanalytic concepts rather than goal-limited therapy. The third factor emphasizes a belief that communication within the therapeutic dyad should be limited to what is in the best interest of clients. Factor IV emphasizes flexibility as opposed to rigidity in controlling the therapeutic process. Six factors were originally derived using principle axis solution and varimax rotation to orthogonal simple structure. Factor I is the only factor with a sufficient significance level, accounting for the largest part of total variance (specific statistics were not listed by the researchers). The fifth and sixth factors were not retained by Wallach and Strupp (1964)

because they were deemed unreliable. These two factors addressed therapists' view of technique as an invariant procedure and the therapists' potential for experiencing difficulties surrounding countertransference. Although the initial factor analysis was derived from a sample of 59 therapists, a replication study with a larger sample (N=248) revealed the same factor structures. However, the factors of the UTP are defined by only one or a few items each. The UTP addresses attitudinal as well as practice variations among therapists, unlike the MSRQ (Roblyer & Harris, 2011), which focuses on therapeutic practice.

Wogan and Norcross (1983) conducted their own factor analysis using a modified version of the UTP (Wallach & Strupp, 1964), which they called the Therapeutic Attitudes, Skills, and Techniques Scale (TAST). The researchers did not explain how the TAST is different from the UTP. The researchers presented the mean, standard deviation, and factor loadings of each of the original 17 UTP items. A sample of 136 members of the American Psychological Association's (APA) Division 29 (Psychotherapy) were asked to rate their agreement with statements on a 5-point Likert scale. Based on the data from the survey, five factors were extracted: (a) Factor I, Personal Distance, (b) Factor II, Activity, (c) Factor III, Flexibility, (d) Factor IV, Therapist Distance, and (e) Factor V, Preference for Goal-Limited Therapy. Wogan and Norcross' findings indicate that the overall content of the UTP and TAST correspond with each other.

Therapist Orientation Sheet. Paul (1966) developed the Therapist Orientation Sheet (TOSh) to use in his extensive research about the effective treatment of anxiety.

The TOSh was modeled after Sundland and Barker's (1962) Therapist Orientation Questionnaire, which will be discussed at length later in this paper. The TOSh consists of 24 questions assessing therapists' general activities, the therapeutic relationship, therapy goals, therapists' comfort and security, clients' comfort and security, clients' personal growth, therapeutic gains, the learning process in therapy, therapeutically significant topics, a theory of motivation, and a curative aspect of the therapist. An additional 21 questions assess specific techniques used in practice. That portion of the TOSh most closely resembles the MSRQ (Roblyer & Harris, 2011) because it contains similar strategies, such as reflection and clarification of feelings, interpretation, and free association. A 5-point Likert scale of frequency is used for measuring responses. No psychometric studies of the TOSh have been conducted.

Wogan and Norcross Questionnaire. The Wogan and Norcross Questionnaire (WNQ; Wogan & Norcross, 1985) is a 99-item measure of therapeutic techniques and skills. The WNQ is one of the few surveys most similar to the MSRQ (Roblyer & Harris, 2011) because it assesses the frequency with which therapists engage in therapeutic activities similar to the activities specified in the MSRQ. A sample of 319 psychotherapists rated the frequency of their therapeutic behavior on a 5-point Likert scale. In a principle components analysis of data, Wogan and Norcross (1985) identified 13 scales which accounted for 53% of the total variance. The 13 components are: (a) Psychodynamic Techniques, (b) Fantasy and Imagery, (c) Physical Contact, (d) Rogerian Skills, (e) Direct Guidance, (f) Psychometric Testing, (g) Frustration, (h) Nonverbal

Evaluation, (i) Education, (j) Flooding, (k) Authenticity, (l) Planning and Structuring, and (m) Self-Disclosure. Most of the component labels explain a type or types of intervention(s) used in psychotherapy. The Physical Contact, Direct Guidance, Psychometric Testing, Frustration, Planning and Structuring, and Self-Disclosure components do not contain items that are similar to items on the MSRQ. Subscale intercorrelations and validity data for the WNQ were not listed in Wogan and Norcross' (1985) research. Factor loadings were greater than .38 and internal consistency ranged from .56 to .94 for the 13 components. Principle components analysis also identified four second-order factors of therapeutic activity: (a) Active and Directive, (b) Psychodynamic, (c) Personal Relationship and (d) Experiential.

Therapy Orientation Questionnaire. The Therapy Orientation Questionnaire (ThOQ; Vardy, 1971) is a 7-item survey with a 7-point answer ranking scale. The survey contains two parts. The first part asks participants to rank in order of importance certain modes of change used in therapy, such as insight and catharsis. The second part of the survey asks participants to choose their top five most desirable therapist characteristics from a list of 42 traits. Twenty-five psychiatry students were asked to complete the ThOQ at both the beginning and end of a six- month rotation. These participants indicated the following traits specified by Vardy to be the most valuable: (a) capable of empathy, (b) perceptive of other's feelings, (c) knows himself, (d) aware of own unconscious, (e) good listener, (f) can tolerate hostility, (g) can be objective, (h) inspires trust, and (i) reasonably fulfilled in private life. Factor analysis of these traits, given at the

start of the rotation, yielded two factors: Nutrient-Giving (Factor 1) and Analytic (Factor 2). Vardy reported that Factor 2 contained the traits *aware of own unconscious*, *good listener*, and *perceptive of other's feelings* but did not make it clear what traits Factor 1contained. Post rotation, Vardy reported that "the Nurturant-Giving and some of the 'Analytic' traits were combined in the first major factor, suggesting a synthesis of the two ideals" (p. 554). Again, Vardy did not make it clear what specific traits made up each of the factors. In addition, reliability and validity data were not provided for this instrument. Another limitation of the instrument is that the content of the survey is specific to psychodynamic theories only. The ThOQ is dissimilar to the MSRQ (Roblyer & Harris, 2011) in that the ThOQ asks about therapists' values instead of the behaviors they practice.

Theoretical Orientation Guide. The Theoretical Orientation Guide (TOG; Finch, Mattson, & Moore, 1993) is a 50-item questionnaire in which respondents answer questions pertaining to students' beliefs about human behavior, the change process, and the purpose of therapy, from the choices *not specified*, *agree*, or *disagree*. The TOG is a paper-and-pencil inventory developed by professors to help students identify their theoretical orientation. It was designed to be used in a format where students indicate with which theoretical orientation they identify, and then compare their answers to see if there is congruency. Reliability and validity data were not obtained; therefore, psychometric validation is required for this survey. The MSRQ (Roblyer & Harris, 2011) is different from the TOG because the MSRQ asks about therapeutic practice.

Early Measures With Limited Psychometric Validation

Other measures with limited psychometric validation have also been developed since 1993. Six of the measures discussed in the next section need further validation or a change in factor structure. Only one of the measures, the Therapists' Orientation Questionnaire (TOQ; Sundland & Barker, 1962), has adequate validity and reliability established.

Therapists' Orientation Questionnaire. Sundland and Barker's Therapists' Orientation Questionnaire (TOQ; 1962) is a 133-item questionnaire consisting of 16 subscales that reflect points of disagreement among different schools of therapy. The subtests are as follows: (a) Frequency of Activity (FA), (b) Type of Activity (TA), (c) Emotional Tenor of Relationship (ET), (d) Spontaneity in the Therapeutic Relationship (STR), (d) Planning of the Therapeutic Relationship (PTR), (e) Conceptualization of the Therapeutic Relationship (CTR), (f) Goals of Therapy (GT), (g) Therapist's Security (TS), (h) Theory of Personal Growth (TPG), (i) Cognitive Therapeutic Gains (CTG), (j) Learning Process in Therapy (LPT), (k) Topics Important to Therapy (TIT), (l) Theory of Neurosis (TN), (m) Criteria for Success (CS), (n) Theory of Motivation (TM), and (o) Curative Aspect of the Therapist (CA). One hundred thirty-nine psychologists were given the TOQ, which is in a 5-point Likert scale format ranging from *strongly agree* to *strongly disagree*. Most of the participants identified Freudian, Rogerian, or Sullivanian to be their theoretical orientation. Subscale inter-correlations were not specified.

Poznanski and McLennan (1995) reported reliability data ranging from .50-.91, but it is unclear where the researchers obtained these data, as it was not directly cited and a review of all studies involving the use of the TOQ (Sundland & Barker, 1962) did not produce this information. Validity data were also not provided. High mean scores on the FA subtest indicate endorsement of a passive, non-talkative, and non-interruptive therapeutic approach. The TA scale measures the degree to which participants believe it is desirable to interpret material beneath clients' conscious awareness. The ET scale describes an impersonal versus warm, personal approach. The STR scale describes the extent to which therapists act in a planful versus spontaneous manner and whether or not it is important to conceptualize the therapeutic relationship. Inter-correlations of the STR items yielded a further breakdown of three subcategories: (a) Spontaneity in the Therapeutic Relationship, (b) Planning of the Therapeutic Relationship, and (c) Conceptualization of the Therapeutic Relationship. The CTG scale inter-correlations also produced two subscales, Cognitive Therapeutic Gains and Learning Process in Therapy, which describe a preference for whether or not clients gain a cognitive understanding of themselves and whether or not learning occurs verbally and conceptually; or nonverbally, nonconceptually, and via affect. The GT scale indicates the extent to which the therapists have goals for their patients. The TS scale describes therapists' personal security in the therapeutic relationship. The TIT scale measures belief in the importance of discussing childhood issues in therapy. Endorsement of the TN scale indicates a belief that an overrestrictive superego is responsible for neuroses. The CS scale measures the extent to

which therapists believe clients should adjust to the goals of society. The TM scale measures the extent to which therapists believe unconscious processes play an important role in behavior. Lastly, the CA scale pertains to the importance of training versus the therapists' personality when conducting psychotherapy.

A factor analysis utilizing the Wherry and Whiner (1953) procedure of the 16 subscales revealed six factors, which the authors (Sundland & Barker, 1962) did not discuss further because they subsequently used all 16 subscales for further data analysis. Factor analysis also revealed a secondary general factor that covered most of the scales and is described by two distinct poles, analytic and experiential. The analytic pole emphasizes conceptualization, therapist training, unconscious processes, a planned approach to therapy, and therapist spontaneity. The experiential pole de-emphasizes these concepts, instead emphasizing non-rational, nonverbal experiencing. It is notable that Factor I (Maintaining personal distance) of Wallach and Strupp's (1964) measure (the UTP), which was discussed above, bears a similarity to this general factor in that they both emphasize the therapists' direct personal involvement with clients.

Howard, Orlinsky, and Trattner (1970) further analyzed the properties of the TOQ (Sundland & Barker, 1962), using a revised version containing 45 items, which they obtained from Sundland via personal communication. A cluster analysis of item inter-correlations produced eight clusters. A centroid factor table (8 x 45) was then constructed, and item loadings resulted in five clusters. Items were then correlated with the five clusters. Cluster I, labeled Psychoanalytic Orientation, describes a careful,

passive, and impersonal orthodox psychoanalytic therapeutic approach. Cluster II, called Impersonal Learning vs. Personal Relationship, is a bipolar measure of the therapeutic learning process as a verbal and conceptual versus nonverbal and affective process. The former approach is characteristic of a controlled, non-evaluative, impersonal therapist, whereas the latter is more characteristic of a frank, spontaneous, and personal therapeutic manner. The third cluster, Therapist's Role Responsibility, measures therapists' sensitivity and helpfulness toward patients. The fourth cluster, Patient's Inner Experience, emphasizes introspection, as opposed to social behavior, as the main target of therapy. Cluster V, Therapist Directiveness, describes an active, guiding, instructing, and confronting therapeutic approach aimed at improving patients' social adjustment. One stand-alone item apart from any cluster, named Recognition of Countertransference Potential, was maintained by the authors because they thought it was an interesting item to consider.

The study done by Howard et al. (1970) was important in part because it provided a degree of structural validity to the TOQ (Sundland & Barker, 1962). The first three clusters found by these researchers comprise Sundland and Barker's (1962) Analytic versus Experiential dimension of the TOQ. Howard et al. indicated that the additional two clusters found could be attributable to using a different version of the TOQ and a different sample than what was used in Sundland and Barker's (1962) original study. The findings of Howard et al. also lend credence to McNair and Lorr's (1964) research involving their instrument, the AID. The AID has three dimensions (Psychoanalytic,

Impersonal vs. Personal, and Directive), which were found to correspond with Howard et al.'s Clusters I, II, and V (Psychodynamic Orientation, Impersonal Learning vs. Personal Relationship, and Therapist Directiveness).

Larson (1980) used yet another version of the TOQ (Sundland, 1977) to poll 339 behavioral, gestalt, psychoanalytic, and transactional analytic therapists. This version of the TOQ contained 104 items. Larson used a principle components and varimax rotation factor analysis, which yielded six factors (Factors I-VI): (a) Humanistic, (b) Psychoanalytic, (c) Goal-Directed Socialization, (d) Inactive-Unobtrusive, (e) Therapist Emotional Involvement, and (f) Non-afffective Focus. Factor I, Humanistic, represents an informal, spontaneous, self-disclosing person-to-person therapeutic relationship. Subscales derived from this factor include Informal/Self-Disclosing; Therapy as Art, Techniques (i.e., empty chair, guided daydream, role-playing, and meditation); and Self-Actualization. Gestalt therapists endorsed this humanistic factor the most. The psychoanalytic factor (Factor II) represents a traditional psychoanalytic approach: dream interpretation, free association, focus on transference, interpretation of unconscious motives, and understanding childhood relationships. As would be expected, psychoanalytic therapists endorsed the items on this factor most frequently. Factor III, Goal Directed Socialization, describes a therapeutic style that is directive, goal-specific, and has a social criterion for outcome. Behaviorists scored highest on Factor III. Psychoanalytic therapists scored highest on Factor IV, Inactive-Unobtrusive, which describes a non-directive therapeutic style in which therapists are more passive than

therapists of other orientations. Factor V, Therapist Emotional Involvement, describes therapists' feelings toward clients and the extent to which they care about and share concern for clients. Surprisingly, behaviorists scored highest on this factor, but it was the only factor that did not contain significant differences between the four orientations. Factor V was also the only factor that contained a significant effect upon further multivariate analysis.

Larson (1980) found that men differed significantly in their responses to Factor V, with higher scores than women. The sixth factor, Nonaffective Focus, emphasizes the degree of focus on client affect and the importance of affect in the goals of therapy. Gestalt therapists scored lowest on this factor, which indicates that they consider affective gain to be a major goal of therapy. High scorers on this factor, which were the behaviorists, believe that affective gain is not important.

Unlike Sundland and Barker (1962), both Larson (1980), and Howard et al. (1970) list the items of the TOQ (Sundland & Barker, 1962) in their respective studies. Based on face value inspection of these items, it appears that some similarities exist between the TOQ and the MSRQ (Roblyer & Harris, 2011). Some of the subscale items of the various versions of the TOQ contain similar items found in what would be the corresponding subscale of the MSRQ. For example, on Howard et al.'s version, the item on the Psychoanalytic Orientation scale, "With most patients, I instruct them to free associate," is similar to the key strategy, "Encouraging Free Association" on the Psychodynamic-Interpersonal strategies scale of the MSRQ. Larson's version also

contains items that correspond with the MSRQ, but there are also interesting item differences. For example, Larson's Factor I, the Humanistic subscale, contains the item, "It is very useful to use the guided daydream technique." This item corresponds with the key strategy, "Working with Imagery," which is found on the Cognitive strategies scale of the MSRQ instead of the Experiential-Humanistic scale. Overall, it is impossible to directly compare the TOQ with the MSRQ because the TOQ measures mostly attitudes about the therapeutic relationship instead of direct therapeutic behavior.

The Therapeutic Technique Items. Weissman, Goldschmid, and Stein (1971) created a 27-item instrument called Therapeutic Technique Items (TTI). The TTI measures the frequency of behaviors therapists practice in therapy on a 6-point Likert scale of responses ranging from *with every patient* to *never*. A factor analysis of the instrument was conducted based on the responses of 224 randomly selected American Psychological Association (APA) Division 12 (Clinical Psychology) members. Results revealed nine factors categorized into five themes: (a) Egalitarian, (b) Dogmatist, (c) Normalist, (d) Pragmatist, and (e) Authoritarian. The egalitarian themed factor items center around an interpersonal therapeutic relationship in which both participants are equal and benefit from the relationship through self-disclosure. The dogmatist theme describes therapy as being formal and systematic, with the precise application of techniques aimed at problem solving (behaviorism fits within this particular theme). The normalist category describes therapists who are most concerned with child and adult patients' ability to form meaningful relationships and adapt to their environment. Within

the authoritarian theme, the therapeutic relationship is very formal; "one in which the therapist by his firm and expert albeit patient manner offers the patient a means of control over psychic forces" (Weissman, et al., 1971, p. 33). The pragmatist category describes therapists who use a broad range of therapeutic techniques in a non-formal manner.

The TTI (Weissman, Goldschmid, & Stein, 1971) is similar to the MSRQ (Roblyer & Harris, 2011) in that it assesses the frequency of specific behaviors practiced by psychotherapists. At face value, the factors within the dogmatist theme most closely resemble Brooks-Harris' (2008) behavioral category of key strategies. The authoritarian themed factor contains experiential and psychodynamic-based items, the egalitarian themed factors contain behavioral and multicultural-feminist principles, the pragmatist factors contain psychodynamic and behavioral items, and the normalist factors contain systemically-based practices. Weissman et al. provide the factor loadings for the TTI scale items (all loadings were .30 or greater), but no reliability or validity data were obtained.

Ideology Scale. Garfield and Kurtz' (1976) Ideology Scale (IS) is a 22-item measure with three subscales: (a) Behavior Modification (BM), (b) Intuitive-Objective (IO) and (c) Psychoanalytic-Psychodynamic (PsD). The IS was developed using data from a survey of 855 clinical psychologists (members of APA's Division 12) who identified themselves to be predominantly eclectic in theoretical orientation. The BM subscale assesses attitudes regarding the etiology of mental illness and approach to treatment from a behavior modification framework. The IO subscale emphasizes attitudes

surrounding practice and research. The PsD subscale addresses maladaptive behavior, therapeutic change, and mode of treatment from a psychoanalytic/psychodynamic perspective. Factor loadings and reliability data were not provided by the researchers. However, a discriminant analysis of the data yielded a coefficient of .86, indicating limited evidence of construct validity. Byrne (1983) later found cross-sample factor stability for this instrument. Unlike the MSRQ (Roblyer & Harris, 2011), the IS measures attitudes, addressing therapeutic interventions only indirectly. Furthermore, the IS is more limited in scope than the MSRQ because it addresses behavioral and psychodynamic orientations only.

