

AN ABSTRACT OF THE THESIS OF

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Title: Psychotherapeutic Skill Preferences of Clinical Psychologists, Licensed
Clinical Psychotherapists, Licensed Specialist Clinical Social Workers, and
Psychiatrists

Abstract Approved:

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This study investigated the psychotherapeutic skill preferences of four groups of professionals familiar with the theory and practice of psychotherapy according to (a) which skills are most helpful in bringing about positive client change through psychotherapy, (b) which models offer the most helpful skills, (c) if differences exist in skill preferences between groups, and (d) if training is reflected in practice of professionals. Participants were 105 practitioners from the fields of psychology, social work, and psychiatry in the state of Kansas. Results indicated three of the top five most useful skills were from the Humanistic model, one was from the Psychodynamic model, and one was from the Cognitive model. Skill items from the Humanistic model ranked 1st, 3rd, and 5th. The item from the Psychodynamic model ranked 2nd and the item from the Cognitive model ranked 4th place. Although the majority of therapists reported their practices as mainly Cognitive in nature, skills from the Humanistic model consistently ranked most helpful. There were few significant differences between skill preferences of groups. Differences that were apparent mainly involved Psychopharmacology. Based on ratings between training and use of models in current practice, suggestions were offered toward the improvement of academic curriculum.

PSYCHOTHERAPEUTIC SKILL PREFERENCES OF
CLINICAL PSYCHOLOGISTS, LICENSED CLINICAL PSYCHOTHERAPISTS,
LICENSED SPECIALIST CLINICAL SOCIAL WORKERS, AND
PSYCHIATRISTS

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by

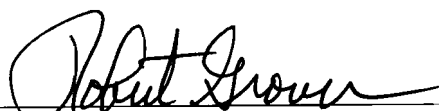
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TABLE OF CONTENTS

ACKNOWLEDGEMENTS	iii
TABLE OF CONTENTS	iv
LIST OF TABLES	vi
CHAPTER	
1 INTRODUCTION	1
Economics of Psychotherapy	2
Models of Psychotherapy	4
Psychoanalysis	4
Behaviorism	6
Humanism	6
Cognitive Therapy	7
Psychopharmacology	8
Trends in Therapy	10
Professionals	12
Clinical Psychologists	12
Licensed Clinical Psychotherapists	13
Licensed Specialist Clinical Social Workers	14
Psychiatrists	15
Research Questions	12
METHOD	19
Participants	19

Design	21
Instrumentation	21
Procedure	21
3 RESULTS	23
Statistical Analysis	23
Research Question 1	24
Research Question 2	25
Research Question 3	27
Research Question 4	27
4 DISCUSSION	33
Research Question 1	33
Research Question 2	34
Research Question 3	35
Research Question 4	36
Conclusion	37
REFERENCES	40
APPENDICES	47
Appendix A: Survey	48
Appendix B: Cover Letter	49
Appendix C: Informed Consent Document	50
Appendix D: Approval to Use Human Subjects	51
Appendix E: Demographics Page	52

LIST OF TABLES

TABLE

	<u>PAGE</u>
1	Mean Ratings of Clinical Psychologists (LP), Licensed Clinical Psychotherapists (LCP), Licensed Specialist Clinical Social Workers (LSCSW), and Psychiatrists (MD) on Usefulness of Model Specific Therapeutic Skills 28
2	Rank Placements of Model Specific Psychotherapeutic Skills According to Clinical Psychologists (LP), Licensed Clinical Psychotherapists (LCP), Licensed Specialist Clinical Social Workers (LSCSW), and Psychiatrists (MD) 29

CHAPTER 1

INTRODUCTION

Psychology started as a philosophical discipline with theorists pondering the substance and functioning of the mind. In the 19th century, psychology incorporated scientific methodology, which clinically resulted in therapists being trained to observe overt behaviors as a basis for treatment planning and assessment of treatment effect. The current scientific zeitgeist of clinical psychology promotes research and treatment toward observable changes through psychotherapy. Do current therapeutic methods meet the needs of therapists and clients?