Therapeutic Procedures Inventory-Revised. The Therapeutic Procedures Inventory-Revised (TPI-R; McNeilly & Howard, 1991) is comprised of 73 items divided into three sections: (a) interpersonal behavior, (b) therapeutic goals, and (c) therapeutic interventions. The first section assesses qualities of the therapeutic relationship and the second section assesses the goals of the therapist. The third section of the TPI-R contains 49 direct therapeutic interventions developed to represent a variety of psychotherapy orientations. The instrument was given to 155 psychodynamic psychiatrists, psychologists, practicum students, interns, and residents. Participants rated the frequency of use of each of the 49 interventions on a 3-point Likert scale from 0 (*not at all*) to 3 (*very much*). A principle components factor analysis of the items yielded three scales with factor loadings of the retained items at .27 or greater (McNeilly & Howard, 1991). The scales are (a) Directive/Behavioral, (b) Psychodynamic/Past-Focused, and (c)

Affective. The directive/behavioral scale items reflect active, present-focused, and direct therapeutic interventions. The psychodynamic/past-focused items emphasize a traditional psychodynamic approach to therapy. The affective scale consists of experiential interventions. Subscale inter-correlations ranged from .05 to .28 and internal reliability of the scales were .63 to .82 (McNeilly & Howard, 1991).

The three scales of the TPI-R (McNeilly & Howard, 1991) bear a very similar resemblance to the AID (McNair & Lorr, 1964). The three factors of the AID were related to a psychoanalytic treatment approach (Factor A), the therapists' affective response to patients (Factor I), and a directive, active approach to treatment (Factor D). The TPI-R is also similar to the MSRQ (Roblyer & Harris, 2011) in that its items describe specific techniques therapists use in therapy. The MSRQ's psychodynamic-interpersonal and experiential-humanistic scales appear to be somewhat comparable to the TPI-R's psychodynamic/past-focused and affective scales, respectively.

Therapist Style Questionnaire. The Therapist Style Questionnaire (TSQ) was developed by Rice, Fey, and Kepecs (1972). Unlike the MSRQ (Roblyer & Harris, 2011), the TSQ measures therapist style as opposed to therapist behavior. Fifty experienced and inexperienced therapists used a 5-point Likert scale from 1 (*Definitely Not or Never)* to 5 (*Definitely Yes or Always*) to rate their behavior on the 23-item survey. Results of a principle components factor analysis and item inter-correlation analysis found six styles of therapeutic behavior: (a) Blank Screen, (b) Paternal, (c) Transactional, (d) Authoritarian, (e) Maternal, and (f) Idiosyncratic. The six factors accounted for 57.4% of

the total variance and no factor predicts any of the other factors. Factor I, Blank Screen, describes a therapeutic style that is passive, unchanging, unprovocative, anonymous, and cautious. The paternal style, Factor II, indicates a businesslike, patient, interpretive, impartial stance of therapists who are interested in patients' history. The third factor, Transactional, represents a "here and now" orientation with a casual, relationship-oriented, interpretive, spontaneous style. The Authoritarian factor, Factor IV, is a theory-oriented, persistent, definite, guiding, business-like and goal-oriented therapeutic approach. Factor V, Maternal, describes therapists who prefer a talkative, explanatory, supportive, guiding, and interpretive style. The sixth factor, Idiosyncratic, emphasizes a critical, unspontaneous, unprovocative, talkative approach that encourages conformity. Cross-sample factor stability was later established by a factor analysis performed by Rice, Gurman, and Razin (1974).

Counseling Orientation Scale. Loesch and McDavis' (1978) Counseling Orientation Scale (COS) assesses for counseling orientation preferences rather than direct therapeutic interventions. A 4-point Likert response scale from 1 (*strongly disagree*) to 4 (*strongly disagree*) is used in this survey of 35 items. The items reflect five characteristics across seven counseling orientations. The characteristics include: (a) Nature of Man (NM), (b) Personality Constructs (PC), (c) Nature of Anxiety (NA), (d) Counseling Goals (CG), and (e) Counseling Techniques (CT). The orientations include (a) Behavioral (B), (b) Client-Centered (CC), (c) Existential (E), (d) Gestalt (G), (e) Freudian (F), (f) Rational-Emotive (RE), and (g) Trait-Factor. Loesch and McDavis' data

were obtained from 294 counseling education graduate students. Subscale inter-correlations ranged from .10 to .43, with 19 of 21 inter-correlations being statistically significant but not practically significant in terms of percentages of shared variance. Although not completely independent, the subscales are not highly correlated either.

Sharpley and Hattie (1983) administered the COS to 55 counselors and found adequate test-retest reliability ranging from .78 to .90. Internal consistency ranged from .04 to .63. The researchers also found that 22 of the 35 COS items were deemed unnecessary. Therefore, six of the counseling orientations could be better accounted for by asking one global question instead of administering the entire COS, suggesting inadequate validity for the instrument.

Theoretical Orientation Survey. The Theoretical Orientation Survey (TOS; Coan, 1979) is a 63-item survey containing eight factors: (a) Factual vs. Theoretical Orientation, (b) Impersonal Causality vs. Personal Will, (c) Behavioral vs. Experiential Content Emphasis, (d) Elementarism vs. Holism, (e) Biological Determinism, (f) Environmental Determinism, (g) Physicalism, and (h) Quantitative vs. Qualitative orientation. Respondents are asked to rate their beliefs about psychology and therapeutic practice on a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*).

The first factor, Factual vs. Theoretical Orientation, stresses empiricism at one end and speculation, interpretation, or theory-building at the opposite end. The second factor, Impersonal Causality vs. Personal Will, describes the extent to which practitioners value individual choice, purpose, and uniqueness. Factor 3, Behavioral vs. Experiential

Content Emphasis, measures therapists' attitudes about the importance of the expression of ego as a valuable source of psychological data. Factor 4, Elementarism vs. Holism, describes a research strategy that emphasizes a global versus elementary approach toward the understanding of psychological processes. The Biological Determinism factor (Factor 5) is a unipolar subscale that measures the importance of genetic factors as determinants of observable human characteristics. Factor 6, Environmental Determinism, is also a unipolar subscale and it measures the extent to which one's social environment causes individual differences. Another unipolar factor, Physicalism (Factor 7), describes the belief that psychological theory should be described in terms of physical conditions and events. The final factor endorses the use of mathematical and geometric models in psychological research as opposed to abstract mathematical or logical equations.

Two second-order factors of Objectivism vs. Subjectivism (Factor I) and Endogenism vs. Exogenism (Factor II) were also found (Coan, 1979). Factor I emphasizes conscious processes, content, or intention as opposed to a positivistic, materialistic, or behavioral viewpoint. Factor II describes an orientation based on internal versus external sources of behavior. Coan (1979) conducted several reliability and validity studies of the TOS using both small and large samples. He did not report subscale intercorrelations. Internal reliability coefficients ranged from .73 to .91. Test-retest reliability yielded coefficients .68 to .91. Krasner and Houts (1984) replicated a factor analysis of a 32-item version of the TOS, which yielded the same eight first-order factors as Coan (1979). Internal consistency alphas of the eight subscales were within

acceptable limits ranging from .85 to .57. Krasner and Houts surveyed 82 behavioral scientists and 37 psychologists for their study. The fundamental difference between the TOS and the MRSQ (Roblyer & Harris, 2011) is that the former measures self-reported attitudes and the latter measures self-reported behaviors.

Contemporary Measures

The following is a discussion of six contemporary measures of psychotherapy practice and therapist attitudes. There is a varying amount of psychometric data that has been reported for these measures.

Psychotherapy Process Q Set. The Psychotherapy Process Q Set (PQS; Jones, Hall, & Parke, 1991) is a method of capturing data about patients' attitudes, behaviors, and experience; therapists' attitudes and behaviors; and the climate of the therapeutic dyad. The method is based on the Q-sort technique, which involves sorting 100 items into nine piles, ranging from *least characteristic* of the respondent at Category 1 and *most characteristic* at Category 9. The items are statements that describe what happens among the patients and therapists from either viewpoint in any given type of therapy. For example, the statements "Therapist actively exerts control over the interaction," Patient is controlling," and "Self image is a focus of discussion" are all PQS items (Ablon & Jones, 1999).

The PQS (Jones, Hall, & Parke, 1991) is typically used as a tool for independent raters judging transcripts of therapy sessions. However, Hickman, Arnkoff, Glass and Shottenbauer (2009) used the PQS to survey 24 experts in psychotherapy integration

about what is most to least characteristic of their treatment of past or current patients. A principle components factor analysis of the data resulted in four factors that accounted for 66.7% of the total variance. The first factor describes therapists who are directive, supportive, encouraging, and help patients achieve present-focused goals. This factor shares similar characteristics with cognitive behavioral therapy. The second factor represents therapists who take a nonjudgmental approach, encouraging introspection, expression of affect, and exploration of thoughts, feelings, and relationships. This factor contains elements of cognitive behavioral, interpersonal, experiential, and psychodynamic therapies. The third factor emphasizes a type of therapy that contains characteristics of psychodynamic, humanistic, and experiential therapies. Items indicative of this factor include drawing connections between the therapeutic relationship and other relationships, and an emphasis on in-session affect and nonverbal behavior. The final factor emphasizes a focus on guiding and reassuring patients instead of introspection. The results of Hickman et al.'s study suggest that there is more than one style of integrative practice. Unlike the MSRQ (Roblyer & Harris, 2011), the PQS is an ipsative measurement system in which respondents compare their answers with each other instead of rating each item independently.

Counsellor Theoretical Position Scale. Poznanski and McLennan's (1999) Counsellor Theoretical Position Scale (CTPS) consists of two 20-item subscales, Rational-Intuitive (R-I) and Objective-Subjective (O-S). The theoretical underpinning of the subscale items are rooted in Sundland and Barker's (1962) and Coan's (1979)

findings. Items were also created to express Family-Systemic and Cognitive-Behavioral points of view, since the earlier measures were not inclusive of these modern approaches. The response choices on the CTPS are based on a 7-point Likert scale from 1 (*completely disagree*) to 7 (*completely agree*). A sample of 132 psychologists from the Australian Psychological Society were asked to state their theoretical orientation and rate the frequency of adherence to various therapeutic principles from four main orientations: (a) Cognitive-Behavioral, (b) Psychodynamic, (c) Experiential/Phenomenological, and (d) Family-Systemic. Factor analysis of item inter-correlations indicated the appropriateness of the two-factor R-I and O-S subscales, with all factor loadings at greater than .30. Internal consistency coefficients were .87 for the O-S subscale and .81 for the R-I subscale. Criterion related validity was measured by comparing the means scores on the R-I and O-S subscales. Cognitive-Behaviorists had the highest mean scores on both subscales. Psychodynamic therapists scored lowest on the R-I subscale, while Experiential/Phenomenological therapists scored lowest on the O-S subscale. Family-Systemic counselors scored in the intermediate range on both subscales. The CTPS is different from the MSRQ (Roblyer & Harris, 2011) in that the majority of items describe attitudes rather than behaviors. Participants were not given the option of selecting "Integrative/Eclectic" as their primary theoretical orientation. However, Poznanski and McLennan (1999) reported that 7% of the respondents listed themselves as being eclectic.

Theoretical Orientation Profile Scale-Revised. The Theoretical Orientation Profile Scale-Revised (TOPS-R; Worthington & Dillon, 2003) is an 18-item measure

consisting of six subscales corresponding to six major theoretical schools: (a) psychoanalytic/psychodynamic, (b) humanistic/existential, (c) cognitive-behavioral, (d) family systems, (e) multicultural, and (f) feminist. For each subscale, three questions assess the extent to which participants identify with a specific theoretical orientation, conceptualizes cases according to this theoretical orientation, and uses techniques grounded in that particular orientation. Overall, the TOPS-R measures the adherence to self-ascribed theoretical orientations. All items are measured on a 10-point Likert scale (1 *not at all* to 10 *completely* and 1 *never* to 10 *always*.). An exploratory analysis of responses from 345 participants yielded a six-factor solution, accounting for 87.5% of the variance, and was similar to the original hypothesized six-factor structure. High internal consistency reliability estimates were found on all six of the factors (a=.94 to .96). A discriminant function analysis revealed that the TOPS-R subscales are effective predictors of theoretical orientation for psychodynamic, cognitive-behavioral, and eclectic counselors. Adequate construct validity was also obtained by testing the inter-correlations of the TOPS-R with the Etiology Attribution Scale (Worthington, 1995), the Cross-Cultural Counseling Inventory-Revised (LaFromboise, Coleman, & Hernandez, 1991), and the Hoffman Gender Scale (Hoffman, Borders, & Hattie, 2000).

Worthington and Dillon (2003) reported sample concerns as a main limitation to their study. There were an inadequate number of humanistic/existential, family systems, feminist, and multicultural therapists in the discriminant analysis and a low representation of participants from racial/ethnic minority groups. The TOPS-R is similar to the MSRQ

(Roblyer & Harris, 2011) in that items are categorized by theoretical orientation. The MSRQ is more comprehensive, however, because it asks about specific techniques common to what would be expected of each theoretical orientation. The TOPS-R asks respondents to identify which orientations they use in practice. The MSRQ also contains items pertaining to a biopsychosocial approach, whereas the TOPS-R does not.

Theoretical Evaluation Self-Test. The Theoretical Evaluation Self-Test (TEST) was developed by Coleman (2004) to categorize statements of belief regarding therapeutic practice. A sample of 130 student or licensed social workers rated their beliefs on a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Results of an exploratory factor analysis based on their responses yielded the following seven factors, or therapeutic approaches: (a) Psychodynamic, (b) Biological, (c) Family Therapy, (d) Ecosystems/Cultural, (e) Cognitive-Behavioral, (f) Pragmatic Case Management, and (g) Humanistic. These factors accounted for 86% of the variance of the 36-item measure. The average scale reliability was found to be low at .65. Five of the factors were able to be tested for convergent validity because some of the test questions were taken from previous measures (i.e., Cocozzelli, 1987; LaFromboise et al., 1991; Larson, 1980). The psychodynamic, family, and ecosystems-cultural subscales had correlations in the strongly associated range, and the cognitive-behavioral and humanistic subscales fell in the moderately associated range, suggesting good convergent validity. The small and clustered sample of social workers is a limitation of Coleman's study. Although the TEST's subscales closely match those of the MSRQ (Roblyer & Harris,

2011) in terms of labeling, the TEST items describe beliefs about therapeutic behaviors, whereas the MSRQ items measure behavioral frequency.

Multitheoretical List of Therapeutic Interventions. The Multitheoretical List of Therapeutic Interventions (MULTI) was developed by McCarthy and Barber (2009) to measure frequency of use of common interventions found in eight subscales classified by theoretical orientation: (a) Behavioral Therapy (BT), (b) Cognitive Therapy (CT), (c) Dialectical Behavioral Therapy (DBT), (d) Interpersonal Therapy (IPT), (e) Person Centered (PC), (f) Psychodynamic (PD), (g) Process-Experiential (PE), and (h) Common Factors (CF). A graphic representation of the MULTI can be found in Figure 2. The MULTI subscales collectively contain a total of 60 items that address what behaviors, attitudes, and interventions occur during therapy. There are three different forms of the MULTI that can be used by therapists, clients, and observers. Respondents rate their answers on a 5-point Likert scale from 1 (*Not at all typical of the session*) to 5 (*Very typical of the session*).

McCarthy and Barber (2009) conducted three separate studies using the MULTI with clients, therapists, and student-raters. In each of the studies, factor structure, reliability, and validity was analyzed. In the first study, which consisted of a sample of 280 clients rating the behavior of their therapists, the eight subscales of the MULTI yielded moderate to excellent internal consistency ranging from .77 to .91. A split-half reliability analysis found that five of the subscales (BT, CF, CT, DBT, & PC) contained moderate reliability ($\rho_I > .70$) and two subscales (IPT & PD) contained reliability close to

the moderate cutoff (ρ_I =.68 each). A confirmatory factor analysis of the measure produced a root mean square error of approximation (RMSEA) value of .07 and a comparative fit index (CFI) value of .74, suggesting that the MULTI is a good model-data fit but lacks parsimony in explaining the relationship between the items. To test criterion validity, McCarthy and Barber conducted a predictive discriminant analysis among the theoretical orientations, which yielded an overall classification error rate of 12%. The maximum posterior probability estimator (MPP; Huberty, Wisenbaker, & Smith, 1987) error rate was 16%, which suggested that the clients who used the MULTI in this study were able to successfully distinguish between sessions containing different theoretical approaches.

The second study conducted by McCarthy and Barber (2009) involved a sample of 146 therapists and also yielded moderate to excellent internal consistency, with Cronbach's alphas ranging from .75 to .89. Six of the MULTI subscales (BT, CF, CT, DBT, IPT, & PD) exhibited moderate split-half reliability (ρ_I = .66-.86). As in the first study, a confirmatory factor analysis indicated an adequate model-data fit (RMSEA = .08) but not parsimony in describing the data (CFI = .64). Classification error rates (10%; MPP = 13%) for this data set also indicated that MULTI subscales adequately differentiate the theoretical orientations.

McCarthy and Barber's (2009) third study consisted of 60 raters who observed therapy sessions and yielded moderate internal consistency (α = > .70) for all but two subscales (DBT & PE; α = .66 each). The BT, CT, and IPT scales exhibited moderate

split-half reliability (ρ_I =.72 - .80), while the other five scales exhibited low but acceptable reliability (ρ_I >.50). Interrater reliability was moderate for the BT subscale, poor for the PE subscale, and low but acceptable for the rest of the subscales. As in the previous two studies, a confirmatory factor analysis indicated that the data fit the model adequately, but not parsimoniously (RMSEA >.08; CFI< .81). However, the researchers point out that the low CFI values are probably due to the inter-correlation between subscales. The apparent error rate for classification was 17%, and the MPP error rate was 14%, indicating adequate criterion validity.