Trained psychotherapists have more to offer toward the improvement of the human mental condition than other prominent avenues sought by lay persons such as talk show hosts or psychics. Yet, in a society with managed health care, technological advancement, and “self-help” alternatives, the utility of psychotherapy is under scrutiny more than ever (Seligman, 1995). Indeed, according to the National Coalition on Health Care and the Institute for Health Care Improvement (1998), there is a call for health care in general to be evidence-based.

Psychological researchers must think about who is likely to have practical use for their results. The push to make psychology a science like biology or chemistry may have left out the “inner man” as a focus of research and treatment (Harmon, 1962). Psychology’s efforts to gain scientific credibility may have resulted in shifting research away from what it actually means to be “human” and how best to therapeutically

improve a human experience. Perhaps this is one explanation for consumers' significant interest in and consumption of alternative and complementary therapies (Knaudt, Conner, & Weisler, 1999; University of California, 2000), self-help materials and groups (Illinois, 2001), psychics (Le Figaro, 1992), and technological trash (Mills, 1995).

How does people's desire to obtain "inner healing" when they visit a psychotherapist contrast with scientifically trained therapists' focus on treatment goals which improve observable behaviors? The goal of this study was to determine which psychotherapeutic skills were found to be most useful by practicing professionals and, thus, determine which psychotherapeutic models offered the most beneficial techniques. The study attempted to answer whether differences existed in the therapeutic preferences of four professional groups and if academic training was reflected in current practice of psychotherapists.

Review of the Literature

Economics of Psychotherapy

The current economics of insurance and medicine in America today necessitates that the utility of psychological therapies be verified (Jones & Lyddon, 2000; Seligman, 1995). Sabin (1995) predicted that by the year 2000 virtually all mental health care would be controlled by Managed Health Care (MHC). He foresaw conflicts arising between the interests of people and the MHC system. He described how the public generally thinks in terms of moral perspectives and values of the individual while MHC maintains a communitarian principle with little consideration of individual

interests. Furthermore, he asserted that in this age only those diagnosed medically ill will be granted third party coverage for psychotherapy. While many of Sabin's observations regarded MHC policies conflicting with the cultural and social interests of the populace, Stone (1995) identified MHC as a for-profit phenomena; the fastest growing segment of the medical industry, and pointed out that as much as one-third of premiums are being invested in clever marketing to earn even more profit for MHC investors. He further reported that when money does go toward health care, cutting costs is a primary concern of MHC. As for mental health treatment, he only included medically diagnosed patients referred by their psychiatrists to a psychiatric nurse or social worker, whose salaries are typically less than master's or doctoral-level psychologists, for therapy.

After completing a historical view of the role of clinical psychologists in conducting psychotherapy, Humphreys (1996) concluded that doctoral-level practitioners have little chance of being able to resist current trends. He called for psychologists to re-envision the training and practice of clinical psychologists. Psychology and psychotherapy have so long been associated together that many people believe that all psychotherapy is conducted by psychologists and that psychotherapy is all psychologists do ("What is a Psychologist?," 2002). Still, with the medically trained psychiatrist and psychiatric nurse/social worker team approved by MHC resulting in fewer psychologists being reimbursed for performing psychotherapy, those within the profession of psychology must consider how psychology will survive among treatment competitors.

Economically speaking, a key to predicting consumer demand for psychotherapy in general lies in determining where people go if not to psychotherapists to address psychological issues. For example, many people use self-help groups for support in dealing with problems including addiction, illness, emotional and mental problems, and bereavement among others (Illinois, 2001). A study conducted by the MacArthur Foundation in 1996 reported that more than 18.1% of people surveyed had attended a self-help group. A study of one self-help group, Alcoholics Anonymous, reported that alcoholics who attended AA achieved higher rates of abstinence than those who had been clinically treated (Emrick, 1987).

Models of Psychotherapy

Psychoanalysis

Although the 20th century has been referred to as “the age of Freud,” many types of psychological therapies have been proposed (Jacobs, 2000). The first half-century was dominated by psychoanalytic methods whereas the second half witnessed the development of cordial relationship among numerous therapies. Sigmund Freud first used psychoanalysis in 1896 (Holinger, 1989). Major contentions of the model are that: (a) human behavior is influenced by both heredity and environment; (b) human behavior is the result of interaction between the “id” (representing drives), the “ego” (representing reason), and the “superego” (representing self-judgment or conscience-restraints); (c) survival and pleasure dominate mental functioning; (d) unconscious wishes give rise to motivation, and conflict between wishes is expressed in normal and psychopathological behavior; and (e) dreams represent subconscious desires (Moss,

1992). Psychoanalytic therapy aims at resolving the inner conflicts that are presumed to be at the root of dysfunction and discontent in living through self-understanding (Dilman, 1994). The psychoanalytic model has been criticized for lack of utility in treating more seriously disturbed patients such as those diagnosed with Borderline Personality Disorder or narcissistic characteristics (Druck, 1989), and it has been suggested that Freudian theory does not adequately account for the richness and variety of human experience and motivation (Sandler, 1988). Furthermore, in contrast to MHC's push for time-efficient, lower-cost treatment, psychoanalytic sessions last 45-50 minutes over a period of years with no time limit (Wolitzky, 1995). Thus, contemporarily, many psychoanalytically-oriented therapists employ psychodynamic therapy, which utilizes briefer, time-limited methods in obtaining treatment goals, while maintaining many of the core concepts of psychoanalytic theory (Kendall & Hammen, 1998). As for whether long-term or brief therapy works better, Seligman and Levant (1998) contend that although MHC pushes toward brief time limits with providers who receive less training, there is no empirical evidence that these policies provide consumers with the best care. Lazar (1997) reported such policies leave a growing number of psychiatric patients without adequate treatment.

Still, in spite of the various theories and treatment models available today, some studies from the latter half of the 20th century showed Sigmund Freud to be recognized as the most influential person in the development of psychology. When surveying which psychological theorists have had the greatest impact on the general populace, Freud, many of whose theories are not scientifically provable, is one of the best recognized

(Moore, 2002). For instance, 134 undergraduate students of psychological history from 1998 through 2000 were asked to name 3 psychologists in order of importance, influence, or eminence from within or without the discipline of psychology (Kanekar, 2001). Freud outranked other psychologists by a widespread margin although he was actually a physician. Similarly, Newstead (1983) surveyed 1,132 psychologists, staff, students, and teaching assistants from the United States and United Kingdom regarding the most important psychologist still living and the most important of all time. Results universally favored Freud as the most important psychologist ever.

Behaviorism

John B. Watson (1913) asserted that thinking was non-existent as an objective, physical form, and therefore, what could best be scientifically studied was the overt behavior of humans. He attempted to promote psychology as an objective science with an experimental method, which he claimed would allow psychologists to predict and control human action (Reed, 1989). The modern behavioral model stresses how environmental factors influence the behavior of a person through learning (Kendall & Hammen, 1998). Learning typically takes place via classical conditioning where neutral stimuli begin to evoke involuntary responses, operant conditioning where behavior is molded from its consequences, and modeling where learning takes place vicariously by observing the behavior and consequences of others. The objective of behavioral therapy is to unlearn behaviors that bring about undesirable consequences and learn behaviors that result in desirable outcomes. However, Kendall and Hammen noted that Behaviorism has been criticized for being unrealistic and oversimplified in treating

psychological disorders and for downplaying the influence of unobservable aspects of human experience, such as cognition, on human behavior.

Humanism

Humanism became prominent in the mid-20th century with Carl Rogers and Abraham Maslow as its two leading proponents (Kendall & Hammen, 1998). The underlying principle of the Humanistic view is an emphasis on the free choices, values, and personal sense of purpose of the individual. Essential components of the model are human needs such as survival and relationship, personal growth experiences, and the role of self as a central focal point. Within this view, well-adjusted individuals accept responsibility for their own thoughts and actions. Maladjustment results when one rejects responsibility for personal behavior and the impact of one's own behavior on others in society. Rogers' humanism values personal authenticity, when one is self-aware and caring of the self and others. Maslow identified a hierarchy of needs in which sequential levels of existence, from basic survival to self-actualization where the person reaches the highest sense of self and purpose, are described. The humanistic therapist perceives the client as a "whole" person with the capacity to generate solutions toward positive change (Bohart & Tallman, 1996). During therapy the client talks freely and thinks creatively with the therapist who offers options for new experiences and responds to client input. Criticisms of this model focus on its weakness in affecting change in unmotivated clients, clients with weak relationship skills, and non-verbal clients (Bohart, 1995).