Overall results of McCarthy and Barber's (2009) research have shown that the MULTI possesses adequate psychometric validity. However, the MULTI items may be better accounted for by fewer subscales. McCarthy and Barber in fact attribute the lack of a good model-data fit based on their confirmatory factor analyses to the presence of intercorrelations between subscales. The highest correlations occurred between the CT and BT subscales, between the DBT and BT subscales, and between the DBT and CT subscales on the therapist version of their measure. The MSRQ (Roblyer & Harris, 2011) is similar to the MULTI in that its items consist of techniques drawn from a variety of theoretical orientations. It appears, however, that the MSRQ addresses a wider breadth of practice by including items rooted in theories the MULTI does not represent, such as biopsychosocial and feminist approaches. It is impossible to provide a prima facie comparison of the item-subscale breakdown between the MSRQ and the MULTI because these data are not presented in McCarthy and Barber's study.

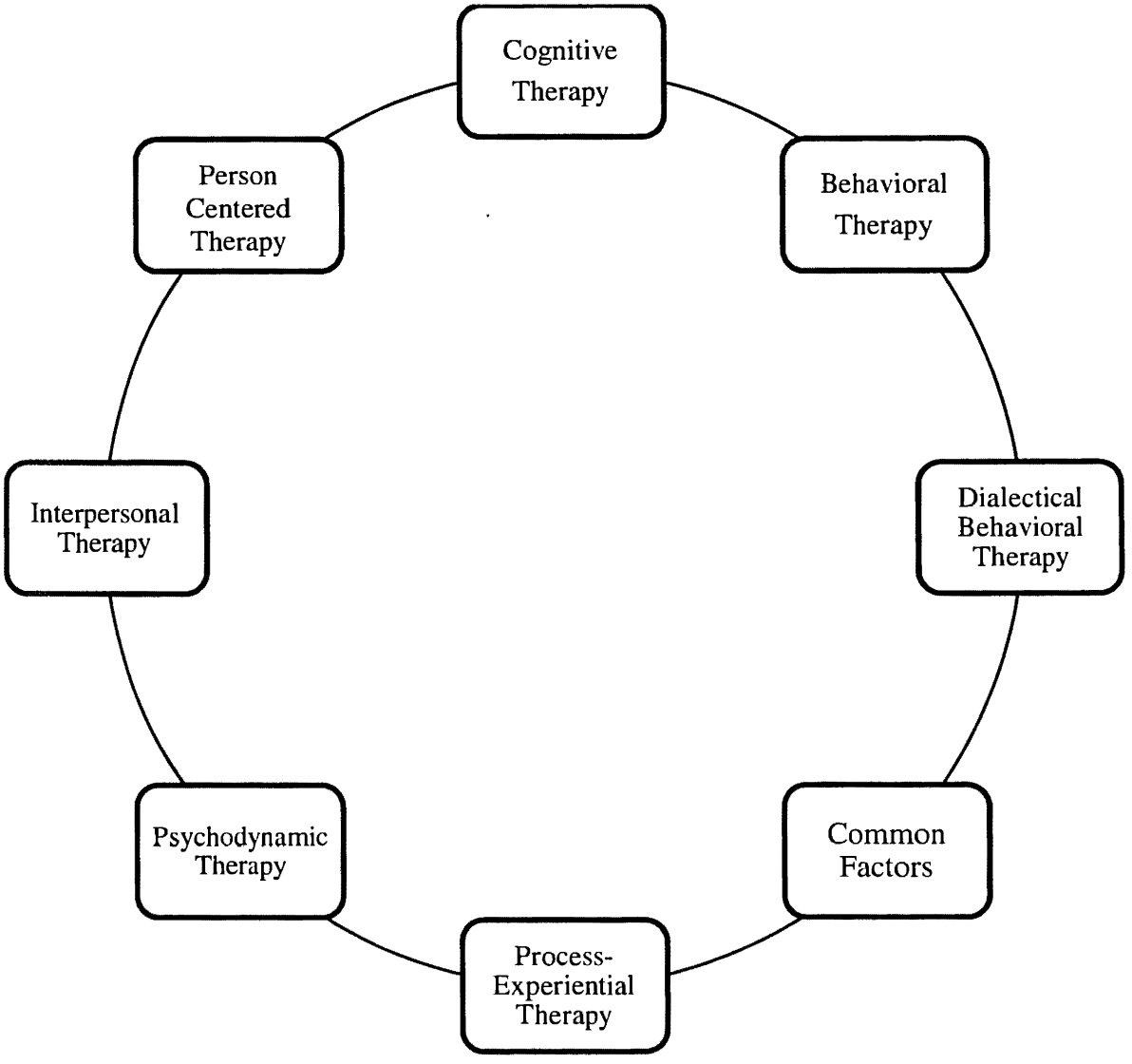

Figure 2. McCarthy and Barber's (2009) Multitheoretical List of Therapeutic Interventions (MULTI) factor structure.

Therapist Techniques Survey Questionnaire. The Therapist Techniques Survey Questionnaire (TTSQ) was developed by Thoma and Cecero (2009) to assess therapeutic techniques across eight theoretical orientations (Behavioral, Cognitive, Constructivist, Existential, Gestalt, Humanistic, Psychodynamic, and Systems). Like the MSRQ

(Roblyer & Harris, 2011), the TTSQ asks about demographics, theoretical orientation, and clinical practice. A sample of 209 doctoral-level psychology practitioners chose one of 14 theoretical orientations with which to self-identify and rated frequency of use of 127 therapeutic techniques on a 5-point Likert scale (1 *not at all* to 5 *very often*). Structural validity of the TTSQ was not obtained via factor analysis. Reliability data yielded internal consistencies in the range of .59 to .90. Significant differences were found between subjects on all categories of techniques except existential techniques, indicating some degree of construct and concurrent validity. As with the MULTI, the TTSQ fails to represent as wide a variety of techniques as the MSRQ does.

Summary of Existing Theoretical Measures

It is apparent that an abundant number of measures exist that attempt to measure what happens in therapy and what perceptions therapists have about the skills and models they use. This chapter contains a review of 14 older measures based on published studies. In addition, six newer measures contained in the literature were also reviewed. Although there are a few early measures that showed promising psychometric data (e.g., Sundland & Barker, 1962), they are unfortunately narrow in scope in terms of describing a limited number of theoretical orientations. Furthermore, some of the measures over-emphasize beliefs over preferred therapeutic practices, and most of the measures lack extensive reliability and validity (Poznanski & McLennan, 1995).

Variables Related to Therapist Behavior

Several of the researchers who have developed measures designed to capture the practices and attitudes employed in psychotherapy have done so in order to explore the differences between variables such as theoretical orientation, therapists' level of experience, and their profession (e.g., psychologist, social worker, or psychiatrist). For the purposes of this section, the phrase *therapist behavior* encompasses both the attitudes and practices of therapists. Early outcomes are mixed concerning the question of whether or not differences exist between therapists of differing theoretical orientations and the techniques they use in practice. Later research has shown that differences in theoretical orientation have persisted over time. Previously in this chapter, measures that currently exist have been discussed, with the primary focus being on their psychometric properties. The following is a review of research that has incorporated these instruments and has found significant differences between therapist behavior, and theoretical orientation, as well as differences among demographic variables. This review is limited to mostly older studies because there is very limited current data exploring the relationship of these variables to therapists' theoretical orientation.

Theoretical Orientation and Therapist Behavior

As part of their classic study developing the TOQ, Sundland and Barker (1962) conducted an analysis of variance of their data, which indicated that among psychoanalytic, Rogerian, and Sullivanian therapists, significant differences existed

between all groups on nine of the 16 subtests measuring therapists' attitudes about the therapeutic relationship. The most significant differences were found among the Freudians and Rogerians, who scored at the ends of the analytic and experiential poles, respectively. Sullivanian responses were located at midpoint.

Using their instrument, the UTP, Wallach and Strupp (1964) found significant differences among four prominent theoretical orientations in their sample: (a) Orthodox Freudian, (b) Psychoanalytic-general, (c) Sullivan, and (d) Client Centered. The Freudians preferred intensive therapy, maintaining personal distance, and keeping verbal interventions at a minimum, while Client Centered therapists endorsed the factor, Psychotherapy as an Art, most frequently. Weissman, Goldschmid, and Stein (1971) also studied therapeutic orientation as it relates to therapeutic practice using the TTI. Unlike previous researchers, they found that theoretical orientation (neo-Freudian, ego analytic, Freudian, Rogerian, and social learning) is unrelated to the techniques therapists used in practice.

In their research involving the development of their measure, the IS, Garfield and Kurtz (1976) conducted a discriminant analysis of their data. This analysis revealed that high intuitive scores on Factor II were associated with psychoanalytic orientations, while high objective scores were associated with participants who identified themselves to be learning theorists. Furthermore, psychoanalytic clinicians and learning theorists scored at completely opposite ends of the continuum across all three factors. Some similarities

between seemingly opposing theoretical viewpoints did emerge from the data, however. Those with an eclectic orientation were relatively less intuitive and psychodynamic than the other therapists (except for learning theory and Rogerian therapists) but did not particularly favor a behavior modification ideology. The Rogerian group endorsed a more similar response pattern to eclectics rather than humanistic and existential groups and was more close to learning theorists than most of the other groups.

Coan (1979), using data obtained with the TOS, found that among a breakdown of four main therapist groups (analytic, experiential, eclectic, and behavioral), the analytic and experiential therapists scored similarly to each other and in most cases, the experiential therapists differed from the behaviorists the most. They noted that behavior therapists tend to be objectivistic and experiential therapists tend to be subjectivistic.

Larson (1980) used the TOQ (Sundland & Barker, 1962) to poll behavioral, gestalt, psychoanalytic and transactional analytic therapists. He used a principle components and varimax rotation factor analysis, which yielded six factors: (a) Humanistic, (b) Psychoanalytic, (c) Goal-Directed Socialization, (d) Inactive, Unobtrusive, (e) Therapist Emotional Involvement, and (f) Nonafffective Focus. Multivariate analysis of variance indicated that the six factors significantly discriminated among the four groups of therapists.

Using the WNQ, Wogan and Norcross (1985) obtained expected results, in that each group of participants representing a Psychodynamic, Behavioral, Humanistic, or

Eclectic approach endorsed different components consistent with the techniques that would be expected to be used within their respective theoretical orientations. Behaviorists endorsed direct guidance, education, and planning at a higher rate than other therapists. Humanistic psychotherapists reported using a significantly greater amount of physical contact, evaluation of nonverbal behavior, and self-disclosure than therapists with a different self-identified theoretical orientation. Psychodynamic therapists endorsed psychodynamic techniques more than others did. Eclectics, on the other hand, scored highest or second-highest on all 13 scales, suggesting that people who believe in an eclectic approach to treatment use a diverse array of therapeutic techniques.

Thoma and Cecero's study (2009) indicated between-group differences in directions that would be expected based on a general knowledge of the typical therapeutic techniques used in the major theoretical schools of practice. As hypothesized, participants from all orientations endorsed some techniques outside of their own preferred orientation. Rogerian techniques received strong endorsement by all four of the theoretical orientation groups. Once the participants identified a theoretical orientation, the 14 orientations were collapsed down into four broadband theoretical groups: Humanistic, Cognitive-Behavioral, Psychodynamic, and Eclectic.

A common theme among the previous studies can be found. Most support the prediction that therapists tend to differ significantly in their practices and attitudes in a way that is congruent with their self-identified theoretical orientation (Poznanski &

McLennan, 1995). Psychotherapy process research has also demonstrated that therapists who espouse different theoretical orientations say and do different things with clients (Ablon & Jones, 1998; Jones & Pulos, 1993). Given the large body of data that mostly demonstrates differentiation among pure-form therapies, a new study exploring discrimination among the seven clusters of Brooks-Harris (2008) key strategies, based on concepts borrowed from pure-form therapies, seems warranted in order to see if Brooks-Harris' model is relevant today.

Theoretical Orientation, Therapist Behavior, and Experience

Fiedler (1950a, 1950b, 1951) used his own questionnaire, the FiQ, to conduct two studies, one with eight subjects and the other with seven. He reported that based on correlational analyses, expert therapists were found to use similar techniques, regardless of the theoretical school with which they were affiliated. He also found that practitioners with more clinical experience had enhanced understanding, communication, and rapport building abilities. Some other early studies supported Fiedler's conclusion that differences exist between expert and novice therapists, independent of orientation. For example, Anthony (1967) found that experienced therapists consider clients' self-understanding to be more important than less experienced therapists do, and they demonstrate more interpretive behaviors. Rice, Gurman, and Razin (1974) reported that more experience results in less predictability of therapeutic behavior.

Contrary to Fiedler's (1950a, 1950b, 1951) initial research, other researchers have found that experienced therapists do not necessarily behave in the same manner. Using his own questionnaire (the FQ) to conduct correlational analyses of 36 therapists, Fey (1958) found that Analysts and less experienced Eclectics were most alike, while Rogerians and experienced Eclectics were least alike in terms of therapeutic practices. The greatest homogeneity of responses was among experienced and inexperienced Rogerians, whereas the least homogeneity was among experienced and inexperienced Analysts. In regard to level of experience, the Analysts' and Rogerians' responses differed on only one subscale of the FQ, Theory of Personal Growth.

In their study using the TOQ with 139 therapists, Sundland and Barker (1962) found that experienced therapists are more similar to inexperienced therapists of their own theoretical orientation than they are to other experts of other theoretical orientations. Specifically, there was a higher correlation of mean scores between inexperienced and experienced groups of the same orientation compared to correlations between inexperienced and experienced groups of different theoretical orientations. There was, however, no significant difference between the mean scores on 16 subtests of therapists with two years or less of experience and therapists with nine or more years of experience, regardless of theoretical orientation. Like Sundland and Barker, Wallach and Strupp (1964) also found significant differences among 307 therapists who completed the UTP for their study. In regard to experience level, older therapists showed a preference for

intensive psychotherapy. Sundland and Barker (1962) pointed out that the differences between their findings and Fiedler's are most likely the result of using different measures that contained different attributes upon which the groups of therapists were compared.

Vardy's (1971) research also demonstrated that experience level has an impact on therapist behavior. Twenty-five psychiatry students from Bronx State Hospital were given the ThOQ. An initial group of 11 residents completed the survey at the beginning and end of their six-month rotation. Results show an initial strong endorsement for the highly traditional analytic modes of change, insight, and catharsis. By the end of their residency, endorsement of these modes declined significantly. Instead, participants indicated an appreciation for less analytically-oriented modes of change, such as Corrective Emotional Experience Through Contact. A second group of 14 residents completed the ThOQ a year later. Initial results indicated no strong endorsement for the traditional psychoanalytic modes of change at the start of their residency. Upon completing residency, their initial views only changed slightly, with the exception of a preference for the factor Corrective Emotional Experience Through Contact, which increased substantially by the end of training much like it did in the first group of participants.

Rice, Fey, and Kepecs (1972) conducted a study of therapists' in-session behavior, attitudes toward co-therapists, and co-therapy effectiveness using the TSQ. Twenty-five experienced and 25 inexperienced therapists were surveyed about 48

married couples treated in co-therapy. The participants were from the University of Wisconsin and consisted of trainees and staff members with a background in psychology, psychiatry, and social work. A factor analysis of therapist styles was obtained and results indicated that experienced therapists endorsed the Idiosyncratic factor most frequently and the Maternal factor the least frequently. According to the researchers, the Idiosyncratic factor represents a somewhat paradoxical and highly individualized style, while the Maternal factor describes a directive and supportive style. The reverse was true for inexperienced therapists. Not only do experienced and inexperienced therapists have different therapeutic styles, but experienced therapists displayed a significant degree of heterogeneity. This finding indicates that within the experienced therapist group, therapeutic styles were significantly different.

Wogan and Norcross (1985) also evaluated the influence clinical experience has on therapeutic activity. Using the WNQ, they surveyed 319 psychotherapists from Division 29 (Psychotherapy), and Division 32 (Humanistic) of the APA, and from the Association for the Advancement of Behavior Therapy. Results analyzing years of experience and scale scores indicated a positive correlation between years of experience and the use of psychodynamic interventions and efforts to be authentic in therapy. The amount of direct guidance, intentional frustration, educational interventions, and planning was inversely related to years of experience.

A small amount of contemporary research using existing measures also supports the previous research findings of differences among experienced and inexperienced therapists. Vasco and Dryden (1997) developed their own questionnaires to study therapeutic styles, theoretical orientation, clinical experience, and epistemological development. They analyzed the responses of 161 Portuguese psychotherapists from seven Portuguese psychotherapeutic societies: (a) Antrophoanalysis, (b) Behavior Therapy, (c) Cognitive-Behavior Therapy, (d) Client-Centered Therapy, (e) Family Therapy, (f) Group-Analysis, and (g) Psychoanalysis. Results found that experienced therapists were not more similar to each other and that theoretical orientation determined the therapeutic style of therapists more than experience level did. Vasco and Dryden's (1997) conclusion supports one made by Sundland and Barker (1962) decades earlier: that theoretical orientation is more important than clinical experience when the variables being studied are at a high or low level of abstraction (i.e., metatheoretical, theoretical, and technical variables).

Ogunfowora and Drapeau (2008) also studied the differences between experienced and inexperienced therapists, using the TOPS-R. They surveyed an international sample of 110 clinical psychologists and 111 counseling psychologists. The results of their study indicated that novice and intermediate level practitioners utilized a cognitive-behavioral approach more than advanced-level practitioners.

Results of studies investigating how therapists' level of experience is related to their theoretical orientation and practice are mixed. Fiedler (1950a, 1950b, 1951) found that experienced therapists used similar therapeutic techniques regardless of their theoretical orientation. Another researcher found that therapists use similar techniques regardless of their experience level (Fey, 1958). Fiedler (1950a, 1950b, 1951) also found differences among experienced and inexperienced therapists independent of theoretical orientation, which was supported by other research (Anthony, 1967; Rice, Gurman, & Razin, 1974). By contrast, Sundland and Barker (1962) found that experienced therapists used similar techniques as those used by inexperienced therapists of the same theoretical orientation. The majority of researchers have found that differences in theoretical orientation and practice exist between experienced and inexperienced therapists (Vardy, 1971; Rice, Fey, & Kepecs, 1972; Wogan & Norcross, 1985; Vasco & Dryden, 1997; Ogunfowora & Drapeau, 2008).

Theoretical Orientation, Therapist Behavior, and Profession

McNair and Lorr (1964) found that participants' profession (under the umbrella of the main discipline of counseling) was associated with particular therapeutic preferences, as measured by the AID. Two hundred sixty-five psychologists, psychiatrists, and social workers endorsed a pattern of response that would be most expected given their differences in training and the types of patients they see. Psychiatrists preferred psychoanalytically derived techniques, an impersonal relationship with patients, and

control over the course of therapy. Psychologists preferred having a personal, affect-oriented relationship and leaving control over the goals and direction of therapy with clients, which most closely reflects a Rogerian orientation. Social workers were split three ways in their preferences, with the majority preferring the use of personal-directive techniques. These results were based on correlating participant responses with the three technique factors of the AID (psychoanalytic, impersonal vs. personal, and directive).

Theoretical Orientation, Therapist Behavior, and Sex

Various researchers have found significant differences among therapists based on the sex of the participant. McNair and Lorr (1964) obtained correlations between scores on their instrument, the AID, and sex. Based on the results from a survey of 265 participants (73 of whom were female), McNair and Lorr reported that a majority of women preferred a detached, impersonal approach to therapy, with a caveat. They stated that this finding was likely due to the fact that the participants saw mostly male clients in a Veterans Affairs (VA) hospital setting.

Wogan and Norcross (1983) also found that women therapists preferred more personal distance in therapy, suggesting that women therapists prefer a more psychoanalytically oriented approach to treatment. To obtain this result, Wogan and Norcross used a version of the UTP (originally developed by Wallach & Strupp, 1964) that they modified to survey 136 therapists from APA's Division 29 (Psychotherapy). Ogunfowora and Drapeau (2008) also analyzed the sex variable in their study using the

TOPS-R. They surveyed 221 psychologists and found that women therapists used feminist techniques in therapy more than men.

In his study using the TOS, Coan (1979) found that in comparison to men, women scored significantly higher on Endogenism and lower on all factors except for Biological Determinism, which indicates that women believe behavior is more internally, as opposed to externally, derived. Coan surveyed 866 APA members and obtained correlational coefficients between sex and subscale scores.

Purpose of the Study

Studies have shown that asking therapists simply to state their theoretical orientation is not always a valid way of measuring theoretical orientation (Poznanski & McLennan, 1995). Self-ascription leaves the door open to broad identification with a theoretical label that is vague and subjective. Therefore, it is important to be able to operationalize what therapists really mean when they describe themselves as having a cognitive-behavioral or psychodynamic theoretical orientation, for example. Those who identify as integrative/eclectic are even more at risk of an individualistic interpretation (Johnson & Brems, 1991). Because survey research has shown that many therapists do not ascribe to a single orientation, it makes sense to develop an instrument that describes therapists' theoretical orientation utilizing a measure that is both objective and comprehensive (Poznanski & McLennan, 1995). Several measures of theoretical orientation, practice, and attitudes have been developed over the past 60 years. Most of

the 20th century measures, however, are limited in scope. They measure the practice and attitudes of therapists within the context of a limited list of pure-form modalities.

Integrative practice has become an extremely widespread modality, with one-third of therapists consistently identifying as integrative/eclectic in theoretical orientation (Norcross, Karpiak, & Santoro, 2005). Hickman, Arnkoff, Glass, and Schottenbauer (2009) contend that integrative/eclectic therapy encompasses a wide range of theoretical influences. However, it appears there is a lack of research demonstrating what integrative therapists in particular actually do in practice (Schottenbauer, Glass, & Arnkoff, 2007). Furthermore, research is needed in the areas of process and outcome as it relates to the practice of integrative psychotherapy (Coscolla, Caro, Avila, Alonso, Rodriguez, & Orlinsky, 2006). In order to meet the needs of researchers, an instrument that more closely describes what the practice of integrative psychotherapy actually looks like is needed.

Contemporary measures do a better job of operationalizing what integrative therapists do in practice because some items are based on practices that move beyond pure-form theories, such as the specific techniques associated with EMDR and DBT that are found in the MULTI (McCarthy & Barber, 2009). Thus far, the MULTI appears to be the most comprehensive measure with adequate psychometric utility. However, the contemporary measures reviewed in this chapter, including the MULTI, are different from the MSRQ (Roblyer & Harris, 2011) in that they have not been specifically

conceptualized from an integrative framework that incorporates all of the major schools of psychotherapy practice. Furthermore, because the MULTI lacks adequate criterion validity (McCarthy & Barber) based on confirmatory factor analyses, it was thought that looking at the structural properties of the MSRQ by performing an exploratory factor analysis would be warranted. With adequate psychometric properties, the MSRQ may prove to be more useful than existing tools because therapists still tend to think of their theoretical orientation in terms of existing theories, as opposed to dimensions that cut across theories, such as Sundland and Barker's (1962) analytic-experiential poles (Gelso, 1995).

The purpose of this study was to investigate the interventions therapists use in practice. The intent was to explore the psychometric properties of the MSRQ (Roblyer & Harris, 2011) by conducting an exploratory factor analysis of the key strategies Brooks-Harris (2008) has defined as part of his model of integrative therapy practice, Multitheoretical Psychotherapy (MTP). This model of psychotherapy integration describes seven main theoretical orientations as a platform for practicing psychotherapy. The MSRQ has the potential to become an important tool used for training in the area of integrative psychotherapy (Brooks-Harris, 2008). The MSRQ might also be an appropriate tool for use in randomized clinical trials for specific mental illnesses should good reliability and validity eventually be demonstrated (Schottenbauer, Glass, & Arnkoff, 2007).

Research Questions

The purpose of this study was to conduct survey research to determine if the MSRQ (Roblyer & Harris, 2011) is a valid measure of multitheoretical psychotherapy. It was believed that the MSRQ would display adequate statistical properties with a factor structure that reflects the theoretical orientations proposed by Brooks-Harris. The intent was to also test the convergent validity of the MSRQ using the MULTI (McCarthy & Barber, 2009). The following research questions and hypotheses were proposed.

1. Are there seven discrete factors corresponding to Brooks-Harris' seven theories of psychotherapy practice?

   Hypothesis: Factor analysis will produce seven subscales of the MSRQ, each with adequate internal consistency.

2. Do each of the key strategies contribute to the operational definition of the corresponding theory of psychotherapy under which they were listed by Brooks-Harris?

   Hypothesis: The key strategy items will load on the factors corresponding to the theoretical approaches from which they were drawn.

3. Are there significant differences between integrative/eclectic and pure-form therapists?

   Hypothesis: Integrative/eclectic therapists will endorse a wider repertoire of key strategies than pure-form therapists.

4. Does theoretical orientation predict the use of key strategies?

   Hypothesis 4a: Pure-form therapists will endorse interventions consistent with their self-identified theoretical orientation at a higher rate than strategies from other theories.

   Hypothesis 4b: Pure-form therapists will endorse some interventions that are not consistent with their self-identified theoretical orientation.

5. Does the MSRQ display adequate convergent validity?

   Hypothesis 5a: The Cognitive subscale of the MSRQ will contain adequate convergent validity with the Cognitive subscale of the MULTI.

   Hypothesis 5b: The Behavior subscale of the MSRQ will contain adequate convergent validity with the Behavior subscale of the MULTI.

   Hypothesis 5c: The Experiential subscale of the MSRQ will contain adequate convergent validity with the Process-Experiential subscale of the MULTI.

   Hypothesis 5d: The Psychodynamic Interpersonal subscale of the MSRQ will contain adequate convergent validity with the Psychodynamic subscale of the MULTI.

Assumptions

The following are the assumptions for the purposes of this study:

1. Participants will accurately and candidly answer all of the questions on the self-report questionnaires.

2. The methodological paradigm is appropriate for the proposed study.

CHAPTER III

METHOD

Participants

Participants included 179 mental health counselors from various disciplines (e.g., counseling psychology, marriage and family therapy), at different points in their careers (e.g., graduate students with at least one semester of practicum completed, practitioners with more than 40 years of experience). Participants' ages ranged from 23 to 73 years, with the average age being 42-years-old (*Mdn* = 39, *SD* = 14.23). Among participants, the average number of years spent engaging in counseling/psychotherapy services was 12 (*Mdn* = 7, *SD* = 10.5). While 56 (31.3%) of participants were practicing in Texas, additional participants reported practicing in 37 other states (*n* = 114, 63.6%), Canada (*n* = 1, 0.6%), and international countries (*n* = 8, 4.5%). Approximately 37.4% (i.e., 67) of participants were graduate students at the time they participated in this study. See Table 1 for a breakdown of the descriptive statistics and frequencies for demographic variables, including: (a) age, (b) race/ethnicity, (c) gender, (d) discipline/degree field, (e) graduate-student status, (f) degree type, and (g) length of time practicing.

Table 1

Descriptive Statistics and Frequencies for Demographic Information

Variable	Frequency	Percentage
Sex		
Women	122	68.2
Men	57	31.8
Age		
20-29	44	24.4
30-39	47	26.1
40-49	32	17.9
50-59	21	11.9
60-69	32	17.9
70-79	3	1.8
Race/Ethnicity		
White/Caucasian	154	86.1
Black/African American	10	5.7
Bi- or Multi-racial/Multiethnic	5	2.9
Latino(a)/Hispanic	4	2.3
East Asian/Asian American	3	1.8
Middle Eastern/West Asian	2	1.2
Discipline/Degree Field		
Clinical Psychology	55	30.7
Counseling Psychology	51	28.5
Counseling/Counselor Education	21	11.7
Marriage & Family Therapy	18	10.1
Other	14	7.8
Social Work	13	7.3
School Counseling	4	2.2
School Psychology	2	1.1
Psychiatry	1	0.6
Graduate Student Status		
Not a Graduate Student	112	62.6
Currently a Graduate Student	67	37.4

(continued)

Table 1 cont'd

Variable	Frequency	Percentage
M.A./M.S.	64	35.7
Ph.D.	51	28.4
Other	25	14.0
None	18	10.1
Psy.D.	15	8.4
Ed.S./Other Specialists Degree	3	1.7
M.D./D.O.	2	1.1
Ed.D.	1	0.6
Number of Years of Experience		
1-5	77	42.9
6-10	33	18.4
11-15	14	7.8
16-20	18	10.0
21-25	15	8.3
26-30	6	3.4
31-35	8	4.6
36-40	5	2.9
41-45	3	1.7

Note: $N = 179$

Instruments

Demographic Questionnaire

A demographic questionnaire (Appendix A) was developed to obtain participants' information, including age, sex, gender, ethnicity, geographic location, education, and professional status, along with the number of years of experience, the settings in which they have practiced, and the client populations with whom they have worked. The questionnaire also asked about clinicians' primary theoretical orientation, the list of

which was developed using the seven main theoretical approaches of multitheoretical psychotherapy described by Brooks-Harris (2008).

Multitheoretical List of Therapeutic Interventions (MULTI)

The MULTI (McCarthy & Barber, 2009; Appendix B) is a 60-item assessment that measures use of psychotherapy interventions by session from clients', therapists', and observers' perceptions. The items assess common techniques of psychotherapy, grouped under eight subscales: (a) behavioral, (b) common factors, (c) cognitive, (d) dialectical behavioral, (e) interpersonal, (f) person-centered, (g) psychodynamic and (e) process-experiential. The interventions are assessed on a 5-point Likert scale ranging from 1 (*Not at all typical of sessions*) to 5 (*Very typical of sessions*). Scoring the MULTI involves averaging the survey items contained in each of the eight subscales. The higher the scale average, the more typically a therapist uses interventions that are aligned with the corresponding theoretical orientation. For the purposes of this study, the questionnaire was administered to therapists only and not independent raters or clients. The survey's instructions ask practitioners to rate how typical each therapeutic approach or technique is based on what generally takes place with clients in any number of sessions, not with one particular client in a specific session. The questionnaire items were listed in random order without respective subscale headings.

Multitheoretical Strategies Rating Questionnaire (MSRQ)

The MSRQ (Roblyer & Harris, 2011; Appendix C) contains 98 items pertaining to the intervention strategies therapists use in psychotherapy practice. These strategies, called key strategies, were identified by Brooks-Harris to be representative of the psychotherapy skills and practices utilized by clinicians who use at least one of the seven major theoretical traditions of practice: (a) cognitive, (b) behavioral, (c) experiential-humanistic, (d) biopsychosocial, (e) psychodynamic-interpersonal, (f) systemic-constructivist, and (g) multicultural-feminist. The key strategies are grouped together under seven headings that correspond with the seven major theoretical orientations. The MSRQ measures the frequency that therapists engage in each of the key strategies. It contains a 7-point Likert scale ranging from 0 (*never)* to 6 (*very frequently*) with instructions for clinicians to indicate how frequently they use each strategy with clients in counseling or psychotherapy. During data collection, the key strategies were listed in random order without their respective theoretical orientation headings. Subscale scores can range from 72-96, with higher scores indicating stronger endorsement of a particular strategy.

Procedure

Scale Development

In order to develop key strategy items, which are the basis of the MSRQ (Roblyer & Harris, 2011), Brooks-Harris (2008) reviewed the psychotherapy literature and chose

therapeutic techniques that were consistent with their respective theoretical fields. Techniques that were deemed to exhibit overlap among theories were parceled out into separate theoretical categories based on the author's judgment. All 98 items of Brooks-Harris' catalog of key strategies were retained for use in the MSRQ, and a 6-point Likert scale was assigned to each item in order to measure frequency of use.

Data Collection

The participants were comprised of a convenience sample obtained via snowball sampling on the Internet. An email recruitment statement (see Appendix D) was sent to various practitioners affiliated with several different academic institutions and counseling-related associations (e.g., directors of college counseling centers; directors of psychiatric, social work, psychology and counseling graduate programs; and members of the American Psychological Association) across the country. The recruitment statement contained the purpose of this study and an invitation to participate in this research by completing an Internet survey. The emailed recruitment statement also informed participants of their opportunity to participate in a drawing for a $50 Visa gift card as compensation for their time. Participants were asked to forward the recruitment statement to other colleagues or students who might be eligible to participate in the study.

Participants who wished to participate in this study were directed to a link on Psychdata.com, a website designed especially for online data collection. Psychdata's survey-hosting capabilities allowed researchers to separate participants' identifying

information from their responses to items, thus allowing for anonymity. Once participants entered the survey via the unique Psychdata link, an informed consent form (Appendix E) appeared. The informed consent form included a brief background of this study and informed participants of their rights, as well as the risks and compensation involved with their participation. After reading and agreeing to informed consent by clicking on a "Continue" button, participants were asked to provide basic demographic information and identify their primary theoretical orientation. They then had to respond to their experience using the therapeutic techniques listed on the MSRQ (Roblyer & Harris, 2011) and the MULTI (McCarthy & Barber, 2009). The key strategy items on the MULTI were presented to participants in random order by utilizing the random sort function of a Microsoft Excel spreadsheet. Upon completion of the survey, participants were given the opportunity to provide their contact information in order to be entered into a drawing to win a $50 Visa gift card, provided by this researcher (see Appendix F). It was expected that it would take participants approximately 30 minutes to complete the survey.

Research Design and Analysis

Initially, this researcher intended to explore the factor structure of the MSRQ (Roblyer & Harris, 2011) by conducting an exploratory factor analysis. In addition, the convergent validity of the MSRQ was also going to be tested with the MULTI (McCarthy & Barber, 2009). As a result, the following hypotheses were proposed:

1. Are there seven discrete factors corresponding to Brooks-Harris' seven theories of psychotherapy practice?

   Hypothesis: Factor analysis will produce seven subscales of the MRSQ, each with adequate internal consistency.

2. Do each of the key strategies contribute to the operational definition of the corresponding theory of psychotherapy under which they were listed by Brooks-Harris?

   Hypothesis: The key strategy items will load on the factors corresponding to the theoretical approaches from which they were drawn.

3. Are there significant differences between integrative/eclectic and pure-form therapists?

   Hypothesis: Integrative/eclectic therapists will endorse a wider repertoire of key strategies than pure-form therapists.

4. Does theoretical orientation predict the use of key strategies?

   Hypothesis 4a: Pure-form therapists will endorse interventions consistent with their self-identified theoretical orientation at a higher rate than strategies from other theories.

   Hypothesis 4b: Pure-form therapists will endorse some interventions that are not consistent with their self-identified theoretical orientation.

5. Does the MSRQ display adequate convergent validity?

Hypothesis 5a: The Cognitive subscale of the MSRQ will contain adequate convergent validity with the Cognitive subscale of the MULTI.

Hypothesis 5b: The Behavior subscale of the MSRQ will contain adequate convergent validity with the Behavior subscale of the MULTI.

Hypothesis 5c: The Experiential subscale of the MSRQ will contain adequate convergent validity with the Process-Experiential subscale of the MULTI.

Hypothesis 5d: The Psychodynamic Interpersonal subscale of the MSRQ will contain adequate convergent validity with the Psychodynamic subscale of the MULTI.

The first, second, and fifth hypotheses were not able to be tested due to an insufficient number of participants necessary for proper data analysis. However, the third and fourth hypotheses were tested. The hypotheses that were tested have been refined from their original version and are renumbered here:

Hypothesis 1-Revised (H1-R): There is a statistically significant difference between the theoretical orientations of therapists and the therapeutic interventions they reportedly use.

Hypothesis 2-Revised (H2-R): There is a statistically significant difference between the repertoire of therapeutic techniques used by integrative/eclectic and pure-form therapists.

In order to test these hypotheses, a multivariate analysis of variance (MANOVA) was conducted. Theoretical orientation status (TOS) and theoretical orientation (TO) were used as independent variables and the eight MULTI (McCarthy & Barber, 2009) subscale scores were used as dependent variables. A post hoc discriminant function analysis was then conducted to evaluate significant multivariate findings.

The first independent variable, TOS, consists of two levels, therapists who identify themselves as being integrative or eclectic, and therapists who identify themselves as being pure-form practitioners. The TOS variable was derived by looking at the percentage of time respondents said they used their primary theoretical orientation. If they stated using their primary orientation (of which integrative was not an option) 100% of the time, they were classified as a pure-form therapist. If they did not use their primary theoretical orientation 100% of the time, or stated that they considered themselves to be integrative or eclectic, they were classified as integrative therapists.

The second independent variable, TO, consists of three levels of theoretical orientations: (a) Behavioral/Cognitive Behavioral (BCB),
(b) Existential/Humanistic/Systemic/Postmodern (EHSP), and
(c) Psychoanalytic/Psychodynamic/Interpersonal (PPI). The TO variable was established in its current form of three theoretical orientation categories (BCB, EHSP, PPI) in order to have adequate cell numbers for the statistical analysis. The first category (BCB) consists of therapists who identified Behavioral or Cognitive Behavioral as their primary

theoretical orientation. The second category (EHSP) consists of participants who identified themselves as being Existential/Humanistic, Feminist/Multicultural, Constructivist/Narrative, Systemic, or Biopsychosocial in orientation. The third category (PPI) consists of Psychodynamic/Psychoanalytic and Interpersonal therapists.