Cognitive Therapy

Cognitive therapy has its roots in the work of Aaron Beck and his treatment of depression in the 1970s (Freeman & Reinecke, 1995). It is based upon the concept of psychological constructivism, defined by Michael Mahoney (1991) as a family of theories about mind and mentation that:

(1) emphasize the active and proactive nature of all perception, learning, and knowing; (2) acknowledge the structural and functional primacy of abstract (tacit) over concrete (explicit) processes in all sentient and sapient experience; and (3) view learning, knowing and memory as phenomena that reflect the ongoing attempts of body and mind to organize (and endlessly reorganize) their own patterns of action and experience - patterns that are, of course, related to changing and highly mediated engagements with their momentary worlds.

(p. 95)

Cognitive therapy techniques are based on social learning processes, where behavior is determined by the interaction of external stimuli and internal mental interpretations.

Cognitive therapists look at the development of emotional problems as based on this interaction and view cognitive restructuring as a means of correcting dysfunctional interpretations. They aid clients in developing social problem solving skills and learned behavioral skills to resolve emotional problems. In short, the cognitive therapist attempts to modify the client's interpretations of the world (Kendall & Hammen, 1998). Yet, as Kendall and Hammen noted, cognitive therapy has been criticized for its lack of evidence that its techniques produce results independent of techniques from

other disciplines (e.g., psychoanalysis, behaviorism, humanism), the lack of treatment effects in persons with co-morbidity, the lack of answers for the origins of maladaptive cognitive functioning, and the assertion that cognitive therapy results are brought on merely by the act of positive self-talk.

Psychopharmacology

Psychopharmacology has been defined as the study of the effects of psychoactive substances on behavior and the practice of experts in prescribing medications in the treatment of psychiatric conditions (Moriarty, Alagna, & Lake, 1984). In ancient times, before the advent of synthetic medicine, natural treatments including opiate therapy, camphor and bromide therapies, humoral therapeutics, herbs, and minerals countered mental disturbance (Sneader, 1990). The modern history of psychopharmacology can be divided into three periods (Ban, 2001). During the second half of the 19th century, physical restraint of the mentally ill was replaced by medications such as morphine, chloral hydrate, and potassium bromide. During the first half of the 20th century, psychosis due to cerebral pellagra and dementia due to syphilis virtually disappeared from psychiatric hospitals with discoveries of penicillin, nicotinic acid, and thiamine among other drugs. The second half of the 20th century witnessed discoveries of drug treatments for a broad range of mental problems including mania, depression, panic disorder and bipolar disorder. The realization that chemical substances could relieve even the mentally insane came about in the 1950s when Thorazine was found to reduce psychotic symptoms in chronic mentally ill patients (Healy, 2002). Currently, neuroleptics, antidepressants, mood stabilizers, and

anxiolytics are the most commonly prescribed drug therapies (Siepmann & Kirch, 2001).

Generally, the privilege of prescribing medication has been limited to medical doctors/psychiatrists and nurse clinicians. The debate over whether or not psychologists should be allowed to prescribe is ongoing (Sammons, Sexton, & Meredith, 1996). Some assert that the current level of basic science training received by graduate students of psychology could easily be modified with the addition of pharmacological training to adequately prepare students to prescribe. However, others contend that root differences in training between the fields of psychology and medicine are too great and, thus, simply adding pharmacology to the curriculum of psychology students would not be enough to prepare them to competently prescribe (Pies, 1991).

The benefits of psychotherapy and pharmacotherapy are greater when used jointly than alone (Dewan, 1992); however, not all patients require medication. Dewan suggested that medication is indicated when patients do not progress in problem resolution with psychotherapy alone or when acting out, increased anxiety, or drastic clinical deterioration occurs. Yet, pharmacology as a treatment for mental illness has been criticized as contributing to mental illness, causing violent acts, and suicidal thoughts (Bibeau, 1994). A study by Mind, a United Kingdom mental health charity, found that 61% of respondents, 75% for blacks and minorities, had not been properly informed of ill side effects of medication (“Mentally Ill Not Warned About Drug Side-Effects,” 2001). Advancements in psychopharmacology during the 1960s have been blamed for the rise in population of mentally ill persons being homeless with little or no

treatment, due to masses being released from institutions to community settings where they lost touch with treatment resources (French, 1987).