Although there was not a sufficient number of participants to test certain psychometric properties of the MSRQ (Roblyer & Harris, 2011), the seven latent variables proposed by Brooks-Harris' (2008) in his model of Multitheoretical Psychotherapy (MTP) are worthy of further study. Therefore, the following exploratory research question and hypothesis was added to this study:

Do the therapeutic interventions used in the MULTI (McCarthy & Barber, 2009) load on each of Brooks-Harris' seven theoretical subscales (Cognitive, Behavioral, Existential/Humanistic, Psychodynamic/Interpersonal, Biopsychosocial, Systemic/Constructivist, and Multicultural) proposed for the MSRQ?

Hypothesis 3-Exploratory (H3-E): The theoretical tenets of Brooks-Harris' proposed model of MTP can be translated into a structure that fits an existing scale, the MULTI, which has been proven to be reliable.

In order to test the third hypothesis, a confirmatory factor analysis (CFA) was conducted to determine fit between MULTI (McCarthy & Barber, 2009) items and Brooks-Harris' (2008) seven theoretical categories, or latent variables, found in his model

of MTP. The latent variables are: (a) Behavioral (Beh), (b) Existential-Humanistic (ExH), (c) Psychodynamic-Interpersonal (Psy), (d) Systemic-Constructivist (Sys), (e) Biopsychosocial (Bio), (f) Multicultural (Mul), and (g) Cognitive (Cog). All 60 of the MULTI items were used as observed variables of the latent variables. MULTI items were assigned to each latent variable based on this researcher's judgment about which latent variable was most reflective of the therapeutic intervention contained in the item. The decision was confirmed after consulting with a professional peer. The hypothesized conceptual model is depicted in Figure 3. Goodness of fit indices used in this analysis included: (a) Chi-Square (χ^2), (b) Root Mean Square Error of Approximation (RMSEA), (c) Comparative Fit Index (CFI), and (e) Non-Normed Fit Index.

CHAPTER IV

RESULTS

Descriptive Statistics

Eighty percent of respondents (143) considered themselves to be integrative/eclectic therapists, whereas 20% (36) did not. Of those in the latter group, 7% reported that they practice using their primary theoretical orientation 100% of the time. Participants were not given the choice to select integrative/eclectic as a primary theoretical orientation option and were asked to indicate whether or not they consider themselves to be integrative or eclectic in a separate question. Table 2 indicates the theoretical orientations participants chose as their primary orientation. Three percent of participants identified their primary theoretical orientation as behavioral, 6% biopsychosocial, 36% cognitive-behavioral, 4.5% constructivist/narrative, 9.5% existential/humanistic, 3% feminist/multicultural, 15% interpersonal, 12% psychodynamic/psychoanalytic, and 9.5% systemic.

Table 2

Descriptive Statistics and Frequencies of Participants' Primary Theoretical Orientation

Theoretical Orientation	Frequency	Percentage
Behavioral	6	3.4
Biopsychosocial	11	6.1

(continued)

Table 2 cont'd

Theoretical Orientation	Frequency	Percentage
Cognitive-Behavioral	65	36.3
Constructivist/Narrative	8	4.5
Existential/Humanistic	17	9.5
Feminist/Multicultural	6	3.4
Interpersonal	27	15.1
Psychodynamic/Psychoanalytic	22	12.3
Systemic	17	9.5

With a possible range of 1-5, the average mean scores on the Multitheoretical List of Therapeutic Interventions (MULTI; McCarthy & Barber, 2009) ranged from 3.42 (*SD* = 0.67) on the Interpersonal subscale to 4.32 (*SD* = 0.48) on the Common Factors subscale (see Table 3).

Table 3

Correlation Matrix, Means, and Standard Deviations for MULTI Subscale Scores

Subscale	1	2	3	4	5	6	7	8
1 BT	1							
2 CF	.51*	1						
3 CT	.87*	.56*	1					
4 DBT	.85*	.60*	.83*	1				
5 IPT	.40*	.45*	.53*	.54*	1			
6 PC	.12	.41*	.30*	.34*	.54*	1		
7 PD	.14	.32*	.31*	.33*	.61*	.81*	1	
8 PE	.40*	.38*	.48*	.49*	.61*	.78*	.82*	1
M	3.46	4.32	3.49	3.58	3.42	3.90	3.54	3.47
SD	.69	.48	.62	.65	.67	.60	.66	.61

Note: n = 179; * $p = < 0.01$ (two-tailed). MULTI = Multitheoretical List of Therapeutic Interventions; BT = Behavioral Therapy, CF = Common Factors, CT = Cognitive Therapy, DBT = Dialectical Behavioral Therapy, IPT = Interpersonal Therapy, PC = Person Centered Therapy, PD = Psychodynamic Therapy, PE = Process-Experiential Therapy.

Analysis of Major Hypotheses

Hypotheses One and Two (Revised)

For both of these hypotheses, a multivariate analysis of variance (MANOVA) was conducted using SPSS version 19 with theoretical orientation status (TOS) and theoretical orientation (TO) as independent variables and mean scores of the eight MULTI subscales as dependent variables. Results of the MANOVA supported this researcher's first hypothesis that a statistically significant difference exists between theoretical orientations and therapeutic interventions used, Wilks' $\lambda = .65$, $F(16, 332) = 5.00$, $p < .001$, $\eta^2 = .19$. This researcher's second hypothesis was not supported; no statistically significant difference between the repertoire of therapeutic interventions used by integrative and pure-form therapists was found, Wilks' $\lambda = .93$, $F(8, 166) = 1.60$, $p < .001$, $\eta^2 = .07$. A statistically significant interaction effect between TO and TOS was also observed, Wilks' $\lambda = .81$, $F(16, 332) = 2.26$, $p < .001$, $\eta^2 = .10$.

To determine the significant multivariate effects, two discriminant function analyses were performed. Results of these analyses yielded one significant discriminant function, Wilks' $\lambda = .688$; $\chi^2 (16) = 64.49$, $p < .001$, which accounted for 30% of the between group variance. Analysis of the discriminant function and structure coefficients (β) of this significant function (see Table 4) indicated that the best predictors for distinguishing behavioral or cognitive-behavioral therapists among therapists of other orientations were scores on the Cognitive, Behavioral, and Dialectical Behavioral

Therapy (DBT) scales of the MULTI. All three subscales were positively related to the function. Scores on the Person Centered and Psychodynamic scales had an inverse relationship to the function and were also found to be good predictors of cognitive and cognitive-behavioral Therapists. No significant differences were found among the demographic variables of experience level, profession, sex, degree held, or student status and any of the other variables measured in this study.

Table 4

Discriminant Function and Structure Coefficients for BCB Theoretical Orientation Group

MULTI Subscale	Discriminant Function	β
Behavioral	.21	.80
Common Factors	-.01	.27*
Cognitive	.68	.71*
DBT	.32	.63*
Interpersonal	-.28	.04
Person-Centered	-.44	-.25*
Psychodynamic	-.22	-.23*
Process-Experiential	.08	-.01

Note: (*) used to indicate the largest absolute correlation between each variable and any discriminant function. BCB = Behavioral and Cognitive-Behavioral; MULTI = Multitheoretical List of Therapeutic Interventions.

Hypothesis Three (Exploratory)

A confirmatory factor analysis (CFA) was conducted using Lisrel version 8.8 and the maximum likelihood (ML) estimation method to test the hypothesized fit between MULTI (McCarthy & Barber, 2009) items and Brooks-Harris' (2008) conceptual

multitheoretical psychotherapy model (MTP). The following fit indices were used in analyzing the results: (a) Chi-Square (χ^2), (b) Root Mean Square Error of Approximation (RMSEA), (d) Non-Normed Fit Index (NNFI), and (e) Comparative Fit Index (CFI). A significant chi-square finding suggests a poor model fit, however such a finding should be analyzed within the context of other fit indices, as chi-square can be influenced by a large sample size and does not negate the values of the other fit indices (Hu & Bentler, 1999). According to MacCallum, Browne, and Sugawara (1996), RMSEA values less than or equal to .05 indicate a good fit, .05 - .08 indicate a reasonable fit, .08 - .10 indicate a mediocre fit, and greater than .10 indicate a poor fit. The closer the value is to 1.0 on the CFI and NNFI, above .90 being ideal, the better the model fit.

Figure 3 depicts a graphical representation of the measurement model. Results indicated that an adequate fit exists between the theoretically-based items found on the MULTI (McCarthy & Barber, 2009) and the theoretical categories of Brooks-Harris' (2008) model of MTP, χ^2 (1689, N = 179) = 3873.34, $p < .001$; RMSEA = 0.09 (CI = .09, .10); NNFI = .86; CFI = .87. Although chi-square was significant, other fit indices indicated goodness-of-fit and showed that 87% (CFI = .87) of the covariance in the data can be accounted for by the model.

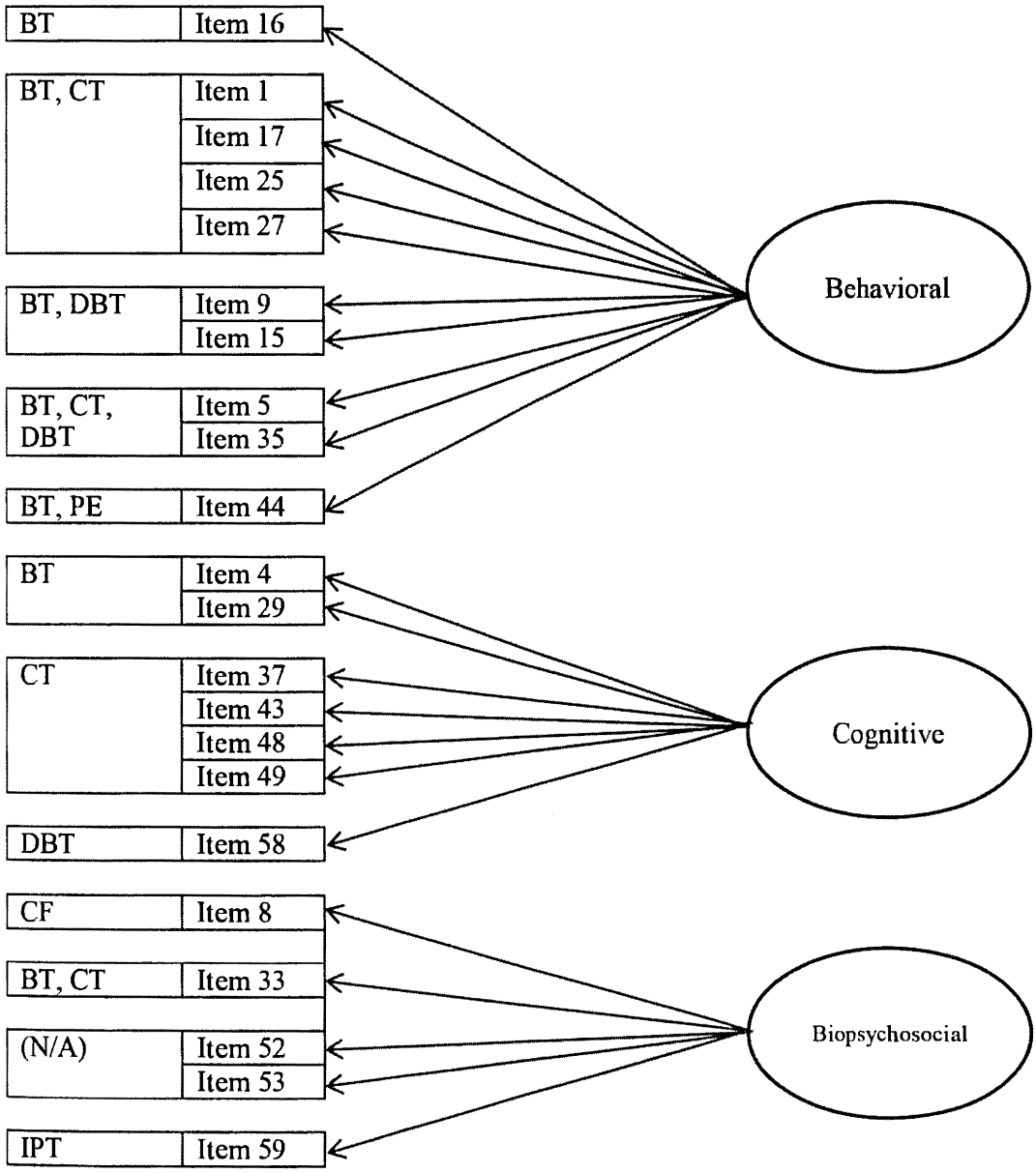

Figure 3. Conceptual model of the fit between Multitheoretical Psychotherapy (MTP) and the items on the Multitheoretical List of Therapeutic Interventions (MULTI). Letters in the first column denote the subscales of the MULTI. (Note: BT = Behavioral Therapy, CT = Cognitive Therapy, DBT = Dialectical Behavioral Therapy, PE = Process-Experiential Therapy, CF = Common Factors, IPT = Interpersonal Therapy, PD = Psychodynamic Therapy, PC = Person-Centered Therapy). The second column contains MULTI item numbers (see Appendix B). Ovals indicate latent variables of MTP model and arrows indicate item loadings of the respective variables based on a confirmatory factor analysis.

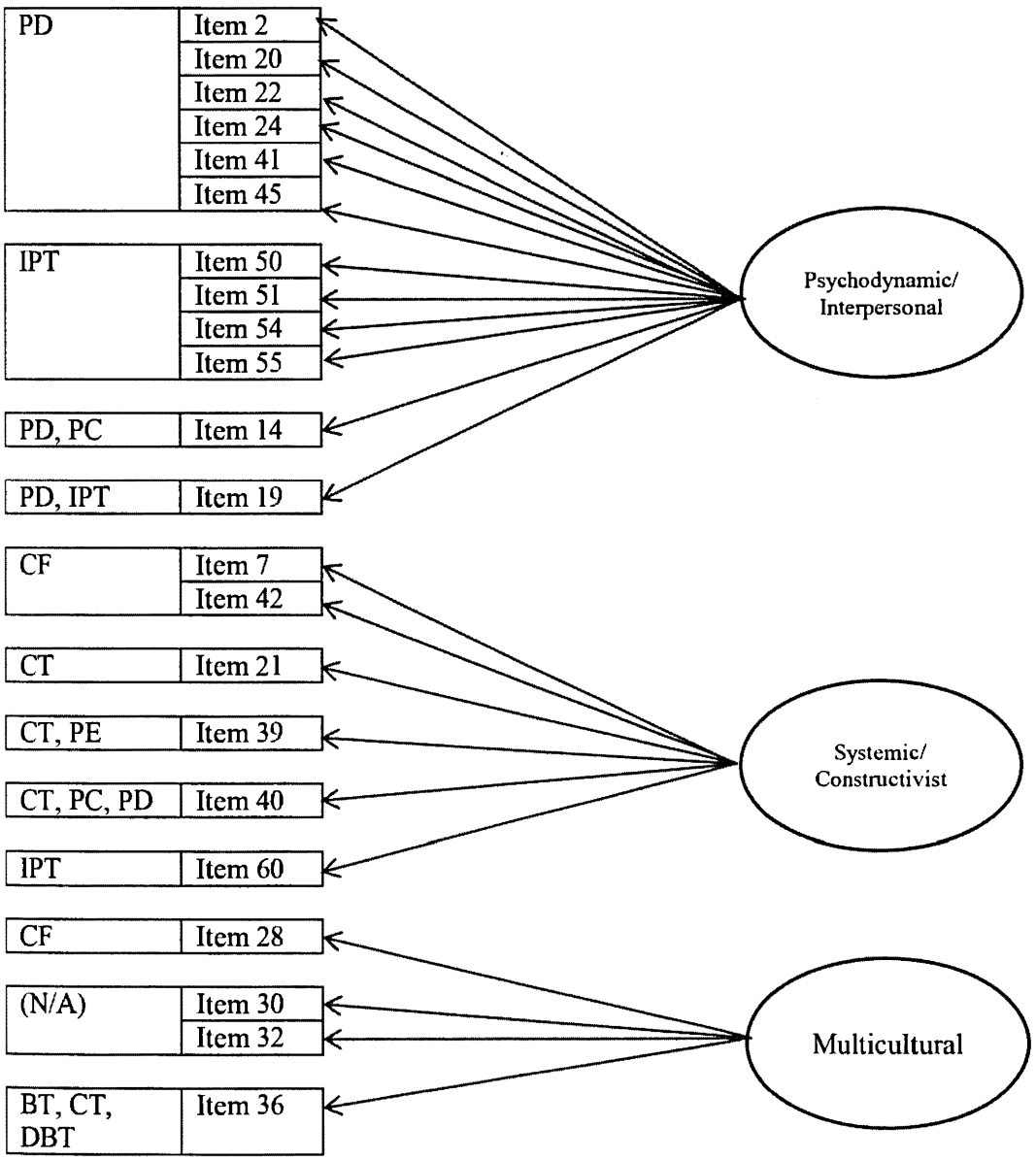

Figure 3 (continued). Conceptual model of the fit between Multitheoretical Psychotherapy (MTP) and the items on the Multitheoretical List of Therapeutic Interventions (MULTI). (Note: BT = Behavioral Therapy, CT = Cognitive Therapy, DBT = Dialectical Behavioral Therapy, PE = Process-Experiential Therapy, CF = Common Factors, IPT = Interpersonal Therapy, PD = Psychodynamic Therapy, PC = Person-Centered Therapy.)