Trends in Therapy

Psychology in some form has spanned thousands of years. Psychology was born from philosophy (Resnick, 1997), and ancient philosophers gave counsel to people who had “problems in living” (Szasz, 1998a). Socrates described his role as being someone who tended to the “soul” of humanity (Plato, 1961), as he stated to opposing Athenian authorities who held him for trial:

It is my belief that no greater good has befallen you in this city than my service to my God. For I spend all my time going about trying to persuade you, young and old, to make your chief concern not for your bodies nor for your possessions, but for the highest welfare of your souls. (p.15)

Assessing the future of psychotherapy requires considering what psychotherapy is and its current status in today’s culture. Szasz (1998b) defined psychotherapy as a freely contracted relationship whereby one person assists another in improving his life with the use of dialogue. Johnson and Sandage (1999) described psychotherapy as a process of determining where one stands in life, where one wishes to be, and how one plans to get there through “conversational orienteering.” In the 20th century, psychotherapeutic processes were based on scientific theories of observable human behavior (Richardson, Fowers, & Guignon, 1999).

Robins, Gosling, and Craik (1998) reviewed the literature on psychoanalytic, behavioral, and cognitive models to determine where they rank regarding popularity

and utility. Humanism and Psychopharmacology were not included in the study. First, they reported that psychoanalysis' popularity had faded since the mid 1900s with a decrease in use of its concepts by psychologists, but that psychoanalytic thought was still prominent in the broader intellectual community. Second, they found that behavioral theories had also declined at the close of the century, although behavioral methods were still utilized in psychotherapy. Third, the cognitive school had become the most popular of the disciplines studied. The authors attributed this popularity to the rise of the computer age (where aspects of the computer's functional processes have been compared to human mental capacities).

Professionals

Four groups commonly expected to be familiar with the theory and practice of various models of psychotherapy are clinical psychologists, licensed clinical psychotherapists, licensed specialist clinical social workers, and psychiatrists. Although practitioners from each group may be familiar with psychotherapy based on common theoretical models, academic training and professional goals may vary substantially.

Clinical Psychologists

The American Psychological Association (2002) states that a psychologist has earned a doctorate in philosophy (PhD), doctorate in psychology (PsyD), or doctorate in education (EdD) from an accredited program. Apart from other mental health fields, training in psychology concentrates in the areas of personality and psychopathology, promoting an extensive knowledge of normal and abnormal adjustment and maladjustment across the life span. Interventions in psychology focus on correcting

skill deficits underlying human dysfunction or distress, personality disturbances, emotional conflicts, and psychopathology. Techniques employed include psychoanalysis, behavior therapy, cognitive retraining and rehabilitation, biofeedback, social learning approaches, and environmental consultation and design. The stated goal of the profession is to promote adaptation, social order, satisfaction, and health.

Clinical psychologists are exposed to a vast array of psychological treatment alternatives and therapeutic orientations which may have contributed to many clinical psychologists considering their practice “eclectic” in nature (Phares and Trull, 1997). Clinical psychologists receive much of their education in psychotherapy during graduate school but may also pursue postdoctoral training (“What is a Psychologist?,” 2002). One prominent school in Kansas requires doctoral candidates to complete 6 hours in Clinical Psychotherapy along with coursework in Advanced Psychopathology and Personality Assessment (University of Kansas, 2002). The Kansas Behavioral Sciences Regulatory Board (2002) requires a licensed clinical psychologist to have completed 15 hours in techniques of effective therapeutic intervention, supervision, and consultation, including coursework in clinical psychotherapy, counseling and interviewing skills, and psychotherapy with families; completed 1800 hours practicum work in a clinical setting, supervised by a doctoral-level staff psychologist; and passed an Examination for Professional Practice in Psychology (EPPP) at a 70% level.

Licensed Clinical Psychotherapists

The goals of psychology as described above for doctoral level practitioners are the same for practitioners at the master’s level of psychology (American Psychological,

2002). In 1999, legislation was passed in Kansas for a new level of independent clinical licensure (transcending the traditional master's level degree in psychology or LMLP), the Licensed Clinical Psychotherapist (LCP). Coursework at the LMLP level must have included a minimum of 6 semester hours specific to the practice of psychotherapy with 12 additional hours that may include treatment of psychopathology or additional psychotherapy coursework. The Kansas Behavioral Sciences Regulatory Board states that an LCP who has transitioned from an LMLP degree must have been actively engaged in practice within the past 5 years as a master's level psychologist; possess a current, active license or registration; be deemed competent to diagnose and treat mental disorders as documented by two of the following: a) pass a national exam; b) complete 9 graduate hours in diagnosis and treatment; or c) obtain attestation from one professional licensed to diagnose and treat mental disorders that the applicant is competent to diagnose and treat; have 3 years clinical experience in a state hospital, mental health center or other setting with experience in diagnosis and treatment; have completed 4000 hours supervised clinical experience beyond that required at the master's level; and have completed an EPPP exam at a 70% pass level.

Licensed Specialist Clinical Social Workers

According to the National Association of Social Workers (2002), the expressed goal of social work is to help meet the basic human need of all people, enhance human well-being, with particular attention to the empowerment and needs of persons who are living in poverty, vulnerable, and oppressed. Core values, unique to the field of social work, are social justice, dignity and worth of the person, integrity, competence,

importance of human relationships, and service. Clinical social workers are expected to be versed in the knowledge of human development and behavior, counseling, and psychotherapy with individuals, families, and groups.

Social work reportedly has a long, involved history with psychotherapy and special education in psychotherapy is required to practice such in the field (Lieberman, 1987). Traditionally, academic programs in this field have often focused on psychodynamic or systemic approaches (Kelley, 1995). According to the Kansas Behavioral Sciences Regulatory Board (2002), a licensed specialist clinical social worker (LSCSW) will have completed licensure as a master's level social worker (MSW); 3 hours in a course discretely focused on psychopathology and the diagnosis and treatment of mental disorders; a practicum at the graduate level with not less than 350 hours direct client contact; 2 years postgraduate internship of not less than 4,000 hours supervised training, with not less than 1,500 hours of direct client contact conducting therapy and assessments as part of or in addition to practicum requirements at the master's level; and a clinical examination for social workers at a 70% pass level.

Psychiatrists

According to the American Board of Psychiatry and Neurology (2002), a psychiatrist has earned a doctorate of medicine (MD) or doctorate of osteopathy (DO). A psychiatrist is expected to understand the psychological, biological, and social components of illness and is qualified to prescribe medications, order diagnostic tests, evaluate and treat psychological and interpersonal problems, and provide continuing care for psychiatric problems. Psychiatrists specialize in the prevention, diagnosis, and

treatment of addictive, mental, and emotional disorders working with individuals or families.

Psychiatric training in psychotherapy has, for the most part, been replaced by study in psychopharmacology and brain physiology (Aldrich, 1993). Historically, psychoanalysis has been the predominant form of psychotherapy for which psychiatrists received training (Wallerstein, 1991). In the years following World War II, as many as 3,000 hours (50%) of a 3 year residency were devoted to training and practice in psychoanalysis, whereas today only 200 hours (2 1/2%) of an 8,000 hour residency are recommended for psychotherapeutic training. Of the training that psychiatrists do receive in psychotherapy, recent focus has been in the areas of psychodynamic, cognitive, and behavioral approaches (Rodenhauser, 1992). The American Board of Psychiatry and Neurology (2002) states that a licensed psychiatrist must be a graduate of an accredited medical school; possess an unrestricted license to practice in the United States; successfully complete a 4 year residency; and pass both written and oral examinations at 65-70% pass levels, depending on the difficulty of the exams as deemed by the board.

Conclusion

Meta-analysis reveals that psychotherapy is found to be effective (Bachar, 1998); however, which methods and time limits work best are still debated. Hovarth (1987) called for research focusing on specific treatments for specific populations. Lindfors et al. (1995) pointed out that differences in outcome due to technique are not as significant as once was thought. These authors assert that research trends are

moving toward answering process-related questions, such as those involving individualized measures and the nature of the therapeutic alliance.