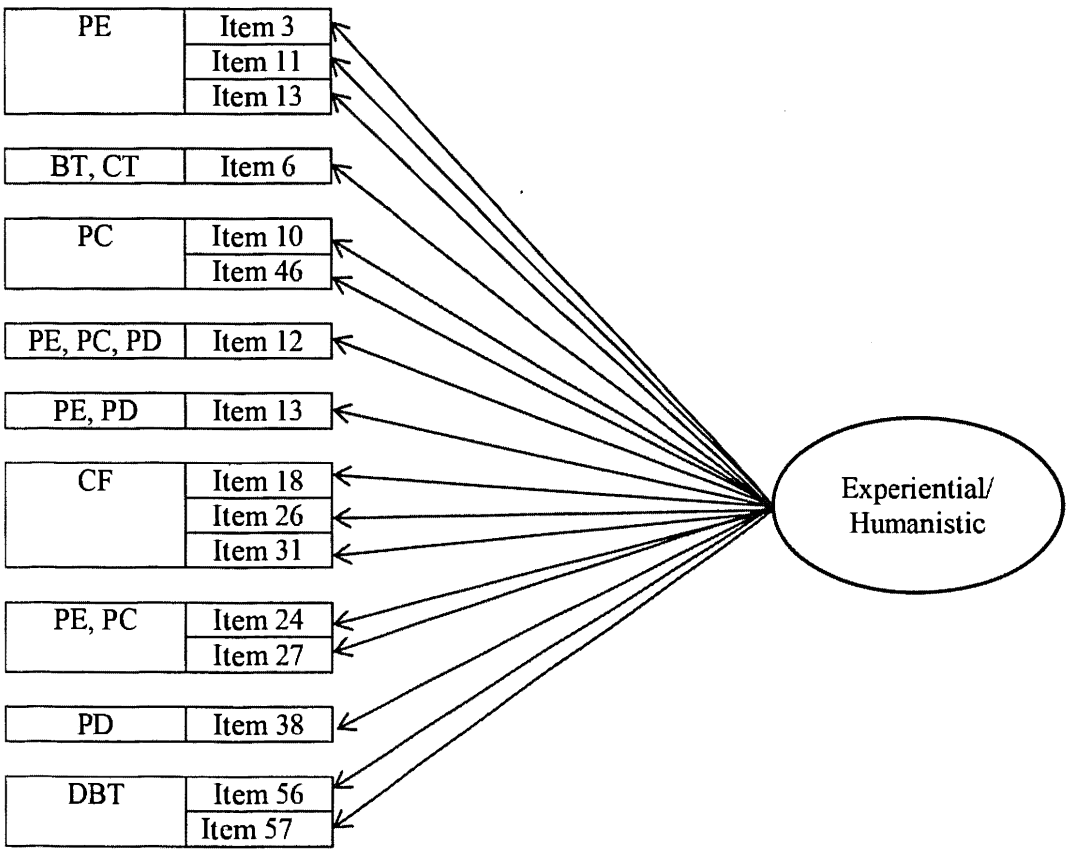

Figure 3 (continued). Conceptual model of the fit between Multitheoretical Psychotherapy (MTP) and the items on the Multitheoretical List of Therapeutic Interventions (MULTI). (Note: BT = Behavioral Therapy, CT = Cognitive Therapy, DBT = Dialectical Behavioral Therapy, PE = Process-Experiential Therapy, CF = Common Factors, IPT = Interpersonal Therapy, PD = Psychodynamic Therapy, PC = Person-Centered Therapy.)

Table 5 includes standardized and unstandardized fit indices for all paths in the analyzed model, of which all were significant at $p < .001$, with the exception of two, Items 6 ($p < .01$) and 30 ($p < .05$). Also reported in Table 5 are the standard error values for the MULTI items, indicating the absence of estimation problems.

Table 5

Unstandardized, Standardized, and Error Estimates with Significance Levels for Measurement Model

Parameter Estimate	Unstandardized	Standardized	*P*
Measurement Model Estimates			
Item 1	.62	.49	.001
Item 5	.64	.62	.001
Item 9	.97	.77	.001
Item 15	.69	.65	.001
Item 16	.43	.38	.001
Item 17	.87	.66	.001
Item 25	.59	.64	.001
Item 27	.64	.68	.001
Item 35	.89	.74	.001
Item 44	.47	.42	.001
Item 3	.64	.55	.001
Item 6	.16	.19	.01
Item 10	.43	.47	.001
Item 11	.52	.53	.001
Item 12	.52	.55	.001
Item 13	.56	.56	.001
Item 18	.21	.25	.001
Item 23	.49	.53	.001
Item 26	.31	.35	.001
Item 31	.20	.39	.001
Item 35	.57	.48	.001
Item 38	.52	.47	.001
Item 46	.29	.40	.001
Item 47	.29	.49	.001

(continued)

Table 5 cont'd

Parameter Estimate	Unstandardized	Standardized	*P*
Item 56	.37	.41	.001
Item 57	.71	.65	.001
Item 2	.49	.47	.001
Item14	.51	.41	.001
Item 19	.58	.68	.001
Item 20	.52	.54	.001
Item 22	.50	.42	.001
Item 24	.61	.50	.001
Item 41	.54	.48	.001
Item 45	.80	.72	.001
Item 50	.64	.68	.001
Item 51	.69	.70	.001
Item 54	.64	.69	.001
Item 55	.55	.57	.001
Item 7	.33	.80	.001
Item 21	.65	.60	.001
Item 39	.48	.50	.001
Item 40	.61	.57	.001
Item 42	.30	.37	.001
Item 60	.44	.43	.001
Item 8	.66	.60	.001
Item 33	.23	.25	.001
Item 52	.51	.54	.001
Item 53	.48	.53	.001
Item 59	.41	.35	.001
Item 28	.27	.38	.001
Item 30	.10	.10	.05

(continued)

Table 5 cont'd

Parameter Estimate	Unstandardized	Standardized	*P*
Item 32	.55	.56	.001
Item 36	.50	.55	.001
Item 4	.39	.34	.001
Item 29	.42	.35	.001
Item 37	.92	.81	.001
Item 43	.87	.73	.001
Item 48	.80	.71	.001
Item 49	.86	.76	.001
Item 58	.34	.32	.001
Error Estimates			
Error in 1	1.20	.76	.001
Error in 5	.65	.61	.001
Error in 9	.67	.41	.001
Error in 15	.66	.58	.001
Error in 16	1.12	.86	.001
Error in 17	.96	.56	.001
Error in 25	.50	.59	.001
Error in 27	.48	.54	.001
Error in 35	.66	.45	.001
Error in 44	1.02	.82	.001
Error in 3	.96	.70	.001
Error in 6	.71	.96	.001
Error in 10	.65	.78	.001
Error in 11	.70	.72	.001
Error in 12	.54	.67	.001
Error in 13	.70	.69	.001
Error in 18	.32	.88	.001

(continued)

Table 5 cont'd

Parameter Estimate	Unstandardized	Standardized	*P*
Error in 23	.61	.71	.001
Error in 26	.71	.88	.001
Error in 31	.23	.65	.001
Error in 34	1.07	.77	.001
Error in 38	.95	.78	.001
Error in 46	.44	.84	.001
Error in 47	.89	.76	.001
Error in 56	.69	.83	.001
Error in 57	.69	.55	.001
Error in 2	.86	.78	.001
Error in 14	1.26	.63	.001
Error in 19	.39	.54	.001
Error in 20	.66	.71	.001
Error in 22	1.18	.82	.001
Error in 24	1.12	.75	.001
Error in 41	1.11	.79	.001
Error in 45	.59	.46	.001
Error in 50	.56	.58	.001
Error in 51	.49	.51	.001
Error in 54	.45	.53	.001
Error in 55	.61	.67	.001
Error in 7	.33	.75	.001
Error in 21	.65	.61	.001
Error in 39	.67	.74	.001
Error in 40	.81	.68	.001
Error in 42	.58	.87	.001
Error in 60	.86	.62	.001

(continued)

Table 5 cont'd

Parameter Estimate	Unstandardized	Standardized	*P*
Error in 8	.79	.64	.001
Error in 33	.81	.94	.001
Error in 52	.63	.71	.001
Error in 53	.59	.72	.001
Error in 59	1.21	.88	.001
Error in 28	.41	.85	.001
Error in 30	1.03	.99	.001
Error in 32	.66	.69	.001
Error in 36	.58	.70	.001
Error in 4	1.15	.88	.001
Error in 29	1.22	.88	.001
Error in 37	.43	.34	.001
Error in 43	.67	.47	.001
Error in 48	.62	.49	.001
Error in 49	.54	.42	.001
Error in 58	1.04	.90	.001

(N = 179)

Internal consistency estimates of the resulting factors ranged from $\alpha = .44$ on the Multicultural factor to $\alpha = .85$ on the Behavioral factor (see Table 6 for a complete list of all internal reliability coefficients). According to Shrout (1995), $\alpha > .70$ indicates moderate internal consistency and $\alpha > .90$ indicates excellent internal consistency. All factors yielded moderate to excellent internal consistency except for: (a) Systemic-Constructivist ($\alpha = .66$), (b) Biopsychosocial ($\alpha = .54$), and (c) Multicultural ($\alpha = .44$). The low alpha values for these factors may be due to the low number of items in these subscales.

Table 6

Internal Consistency Estimates and Number of Subscale Items for Measurement Model

MTP Factor	MULTI Items	α
1 Behavioral	10	.85
2 Experiential-Humanistic	16	.81
3 Psychodynamic-Interpersonal	12	.84
4 Systemic-Constructivist	6	.66
5 Biopsychosocial	5	.54
6 Multicultural	4	.44
7 Cognitive	7	.77

Note: MTP = Multitheoretical Psychotherapy; MULTI = Multitheoretical List of Therapeutic Interventions.

CHAPTER V

DISCUSSION

Summary of Results

As this researcher initially hypothesized, therapists espousing different theoretical orientations have a different repertoire of therapeutic interventions. Specifically, it was found that the best predictors for distinguishing behavioral or cognitive-behavioral therapists among therapists of other orientations were high scores on the Cognitive, Behavioral, and Dialectical Behavioral Therapy (DBT) scales of the MULTI (McCarthy & Barber, 2009). Inversely, low scores on the Person Centered and Psychodynamic scales were also good predictors for distinguishing between cognitive and cognitive-behavioral therapists among others. This suggests that five of the eight subscales of the MULTI were good at describing what the cognitive and cognitive-behavioral therapists in this study said they do (and don't do) in therapeutic practice.

This researcher also expected there to be a significant difference in the techniques used by integrative and pure-form therapists, which was not the case. This suggests that participants' scores on the MULTI subscales did not predict whether or not they identified themselves as integrative/eclectic in theoretical orientation. However, it is notable that 80% of the respondents said they were either integrative or eclectic in practice, which may provide at least a partial explanation for the lack of differences

between these two groups. For example, perhaps even pure-form therapists, who may conceptualize cases from one theoretical frame of reference, use a wide range of techniques in actual practice.

This researcher's exploratory hypothesis regarding Brooks-Harris' (2008) model of integrative psychotherapy, MTP, was also supported. Using established test items from an instrument with good psychometric properties to test the seven-factor structural model of MTP resulted in an adequate fit according to four fit indices. This suggests that the current measurement model of MTP is an adequate way to organize integrative therapeutic techniques.

Integration with Prior Literature and Implications for Theory

The significant differences in therapeutic practice found among therapists of different theoretical orientations is not surprising, given the existence of previous research that suggests so (i.e., Fey, 1958; Larson, 1980; Wogan & Norcross, 1985; Thoma & Cecero, 2009). There is plentiful research supporting significant differences in attitudes about therapeutic practice, based on identified theoretical orientation (Coan, 1979; Garfield & Kurtz, 1976; Sundland & Barker, 1962; Vasco & Dryden, 1997; Wallach & Strupp, 1964).

The results of this study bear some specific similarity to the findings of Garfield and Kurtz (1976), who also performed a discriminant analysis of their data. They reported a significant difference between psychoanalysts and learning theorists,

who scored at opposite ends of the spectrum across all three of the scales on their measure, the Ideology Scale (IS). Garfield and Kurtz' results complement this researcher's finding that scores on the behavioral and psychodynamic scales of the MULTI (McCarthy & Barber, 2009) were good at distinguishing cognitive and cognitive-behavioral therapists. It should be noted that such a parallel between the two studies assumes that substantial similarities exist between the learning theorists and the behaviorists, as well as between the psychoanalysts and the psychodynamic therapists in the two studies.

The fact that 80% of the therapists who responded to this study identify as being either integrative or eclectic in practice is also an important finding. First, it may help account for the lack of a significant difference found in the techniques used by integrative and pure-form therapists in this study. Second, the literature has clearly demonstrated a trend toward integration in the practice of psychotherapy (e.g., Glass, Victor, & Arnkoff, 1993; Hollanders & McLeod, 1999; Norcross, Hedges, & Castle, 2002; Norcross, Karpiak, & Santoro, 2005; Watkins & Watts, 1995), and such a result supports this trend. However, it should be noted that the reason the percentage of integrative therapists was so high is likely due to the fact that the therapists in this study were not given integrative/eclectic as a choice to select when choosing a primary theoretical orientation. Instead, they were asked to specify whether or not they considered themselves to be integrative or eclectic in addition to selecting a primary theoretical orientation.

Previous research shows that one- to two-thirds of therapists have identified themselves as being integrative or eclectic. (Glass, Victor, & Arnkoff, 1993; Hollanders & McLeod, 1999; Norcross, Hedges, & Castle, 2002; Norcross, Karpiak, & Santoro, 2005; Watkins & Watts, 1995). In a recent survey of 2,739 therapists from different professional disciplines, such as social work and marriage and family therapy, Cook, Biyanova, Elhai, Schnurr, and Coyne (2010) found that only two percent of the respondents identified themselves as being only one theoretical orientation. The rest endorsed either an eclectic orientation or specified the exact percentages that each orientation informed their practice. (A specific percentage of eclectic-only therapists could not be obtained by contacting Cook et al.)

Cook, Biyanova, Elhai, Schnurr, and Coyne (2010) also found that cognitive behavioral therapy (CBT) was the most popular approach endorsed by the participants in their sample, as it constituted the largest percentage of the theoretical approaches combined. Similarly, of those participants in the current study who did endorse a specific model of therapy, CBT had the highest percentage (36%). It is interesting that a significant difference based on theoretical orientation found in this study also pertained to cognitive-behavioral therapists. These findings might possibly suggest that of all the theoretical approaches to therapy, a cognitive-behavioral approach may be among the most solidly understood, practiced, or preferred modes of therapeutic treatment.

The confirmatory factor analysis (CFA) performed for this study yielded higher fit indices on Brook-Harris' (2008) seven-factor model of multitheoretical psychotherapy than did McCarthy and Barber's (2009) eight-factor model of integrative psychotherapy. This finding suggests that Brooks-Harris' model may be a more parsimonious way to describe integrative therapy than McCarthy and Barber's (2009) model. However, it is important to note that McCarthy and Barber's sample ($N = 280$) was larger than the sample used in this study, which may have increased the statistical power of their study.

There appears to be a waning loyalty to the specific therapeutic interventions associated with the theoretical orientation with which a pure-form therapist identifies. Moreover, an increasing number of therapists are not identifying themselves as pure-form in theoretical orientation anymore, opting instead for the label of integrative or eclectic (Gold & Stricker, 2006). Yet cognitive, behavioral, and DBT approaches were found to be good positive predictors of those who did consider themselves to be behavioral or cognitive-behavioral in theoretical orientation. Furthermore, person-centered and psychodynamic techniques were also good inverse predictors of cognitive, behavioral, and cognitive-behavioral therapists. These findings may reflect that the largest proportion of respondents in this study, when asked to choose an orientation, picked cognitive-behavioral (36%), which is arguably already an integrated approach. In a related vein, the largest group of participants in this study were those in Clinical Psychology, a

specialty that may have particularly strong historical allegiance to CBT as a training model (APA Division 12, 2011).

Implications for Practice and Training

In a profession which can be very isolating depending on practice setting, it is of perhaps some value for therapists to know that the practice of integrating therapeutic techniques is becoming an increasingly shared phenomenon among their peers. In addition, based on this preliminary analysis of Brooks-Harris' (2008) approach to integrative psychotherapy, it appears that MTP is a viable framework therapists can use to help guide them in their practice of integrating techniques. In addition, the MSRQ (Roblyer & Harris, 2011) is a promising tool designed to describe what therapists actually do in practice.

These trends and observations have a potential impact on the training of psychotherapy theory in the future. Natural questions emerge, such as: How often is training geared toward a purist approach in which professors teach theories in isolation from one another and then ask students to "pick one or two"? Is this a beneficial approach? Clearly the traditional theoretical constructs of cognitive, behavioral, person-centered and psychodynamic approaches appear to endure, which suggests that taking a purist approach may still be warranted. However, viable and current questions are being posed regarding the evolution of training in counseling theories (and how such training might evolve) as more and more practitioners are becoming integrative.

Implications for Future Research

Multitheoretical psychotherapy as proposed by Brooks-Harris (2008) appears to be a viable framework for understanding and implementing integrative psychotherapy; therefore, further research that explores the psychometric properties the Multitheoretical Strategies Rating Questionnaire (MSRQ; Roblyer & Harris, 2011) is warranted. Because the initial measurement model of MTP is a good fit, a reasonable next step would be to review the fitted and standardized residual indices of the CFA data in this study, make modifications to the model accordingly, and conduct another CFA to see whether or not goodness-of -fit is improved. Other modifications to the model might be to incorporate variables that account for the integration of spirituality and more specialized therapeutic techniques, such as hypnotherapy, into the model.

In the future, it is recommended that validity studies of the MSRQ (Roblyer & Harris, 2011) using a sufficient sample size be conducted. Should the MSRQ prove to be valid measure of integrative therapy, it would be an important tool to use in conjunction with other measures that assess therapists' attitudes and decision-making processes so that a more complex understanding of what it means to be an integrative therapist can be reached. In addition, outcome studies using the MSRQ would help further our understanding of the efficacy of integrative psychotherapy, which is especially important given that evidence-based practice is such a prevalent force in psychotherapy (Thomason,

2010). Lastly, client and independent rater forms of the MSRQ are needed in order to help reduce potential bias when the MSRQ is used for research purposes (Hoyt, 2002).

Limitations

A limitation of this study was the insufficient sample size needed in order to investigate the psychometric properties of the MSRQ (Roblyer & Harris, 2011). The sample size also limited the statistical analysis between theoretical orientations. An unequal number of participants reported being either Behavioral/Cognitive-Behavioral or Psychodynamic/Psychoanalytic/Interpersonal, thus limiting the ability to better discriminate among the other theoretical orientations (i.e., Biopsychosocial, Constructivist/Narrative, Existential/Humanistic, Feminist/Multicultural, and Systemic).

Another limitation of this study is that its generalizability is unknown, due to the lack of data on nationally representative samples of psychotherapists (Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010). Furthermore, although the sample consists of therapists from a variety of disciplines, some fields like psychiatry and school counseling are markedly underrepresented.

The MSRQ (Roblyer & Harris, 2011) as an assessment tool also has its limitations. In addition to lacking psychometric validation, it does not indicate the effectiveness of the therapeutic interventions it is designed to assess (Prochaska & Norcross, 1983). And although the MSRQ gives a glimpse into what happens in therapy, it does not assess the attitudes of pure-form and integrative therapists. Furthermore, while

the MSRQ contains items that describe techniques common to the practice of general psychotherapy, it does not assess the practice of more specialized forms of therapy, such as hypnotherapy and neurobiofeedback. The measure also does not include strategies describing the integration of spirituality into the practice of therapy.