For those who will have access to mental health care in the future, a wide variety of propositions toward the direction that psychotherapy should take to improve outcomes has been proposed. For example, Shilo (1995) called for psychotherapists to draw collectively from various therapeutic models, with relationships and social responsibilities of the client a focus of treatment. Malony (1998) suggested a middle-of-the-road discipline, between the two extremes of physicalism and spiritualism, where the soul (the non-physical essence of a person) is incorporated into the philosophy and practice of counseling. Mann (1998) proposed consciousness, an awareness of self, as the key to any healing. And finally, Wood, Belar, and Snibbe (1998) showed that computer-assisted therapy (Therapeutic Learning Program) is as effective and acceptable to participants as short-term cognitive-behavioral therapy.

If predictions are correct regarding the future of mental health care, then the greatest competition for psychologists in the mental health care market lies with psychiatrists and social workers. At the forefront of therapeutic debate in psychiatry is the issue of psychoanalysis versus drug therapy (Stone, 1992). Freudian psychiatrists, believing that mental illness stems from the mind and is best treated with a “talking cure,” have experienced serious criticism by biological psychiatrists who believe mental illness stems from chemical imbalance in the brain and is best treated with medication. On the other hand, Stone noted that Freudians have criticized drug therapy for its lack

of effect in about one-third of patients treated, drug toxicity and withdrawal problems, and its masking of underlying mental dysfunction.

Research Questions

Based on the training of clinical psychologists, licensed clinical psychotherapists, licensed specialist clinical social workers, and psychiatrists, practitioners should be expected to prefer using the therapeutic skills they have been trained to perform. The current study will attempt to answer the following research questions:

1. What psychotherapeutic skills do clinical psychologists, licensed clinical psychotherapists, licensed specialist clinical social workers, and psychiatrists collectively find most useful as aiding clients in successfully attaining positive change with therapy?
2. Which psychological models are the most useful skills representative of?
3. Do different categories of professionals prefer different psychotherapeutic techniques?
4. Is pre-licensure training reflected in current practice of psychotherapists?

CHAPTER 2

METHOD

Participants

This study was designed with the purpose of comparing and contrasting the therapeutic skill preferences of clinical psychologists, licensed clinical psychotherapists, licensed specialist clinical social workers, and psychiatrists. The target population was professionals familiar with the practice of psychotherapy in the United States. The accessible population was professionals in the state of Kansas. At the time of the study, according to the Kansas Behavioral Sciences Regulatory Board (2002), 297 clinical psychologists, 284 licensed clinical psychotherapists, and 1520 licensed specialist clinical social workers practiced in the state. According to the Kansas State Board of Healing Arts (2002), there were 282 licensed psychiatrists in the state. Names and addresses of professionals in the state of Kansas were obtained from the Behavioral Sciences Regulatory Board and the Kansas State Board of Healing Arts. A simple random sample of 200 professionals, consisting of 50 participants each per 4 professional groups, was drawn from obtained source lists, randomized via Research Randomizer (1997). Prospective participants were distinguished by code numbers for tracking and confidentiality purposes and a return rate of at least 50% in each stratum was the goal.

Of the 200 surveys mailed, 117 were returned from which 105 were deemed usable, thus yielding a final sample of 105 participants. The 12 surveys deemed non-usable were excluded on the grounds of lack of signature on the Informed Consent

and/or improper or lack of response to the survey. Of the 105 usable surveys, 35 (70% of group) came from clinical psychologists, 30 (60% of group) were from licensed clinical psychotherapists, 25 (50% of group) were from licensed specialist clinical social workers, and 15 (30% of group) were from psychiatrists. Thus, the target of a 50% respondent rate was achieved for all groups except psychiatrists. In search of an explanation for the lower response rate of this group, the researcher considered the 6 non-usable surveys returned by psychiatrists. Four had filled out the item checklist, but none of the Informed Consent documents were signed. One insight toward the lower response rate came from a doctor who offered an explanation for his lack of participation. He signed a written note on the form stating, *I do medication management so don't feel you'd get a valid response from me*, even though Item 15, *assist person in medication management*, was offered. Perhaps some of the items placed medical doctors in an awkward position. For example, should it be the goal of doctors of medicine to keep mental health patients medicated, or, should they attempt to bring patients to a point where medication is no longer necessary (also an item option)?