Conclusion

The results of this study found that a significant difference existed between therapists of different theoretical orientations. Cognitive, behavioral, and DBT techniques were good positive predictors of behavioral and cognitive-behavioral therapists. In addition, person-centered and psychodynamic techniques were good inverse predictors of those who identified themselves as being behavioral or cognitive-behavioral in theoretical orientation. However, 80% of the participants identified themselves as being either integrative or eclectic. So while the practice of integrative therapy is clearly flourishing, pure-form theoretical orientations as we currently understand them are not necessarily a thing of the past.

A promising new model of multitheoretical psychotherapy (MTP; Brooks-Harris, 2008) has gained some initial support from this study. Therefore, the measure designed as a result of this model (the MSRQ; Roblyer & Harris, 2011) provides a new direction for future studies. MTP incorporates seven major theories of practice (cognitive, behavioral, humanistic-experiential, biopsychosocial, psychodynamic-interpersonal, systemic-constructivist, and multicultural) into its model, and the MSRQ contains 98 key strategies

that reflect how each theory is practiced. Using a valid and reliable version of the MSRQ in conjunction with other measures will help contribute to a greater understanding of what integrative psychotherapy is and how it is practiced. In addition, use of the MSRQ in outcome studies may eventually help integrative therapy earn a place on the list of empirically supported treatments for common disorders such as depression and anxiety.

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APPENDIX A

Demographic Questionnaire

Demographic Questionnaire

INSTRUCTIONS: Please answer the following questions to the best of your ability.

1. Age: _____

2. Zip/postal code of your primary residence: _____

3. Sexual Orientation(select one):

☐Bisexual
☐Gay
☐Heterosexual
☐Lesbian

4. Ethnicity(select one):

☐American Indian/Alaskan Native
☐Black/African American
☐East Asian/ Asian American
☐Latino/Hispanic
☐Middle Eastern/West Asian
☐Native Hawaiian/Pacific Islander
☐South Asian/Asian Indian
☐White/Caucasian
☐Biracial/Multiracial/Multiethnic

5. Gender (select one):

☐ I am a man
☐ I am a woman
☐ I am trans

6. Sex (check one):

☐ I am female
☐ I am male
☐ I am intersex

7. Are you currently a full -or part-time graduate student? ☐ Yes ☐ No

8. Are you currently providing or have you ever provided mental health services (e.g., individual psychotherapy, group therapy, couples counseling) under your own license or under the supervision of a licensed professional?
☐ Yes ☐ No

9. State in which you or your supervisor is licensed: (On the internet survey, a dropdown menu will list the 50 states of the U.S. as well as the choices "Other U.S. Province," "Canada," "International," and "Don't Know" as choices for participants to choose from.)

10. Date in which you or your supervisor was licensed (write "DK" if you don't know):

    Month:_____ Year:_____

11. What is the total amount of time you have spent providing mental health services under your own license or under the supervision of another?

    Number of Years:_____ Number of Months:_____

12. Highest degree completed that allows you to engage in mental health services (select one):

    ☐Ed.D.
    ☐Ed.S. (or any specialist's degree)
    ☐M.A. or M.S.
    ☐M.D. or D.O..
    ☐Ph.D.
    ☐Psy.D.
    ☐None (I am a student)
    ☐Other (Please specify)_____

13. In what field is the degree you have obtained or are currently pursuing? (select one):

    ☐Clinical Psychology
    ☐Counseling or Counseling Education
    ☐Counseling Psychology
    ☐Marriage and Family Therapy
    ☐School Counseling
    ☐School Psychology
    ☐Social Work
    ☐Psychiatry
    ☐Other (Please specify)_____

14. How many graduate classes have you had that were expressly focused on counseling theories?____

15. Was your training program offered primarily online or via distance education?

    ☐ Yes ☐ No

16. The following four items ask about the amount of time you have spent providing mental health services during the past three, six, nine, and 12 months.

    a. During the past three months, how many hours of direct mental health services (e.g., individual psychotherapy, couples counseling, group therapy) do you estimate you have provided?____

    b. During the past six months, how many hours of direct mental health services (e.g., individual psychotherapy, couples counseling, group therapy) do you estimate you have provided?____

    c. During the past nine months, how many hours of direct mental health services (e.g., individual psychotherapy, couples counseling, group therapy) do you estimate you have provided?____

    d. During the past 12 months, how many hours of direct mental health services (e.g., individual psychotherapy, couples counseling, group therapy) do you estimate you have provided?____

17. The following four items ask about the number of clients you have worked with during the past three, six, nine, and 12 months.

    a. During the past three months, how many separate clients (including individuals, couples, families, and group members) do you estimate you have worked with?____

    b. During the past six months, how many separate clients (including individuals, couples, families, and group members) do you estimate you have worked with?____

c. During the past nine months, how many separate clients (including individuals, couples, families, and group members) do you estimate you have worked with?____

d. During the 12 months, how many separate clients (including individuals, couples, families, and group members) do you estimate you have worked with?____

18. In the following four columns, select the population you have spent the most time working with during the last three, six, nine, and 12 months.

3 Months
6 Months
9 Months
12 Months

The choices for each are as follows:

☐Children (Age 2-6)
☐Children (Age 9-13)
☐Adolescents (Age 14-18)
☐Young Adults (Age 19-25)
☐Adults (Age 26-40)
☐Adults (Age 41-65)
☐Adults (Age 66-90)
☐Adults (Age 91+)
☐None

19. In the following four columns, select the subpopulation you have spent the most time working with during the last three, six, nine, and 12 months.

3 Months
6 Months
9 Months
12 Months

The choices for each are as follows:

☐LGBT
☐Ethnic Minorities

☐Veterans
☐College/University Students
☐International Students
☐Students (K-12)
☐Spanish Speaking
☐Disabled/Rehabilitation
☐Deaf/Hearing Impaired
☐Low Income
☐Homeless
☐Athletes
☐Urban
☐Rural
☐None
☐Other (Please specify):_____

20. In the following four columns, select the primary modality you have used during the last three, six, nine, and 12 months.

3 Months
6 Months
9 Months
12 Months

The choices for each are as follows:

☐Individual Counseling
☐Couples Counseling
☐Family Therapy
☐Group Therapy
☐Consultation/Liaison
☐Community Intervention
☐Crisis Intervention
☐Cognitive Rehabilitation
☐Training
☐Teaching
☐Administration
☐None

21. In the following four columns, select your primary area of focus or specialization during the past three, six, nine, and 12 months.

3 Months
6 Months
9 Months
12 Months

The choices for each are as follows:

☐Health Psychology
☐Primary Care
☐Women's Health
☐Eating disorders
☐Sexual Disorders
☐Sports Psychology
☐Rehabilitation Psychology
☐Physical Disabilities
☐Learning Disabilities
☐Developmental Disabilities
☐Assessment
☐Neuropsychology
☐Serious mental illness
☐Trauma/PTSD
☐Sexual abuse
☐Substance use disorders
☐Forensics/Corrections
☐Sexual offenders
☐Geropsychology
☐Pediatrics
☐Vocational/Career Development
☐Multicultural Therapy
☐Feminist Therapy
☐Religion/Spirituality
☐Empirically-supported treatments
☐Public Policy/Advocacy
☐Program Development/Evaluation
☐Supervision
☐Research
☐Administration
☐Training/Teaching
☐None/N/A

☐Other (Please specify):_____

22. In the following four columns, select what setting have you spent the most time working in during the past three, six, nine, and 12 months.

    3 Months
    6 Months
    9 Months
    12 Months

    The choices for each are as follows:
    ☐Addiction Treatment/Recovery Facility
    ☐Armed Forces Medical Center
    ☐Career/Vocational Center
    ☐Children's/Pediatric Hospital or Clinic
    ☐Community Mental Health Facility
    ☐Consortium
    ☐Hospital or Medical Center (non-VA; non-psychiatric)
    ☐Forensic/Justice/Correctional
    ☐Industrial/Organizational
    ☐Inpatient Psychiatric Hospital
    ☐Outpatient Psychiatric Clinic/Hospital
    ☐Private or Independent Practice
    ☐School (K-12)
    ☐University or College Counseling Center
    ☐VA Hospital or Clinic
    ☐None

23. Please consider your current (or most recent) position (e.g., professor, administrator, clinician/practitioner, intern/practicum student, researcher) when responding to the following item:

    _____ is the % of time I estimate I spend providing mental health services directly to clients.

24. For the following two items, please select your primary and, if appropriate, secondary theoretical orientation(s). Also, please indicate the percentage of time you estimate you use your theoretical orientation(s) when providing mental health services:

a._____is my primary theoretical orientation (select one):

☐Behavioral
☐Biopsychosocial
☐Cognitive-Behavioral
☐Constructivist/Narrative
☐Existential/Humanistic
☐Feminist/Multicultural
☐Interpersonal
☐Psychodynamic/Psychoanalytic
☐Systemic

_____% of time I use my primary theoretical orientation in practice.

b._____ is my secondary theoretical orientation (select one):

☐Behavioral
☐Biopsychosocial
☐Cognitive-Behavioral
☐Constructivist/Narrative
☐Existential/Humanistic
☐Feminist/Multicultural
☐Interpersonal
☐Psychodynamic/Psychoanalytic
☐Systemic

_____% of time I use my secondary theoretical orientation in practice.

25. Do you consider yourself to be an integrative or eclectic therapist? ☐ Yes ☐ No

APPENDIX B

Multitheoretical List of Therapeutic Interventions (MULTI)

Multitheoretical List of Therapeutic Interventions (MULTI; McCarthy & Barber, 2009)

Instructions: The following items represent actions that you may or may not typically use with clients. Please rate each item using the scale provided. There are no right or wrong answers.

1	2	3	4	5
Not at All Typical of Sessions	**Slightly Typical of Sessions**	**Somewhat Typical of Sessions**	**Typical of Sessions**	**Very Typical of Sessions**

1.	I set an agenda or establish specific goals for therapy sessions.	1	2	3	4	5
2.	I make connections between my client's current situation and his/her past.	1	2	3	4	5
3.	I focus on identifying parts of my clients' personality that are in conflict, like: one part that wants to be close to others and another part that does not.	1	2	3	4	5
4.	I ask my clients to visualize specific scenes or situations in detail.	1	2	3	4	5
5.	I encourage my clients to identify specific situations or events that tended to precede their problematic behavior.	1	2	3	4	5
6.	I often focus on my clients' recent experiences.	1	2	3	4	5
7.	I work to give my clients hope or encouragement.	1	2	3	4	5
8.	I convey my belief in the effectiveness of the methods I am using to help my clients.	1	2	3	4	5
9.	My clients and I discuss a plan for them to try to control (increase or decrease) specific behaviors, like: smoking; eating; exercising; checking something repeatedly; saying or thinking certain things; hurting him/herself.	1	2	3	4	5
10.	I repeat back to my clients (paraphrased) the meaning of what they say.	1	2	3	4	5
11.	I encourage my clients to identify or label feelings that they have in or outside of the session.	1	2	3	4	5
12.	I encourage my clients to talk about feelings they have previously avoided or never expressed.	1	2	3	4	5
13.	I point out times when my clients' behavior seems inconsistent with what they were saying, like when they: suddenly shift their moods or topics; were silent a long time; laugh, smile, look away, or are uncomfortable; avoid talking about specific topics or people.	1	2	3	4	5

1	2	3	4	5
Not at All Typical of Sessions	**Slightly Typical of Sessions**	**Somewhat Typical of Sessions**	**Typical of Sessions**	**Very Typical of Sessions**

14.	I encourage my clients to talk about whatever comes to their mind.	1	2	3	4	5
15.	I teach my clients specific new skills or behaviors, like how to: relax their muscles; control their emotions; be assertive with others; act in social situations.	1	2	3	4	5
16.	I encourage my clients to think about, view, or touch things that they are afraid of.	1	2	3	4	5
17.	I review or assign homework exercises, like: writing down certain thoughts or feelings outside the session; practicing certain behaviors.	1	2	3	4	5
18.	I am warm, sympathetic, and accepting.	1	2	3	4	5
19.	I point out recurring themes or problems in my clients' relationships.	1	2	3	4	5
20.	I talk about the function or purpose that my clients' problem might have, like how it: lets them avoid responsibility; keeps others away from them.	1	2	3	4	5
21.	I encourage my clients to explore explanations for events or behaviors other than those that first came to their mind.	1	2	3	4	5
22.	I make connections between the way my clients act or feel toward me and the way that they act or feel in their other relationships.	1	2	3	4	5
23.	I encourage my clients to see the choices they have in their lives.	1	2	3	4	5
24.	My clients and I discuss their dreams, fantasies, or wishes.	1	2	3	4	5
25.	I encourage my clients to consider the positive and negative consequences of acting in a new way.	1	2	3	4	5
26.	I make sessions a place where my client could get better or solve their problems.	1	2	3	4	5
27.	I try to help my clients identify the consequences (positive or negative) of their behavior.	1	2	3	4	5
28.	My clients and I worked together as a team.	1	2	3	4	5
29.	I give my clients advice or suggest practical solutions for their problems.	1	2	3	4	5
30.	I share personal information with my clients.	1	2	3	4	5
31.	I listen carefully to what my clients are saying.	1	2	3	4	5
32.	I often explain what I am trying to do.	1	2	3	4	5

1	2	3	4	5
Not at All Typical of Sessions	**Slightly Typical of Sessions**	**Somewhat Typical of Sessions**	**Typical of Sessions**	**Very Typical of Sessions**

33.	I led the discussion most of the time.	1	2	3	4	5
34.	I focus on how disagreements between certain parts of my clients' personality have caused my clients' problems.	1	2	3	4	5
35.	I encourage my clients to change specific behaviors.	1	2	3	4	5
36.	I focus on the ways my clients cope with their problems.	1	2	3	4	5
37.	I encourage my clients to look for evidence in support of or against one of their beliefs or assumptions.	1	2	3	4	5
38.	I explore my clients' feelings about therapy.	1	2	3	4	5
39.	I encourage my clients to view their problems from a different perspective.	1	2	3	4	5
40.	I encourage my clients to explore the personal meaning of an event or a feeling.	1	2	3	4	5
41.	I often focus on my clients' childhood experiences.	1	2	3	4	5
42.	I focus on improving my clients' ability to solve their own problems.	1	2	3	4	5
43.	I encourage my clients to list the advantages and disadvantages of a belief or general rule that they follow.	1	2	3	4	5
44.	I have my client role-play (act out or rehearse) certain scenes or situations.	1	2	3	4	5
45.	I try to help my clients better understand how they relate to others, how this style of relating developed, and how it causes their problems.	1	2	3	4	5
46.	I convey my interest in trying to understand what my clients are experiencing.	1	2	3	4	5
47.	I encourage my clients to focus on their moment-to-moment experience.	1	2	3	4	5
48.	I try to help my clients better understand how their problems are due to certain beliefs or rules that they follow.	1	2	3	4	5
49.	I encourage my clients to question their beliefs or to discover flaws in their reasoning.	1	2	3	4	5
50.	I focus on a specific concern in my clients' relationships, like: disagreements or conflicts; major changes; loss of a loved one; loneliness.	1	2	3	4	5

1	2	3	4	5
Not at All Typical of Sessions	**Slightly Typical of Sessions**	**Somewhat Typical of Sessions**	**Typical of Sessions**	**Very Typical of Sessions**

51.	I encourage my clients to explore ways in which they could make changes in their relationships, like ways to: resolve a conflict in a relationship; fulfill a need; establish new relationships or to contact old friends; avoid problems they have experienced in previous relationships.	1	2	3	4	5
52.	I review the gains my clients have made while in therapy.	1	2	3	4	5
53.	I review the difficulties that my clients are currently experiencing.	1	2	3	4	5
54.	I encourage my clients to examine their relationships with others, like: positive and negative aspects of their relationships; what they want and others want from them; the way they act in relationships.	1	2	3	4	5
55.	I encourage my clients to think about ways in which they might prepare for major upcoming changes in their relationships, like: learning new skills; finding new friends.	1	2	3	4	5
56.	I both accept my clients for who they are and encourage them to change.	1	2	3	4	5
57.	I encourage my clients to identify situations in which their feelings were invalidated; times when a significant other told my clients their feelings were incorrect; situations in which my clients had strong feelings that seemed inappropriate.	1	2	3	4	5
58.	I encourage my clients to think about or be aware of things in their life without judging them.	1	2	3	4	5
59.	I make it clear that my clients' problem was a treatable medical condition.	1	2	3	4	5
60.	I try to help my clients better understand how their problems were due to difficulties in their social relationships.	1	2	3	4	5

(Used with permission from McCarthy & Barber)

APPENDIX C

Multitheoretical Strategies Rating Questionnaire (MSRQ)

Multitheoretical Strategies Rating Questionnaire (MSRQ; Roblyer & Harris, 2011)

Instructions: For each of the following items, please indicate how frequently you use this strategy with clients in counseling or psychotherapy.

<u>Cognitive Psychotherapy Strategies</u>

1. Identifying Thoughts. Identifying automatic thoughts, self-talk, and cognitive patterns.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

2. Clarifying the Impact of Thoughts. Clarifying the impact of thoughts on feelings, actions, and interpersonal relationships.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

3. Challenging Irrational Thoughts. Challenging or disputing irrational thoughts or inaccurate beliefs.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

4. Illuminating Core Beliefs. Illuminating core beliefs or schemas by exploring the meaning of thoughts and patterns.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

5. Evaluating Evidence. Evaluating evidence that may support or challenge clients' cognitions.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

6. Testing Hypotheses. Forming and testing hypotheses about clients' beliefs and perceptions.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

7. Modifying Beliefs. Modifying specific beliefs to be more accurate and adaptive.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

8. Reinforcing Adaptive Cognitions. Reinforcing adaptive cognitions and extinguishing dysfunctional ones.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

9. Encouraging Accurate Perceptions. Encouraging accurate perceptions of realistic constraints impacting clients' lives.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

10. Supporting Dialectical Thinking. Supporting dialectical thinking and helping clients move toward synthesis rather than focusing on only one mode of thought.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

11. Fostering Mindful Awareness. Fostering mindful observation and awareness to help clients live in the present rather than making judgments.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

12. Working with Imagery. Working with imagery, metaphors, or stories to reduce negative images and encourage clients to visualize adaptive images and embrace positive metaphors.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

13. Brainstorming Solutions. Brainstorming alternative solutions as part of active problem solving.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

14. Providing Psychoeducation. Providing psychoeducation by sharing information from theory and research to aid therapeutic change.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

15. Supporting Bibliotherapy. Supporting bibliotherapy by recommending relevant books or articles that support therapeutic learning.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

Behavioral Psychotherapy Strategies

1. Clarifying the Impact of Actions. Clarifying the impact of actions on thoughts, feelings, and interpersonal relationships.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

2. Illuminating Reinforcement and Conditioning. Illuminating how current behavioral patterns have been shaped by environmental reinforcements and conditioned responses.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

3. Identifying Target Actions. Identifying specific target actions that a client wants to increase or decrease.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

4. Determining Baselines. Determining the frequency and duration of specific behaviors in order to establish baselines and gauge progress.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

5. Encouraging Active Choices. Encouraging clients to make active choices based on a realistic assessment of the likely consequences of their actions.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

6. Assessing Stages of Change. Assessing stages of change and preparing clients to move steadily toward action.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

7. Establishing Schedules of Reinforcement. Establishing schedules of reinforcement and punishment in order to increase or decrease targeted behaviors.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

8. Prescribing Actions. Prescribing specific action or assigning homework that activates behavior or alters long-standing patterns.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

9. Constructing a Hierarchy. Constructing a hierarchy of related behaviors or situations that result in different levels of distress in order to identify an intervention strategy.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

10. Exposing Clients to Images or Experiences. Exposing clients to distressing images or real-life experiences in order to desensitize them or extinguish problematic conditioned responses.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

11. Fostering Acceptance. Fostering acceptance of uncomfortable thoughts, feelings, or sensations rather than taking action to try to change or avoid them.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

12. Encouraging Commitments. Encouraging clients to identify their values and to make commitments to actions that are consistent with personal values.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

13. Providing Training and Rehearsal. Providing skills training and behavioral rehearsal related to therapeutic goals.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

14. Coaching and Shaping. Coaching clients, providing social reinforcement, and shaping behavioral patterns.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

<u>Experiential-Humanistic Psychotherapy Strategies</u>

1. Identifying Feelings. Identifying specific feelings and distinguishing them from thoughts and physical sensations.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

2. Clarifying the Impact of Feelings. Clarifying the impact of feelings on thoughts, actions, and other dimensions of human functioning.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

3. Encouraging Expression of Feelings. Encouraging awareness and expression of feelings in order to embrace adaptive emotions and let go of maladaptive feelings.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

4. Fostering Self-Actualization. Celebrating the desire for growth and fostering self-actualization as an innate human need.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

5. Communicating Empathy and Positive Regard. Communicating empathy and unconditional positive regard in a congruent manner that encourages growth.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

6. Supporting Authenticity. Supporting the discovery and expression of a client's personal sense of authenticity.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

7. Integrating Parts of Self. Identifying, connecting, and integrating different parts of the self.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

8. Focusing Attention. Focusing attention to increase awareness of feelings, thoughts, actions, or physical sensations.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

9. Fostering Here-and-Now Awareness. Fostering here-and-now awareness in order to promote discovery and growth.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

10. Creating Experiments. Creating in-session experiments to facilitate discovery and change.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

11. Accepting Freedom and Responsibility. Promoting an acceptance of freedom and responsibility that leads to mature decision-making.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

12. Recognizing Existential Limitations. Facilitating recognition of existential limitations like death, freedom, isolation, and meaninglessness.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

Biopsychosocial Psychotherapy Strategies

1. Exploring the Effect of Biology on Psychological Functioning. Exploring how biological functioning, including health or illness, can affect thoughts, actions, and feelings.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

2. Recognizing the Influence of Psychological Functioning on Health. Recognizing the influences of thoughts, actions, and feelings on biological health and physical wellness.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

3. Considering the Interaction Between Health and Relationships. Considering the interaction between biological health and interpersonal or systemic relationships.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

4. Understanding Health within a Sociocultural Context. Understanding biological health, health behaviors, and physical symptoms within their social and cultural contexts.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

5. Encouraging Physical Wellness. Helping clients establish healthy patterns of living that result in physical wellness—including proper nutrition, exercise, and sleep.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

6. Reducing Substance Use. Helping clients reduce or eliminate their use of alcohol, tobacco, or other drugs that threaten physical and mental health.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

7. Teaching Relaxation. Teaching clients to relax using muscle relaxation, breathing, stretching, imagery, meditation, or autogenic training.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

8. Fostering Physiological Awareness. Fostering physiological awareness and attention to biological cues related to psychological functioning and physical health.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

9. Working Interactively with Body and Brain. Working physically with the body or altering brain activity to relieve psychological and emotional distress.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

10. Facilitating Acceptance of Illness. Facilitating acceptance of illnesses or physical limitations and encouraging behavioral changes that adapt to new biological realities.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

11. Encouraging an Active Role in Health Care. Encouraging an active role in health care through personal decision-making and proactive negotiation with health-care providers.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

12. Considering Psychotropic Medication. Encouraging clients to consider the potential benefits of medication to reduce psychiatric or medical symptoms.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

13. Considering Alternative Interventions. Considering alternative interventions that impact biological functioning (e.g. hypnosis, acupuncture, yoga).

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

Psychodynamic-Interpersonal Psychotherapy Strategies

1. Listening to Narratives. Listening with a receptive attitude and enabling clients to relate their life narratives in a way that illuminates conflicts and patterns.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

2. Encouraging Free Association. Encouraging clients to say whatever comes to mind in order to discover unconscious thoughts and feelings that might not emerge in a structured conversation.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

3. Identifying Relationships Themes. Examining current relationships and identifying interpersonal themes that may represent long-term patterns.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

4. Making Interpersonal Interpretations. Interpreting subtle thoughts, actions, and feelings in order to bring them into awareness and illuminate their relationship to interpersonal patterns.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

5. Honoring Resistance. Honoring resistance and fostering awareness of the way clients resist change and maintain the status quo in order to protect themselves from fearful changes.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

6. Exploring Childhood Experiences. Exploring childhood experiences in order to understand the origin of interpersonal patterns and how early relationships may shape or distort current interpersonal perceptions.

0 1 2 3 4 5 6

Never Sometimes Very Frequently

7. Working Through Past Conflicts. Expressing and working through thoughts and feelings related to painful interpersonal conflicts from the past.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

8. Identifying Attachment Styles. Examining early and ongoing attachment experiences and identifying attachment styles in order to encourage more secure attachments.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

9. Observing the Therapeutic Relationship. Observing the way clients relate to the psychotherapist in order to understand the way interpersonal patterns are enacted and repeated within the therapeutic relationship.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

10. Attending to Subjective Responses. Attending to the psychotherapist's own subjective responses as a basis for understanding clients' interpersonal experiences and how they may be perceived by others.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

11. Resolving Conflicts in the Therapeutic Relationship. Working through interpersonal problems in the therapeutic relationship in order to resolve conflicts that were learned earlier in life.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

12. Modifying Relational Interactions. Identifying ways that current relationships outside therapy can be modified to change interaction patterns and to generalize lessons that have been learned in psychotherapy.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

13. Interpreting Dreams. Exploring dreams and helping clients discover interpretive meaning that illuminates thoughts or feelings outside of awareness.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

14. Adapting to Interpersonal Losses or Disputes. Helping clients adapt to significant changes in interpersonal relationships by grieving losses or resolving disputes.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

15. Encouraging New Relationships. Encouraging clients to form new relationships and reduce social isolation as a result of role transitions or interpersonal deficits.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

16. Learning from Termination. Using the end of the therapeutic relationship to enact a healthy separation, consolidate self-awareness, and support interpersonal changes.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

Systemic-Constructivist Psychotherapy Strategies

1. Understanding Problems within their Social Context. Understanding individuals' psychological problems within the social context of families and other relational groups.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

0 1 2 3 4 5 6
Never Sometimes Very Frequently

13. Interpreting Dreams. Exploring dreams and helping clients discover interpretive meaning that illuminates thoughts or feelings outside of awareness.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

14. Adapting to Interpersonal Losses or Disputes. Helping clients adapt to significant changes in interpersonal relationships by grieving losses or resolving disputes.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

15. Encouraging New Relationships. Encouraging clients to form new relationships and reduce social isolation as a result of role transitions or interpersonal deficits.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

16. Learning from Termination. Using the end of the therapeutic relationship to enact a healthy separation, consolidate self-awareness, and support interpersonal changes.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

Systemic-Constructivist Psychotherapy Strategies

1. Understanding Problems within their Social Context. Understanding individuals' psychological problems within the social context of families and other relational groups.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

2. Viewing Families as Systems. Viewing families as interactive systems in which all members impact one another through direct and indirect communication.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

3. Detecting Repetitive Interaction Patterns. Detecting repetitive interaction patterns and feedback loops that are used to maintain family homeostasis.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

4. Describing the Structure of the Family. Describing the structure of the family including subsystems, boundaries, and patterns of enmeshment and disengagement.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

5. Identifying Family Roles. Identifying functions or roles that family members frequently play in order to maintain family stability.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

6. Searching for Multigenerational Patterns. Searching for multigenerational patterns that demonstrate the way interpersonal relationships are influenced by extended families.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

7. Clarifying Family Belief Systems. Clarifying family belief systems and rules that govern the way families interact and influence member's thoughts, actions, and feelings.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

8. Giving Directives for Strategic Change. Giving strategic directives that alter a maladaptive sequence of behaviors in order to initiate change within an entire system.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

9. Exploring the Social Construction of Meaning. Exploring the social construction of personal meaning and helping clients recognize how families and other groups have shaped the way reality is perceived.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

10. Externalizing Problems. Externalizing problems by describing them as separate entities outside of clients rather than as defining parts of identity.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

11. Encouraging Adaptive Narratives. Helping clients tell their stories or personal narratives in new ways that support the possibility for change.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

12. Utilizing Clients' Resources. Utilizing clients' resources and symptoms to help them meet their needs in more adaptive ways.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

13. Constructing Solutions. Constructing solutions by building on past successes and discovering exceptions to the rules that support psychological problems.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

14. Orienting Toward the Future. Orienting clients toward the future and helping them imagine a time when their problems have been solved.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

Multicultural-Feminist Psychotherapy Strategies

1. Viewing Clients Culturally. Observing and understanding clients' thoughts, actions, and feelings from a cultural point of view.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

2. Clarifying the Impact of Culture. Clarifying the impact of cultural contexts on current functioning, interpersonal relationships, and social systems.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

3. Creating Culturally-Appropriate Relationships. Creating therapeutic relationships that appropriately match clients' cultural expectations.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

4. Celebrating Diversity. Celebrating diversity in order to help clients accept and express their uniqueness.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

5. Illuminating Similarities and Differences. Illuminating similarities and differences between psychotherapist and clients and acknowledging the impact on the relationship.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

6. Recognizing the Impact of Identity. Assessing identity development and recognizing its impact on how clients value different worldviews and make attributions of personal success and failure.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

7. Facilitating Identity Development. Facilitating the awareness and development of cultural identity in order to promote self-acceptance and empowerment.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

8. Appreciating Multiple Identities. Appreciating the intersection of multiple identities including race, ethnicity, gender, sexual orientation, religion, class, ability, and age.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

9. Highlighting Oppression and Privilege. Highlighting the impact of societal oppression, privilege, status, and power on clients' thoughts, actions and feelings.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

10. Exploring Societal Expectations. Exploring societal expectations and supporting informed decisions about which roles to embrace and which to discard.

0	1	2	3	4	5	6
Never			Sometimes			Very Frequently

11. Supporting Social Action. Supporting clients who participate in social action in order to change oppressive societal structures or practices.

0	1	2	3	4	5	6

Never Sometimes Very Frequently

12. Integrating Spiritual Awareness. Integrating clients' spiritual awareness or faith development into holistic growth.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

13. Becoming Aware of the Therapist's Worldview. Becoming aware of your own worldview and how it impacts your role as psychotherapist.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

14. Reducing Cultural Biases. Recognizing possible cultural biases and presenting options with as little partiality as possible.

0 1 2 3 4 5 6
Never Sometimes Very Frequently

APPENDIX D

Electronic Recruitment Statement

Electronic Recruitment Statement

Subject: Research About Theoretical Orientation And Practice

Hello,

I am a Ph.D. candidate in Counseling Psychology at Texas Woman's University (TWU). I am requesting your participation in a study I am conducting for my dissertation (TWU-IRB: #16733). The purpose of this study is to investigate the theoretical orientation and therapeutic practices of mental health providers.

If you are a student or professional with current or past experience conducting therapy in any setting, you are eligible to participate in this study. (Students must have at least one semester of practicum experience to participate.)

Should you choose to participate in this study, you will be asked to complete an internet survey, which will take approximately 30 minutes. Your participation is voluntary and anonymous. However, there is a potential risk of loss of confidentiality in all email, downloading, and internet transactions. Upon completion of the survey, you will be given the option of registering to win a $50 Visa gift card. If you choose to do so, you will be asked to email your contact information, but it will not be linked to your responses on the survey in any way. You may choose to discontinue your participation at any time. If you have any questions or concerns, you may contact me at nicoleroblyer@twu.edu or my research advisor, Dr. Jeff Harris, at JHarris18@twu.edu.

Click here to participate or receive further information about this study:
https://www.psychdata.com/s.asp?SID=142304
I would very much appreciate your help with my research. If you know of other qualified individuals who may be interested in participating, please forward this email request to them. Thank you!

Sincerely,

Nicole Roblyer, M.A., LPC
Doctoral Candidate
Texas Woman's University
Department of Psychology & Philosophy
P.O. Box 425470
Denton, TX76204-5470
(940) 898-2303

APPENDIX E

Texas Woman's University Consent to Participate in Research

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

TITLE: Multitheoretical Assessment with Integrative and Pure-Form Therapists: An Exploratory Study

PRINCIPLE INVESTIGATOR: Nicole R. Roblyer, M.A., LPC
940-898-2303; nicoleroblyer@twu.edu

RESEARCH ADVISOR: Jeff E. Harris, Ph.D., ABPP
940-898-2313; jharris18@twu.edu

Explanation and Purpose of the Research:
You are being asked to participate in a research study for Nicole Roblyer's doctoral dissertation at Texas Woman's University (TWU). The purpose of this research is to investigate the theoretical orientations and therapeutic practices of mental health providers. You have been asked to participate in this study because you have current or past experience conducting therapy.

Description of Procedures:
As a participant in this study, you will be asked to spend approximately 30 minutes completing an internet survey. In order to be a participant in this study, you must have current or past experience conducting therapy.

Potential Risks:
Potential risks related to your participation in this study may include fatigue stemming from the use of a computer for an extended period of time. If you experience discomfort during the completion of this questionnaire, you may take breaks or discontinue answering the questions at any time. Another risk of participating in this study includes loss of time. To reduce this risk, you have the option of withdrawing at any time.

Another possible risk resulting in your participation is the release of confidential information. There is a potential risk of loss of confidentiality in all email, downloading, and internet transactions. Confidentiality will be protected in several ways to the extent that the law allows. Participants will not be asked to provide identifiable information (such as one's name, date of birth, social security number, physical address, or phone number), and any other identifying information (such as IP addresses) will be stored

separately from participants' responses. Data is password protected and will be stored in the database of the website that hosts this survey (Psychdata). Only the study's investigators will have access to data. It is possible that the results of this study will be published in research publications other than the dissertation. If this occurs, no names or identifying information will be included in any publication.

Participation and Benefits:
Your involvement in this research is completely voluntary. You may discontinue your participation at any time without penalty. Following the completion of the study, you will be given the option of registering to win a $50 Visa gift card. If you decided to do so, you will be asked to email your contact information, which will not be linked to your survey responses in any way. Your participation in this research study will serve to further the current knowledge base of integrative psychotherapy theory and practice.

Questions Regarding the Study:
If you have any questions about this research study (TWU-IRB: #16733) you may contact the principle investigator, Nicole Roblyer (940-898-2303; nicoleroblyer@twu.edu), or research advisor, Dr. Jeff Harris, (940-898-2313; JHarris18@twu.edu). If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact TWU Office of Research and Sponsored Programs at 940-898-3378 or via email at IRB@twu.edu.

Consent to Participate:
By clicking on the CONTINUE button, and by completing the questionnaires in this study, you are giving your informed consent and indicating that you understand the nature of this research study and your role in it.

APPENDIX F

End of Online Survey Script

End of Online Survey Script

Thank you for participating in our study—your willingness to complete all of the surveys, along with the time and energy you invested, is enormously useful and very much appreciated. Should you have any questions or concerns, please contact Nicole Roblyer (nicoleroblyer@twu.edu; 940-898-2071), or Dr. Jeff Harris (jharris18@twu.edu; 940-898-2309). In addition, if you have questions about your rights as a participant in this research, you may contact the TWU Office of Research and Sponsored Programs (IRB@twu.edu; 940-898-3378). If you do so, please reference TWU-IRB: #16733.

If you wish to be entered into a drawing to win a $50 Visa gift card, send an email to nicoleroblyer@twu.edu and include your name and address, with "Gift Card" in the Subject line. Your responses to this survey will NOT be connected to your email in any way.

Please feel free to pass along the following link
https://www.psychdata.com/s.asp?SID=142304
to any colleagues and friends who are mental health practitioners and who may be interested in participating in this study.

APPENDIX G

IRB Approval Letter

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Institutional Review Board
Office of Research and Sponsored Programs
P.O. Box 425619, Denton, TX 76204-5619
940-898-3378 FAX 940-898-4416
e-mail: IRB@twu.edu

July 19, 2011

Ms. Nicole Roblyer
3937 Glenwyck Drive
North Richland Hills, TX 76180

Dear Ms. Roblyer:

Re: An Exploratory Factor Analysis of the Multitheoretical Strategies Rating Questionnaire (Protocol #: 16733)

The above referenced study has been reviewed by the TWU Institutional Review Board (IRB) and was determined to be exempt from further review.

If applicable, agency approval letters must be submitted to the IRB upon receipt PRIOR to any data collection at that agency. Because a signed consent form is not required for exempt studies, the filing of signatures of participants with the TWU IRB is not necessary.

Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any unanticipated incidents. If you have any questions, please contact the TWU IRB.

Sincerely,

Kathy DeOrnellas, PhD.

Dr. Kathy DeOrnellas, Chair
Institutional Review Board - Denton

cc. Dr. Dan Miller, Department of Psychology & Philosophy
Dr. Jeff Harris, Department of Psychology & Philosophy
Graduate School