The final sample consisted of 53 women and 52 men. Based on participant report, the mean age of the group was 46.3 years and the mean length of time in practice was 17.6 years. There were 50 doctorate and 55 master level participants. Of those reporting, 8.7% claimed a primary work setting in academia, 22.1% in a hospital, 43.3% in a mental health center, 32.7% in private practice, and 10.6% reported primary involvement in *other* areas (e.g., the penal system).

Design

This study was conducted using the survey method of research. Participants were mailed a list of psychotherapeutic skills (Appendix A) of which they were asked to rank order items from the most to the least useful in helping clients successfully attain positive change through psychotherapy.

Instrumentation

The survey list consisted of randomly arranged items specific to 5 therapeutic models, 3 items each, for a final 15-item survey. Item response options were representative of various therapeutic skills based on the theoretical precepts of: 1) Psychodynamic Therapy, 2) Behaviorism, 3) Humanism, 4) Cognitive Therapy, and 5) Psychopharmacology. Items were randomly sorted via Research Randomizer (1997) in an effort to detract participants from choosing items based on theoretical orientation or model preference. Items were singular in nature, neutral in the sense of not “intentionally” drawing a response, and stated as declarations, rather than questions. Respondents were asked to rank order the skills from most (#1) to least (#15) useful in bringing about positive client change with psychotherapy. To address possible instrumental weakness and insure test validity, the researcher established face validity and face reliability by having two professors of psychology at Emporia State University examine potential items and offer suggestions toward insuring items were distinct to and clustered around specific models of psychotherapy.

Procedure

An introductory cover letter (See Appendix B) describing the purpose and

nature of the study was mailed with each survey (Appendix A). Participants in the study were asked to sign an Informed Consent Document (Appendix C). Before data collection, approval for the study was obtained from the Institutional Review Board for Treatment of Human Subjects, Research and Grants Center, Emporia State University (Appendix D).

Participants were mailed a survey with instructions to rank order therapeutic skills from those they found to be most useful to those they found to be least useful in helping clients successfully attain positive change through psychotherapy. Envelopes and surveys were color specific to each group to initially attract attention of participants and aid in distinguishing groups of incoming responses. Demographic questions followed the survey and were utilized to gain a fuller description of the respondent sample (Appendix E). Participants were offered the option of being mailed a results report by submitting addresses on the demographics page. Participants were instructed to return the survey within one week of receipt using a pre-stamped, pre-addressed envelope. A reminder postcard was sent to non-respondents after the week had elapsed. Surveys returned with at least 1 item marked were included in calculations.

CHAPTER 3

RESULTS

In the spring of 2003, professionals from four groups of practitioners familiar with the practice of psychotherapy were mailed surveys (Appendix A) asking them to rank 15 skills according to usefulness in helping persons obtain positive change through psychotherapy. Professional groups included clinical psychologists (LPs), licensed clinical psychotherapists (LCPs), licensed specialist clinical social workers (LSCSWs), and psychiatrists (MDs). The item list consisted of three skills each from the psychological models of Behavioral, Cognitive, Humanistic, Psychodynamic, and Psychopharmacological Therapy. Four questions were presented for research:

1. What psychotherapeutic skills do clinical psychologists, licensed clinical psychotherapists, licensed specialist clinical social workers, and psychiatrists collectively find most useful as aiding clients in successfully attaining positive change with therapy?
2. Which psychological models are the most useful skills representative of?
3. Do different categories of professionals prefer different psychotherapeutic techniques?
4. Is pre-licensure training reflected in current practice of psychotherapists?

Statistical Analysis

Data were analyzed using the Statistical Package for the Social Sciences 11.5. To determine skills preferences of the sample of professionals as a whole and within and between groups, which models professionals preferred, and from which model

participants claimed they most often derived therapeutic skills, participant response data were computed using 4 (category of professional) X 15 (item) and 4 (category of professional) X 5 (model) crosstabulations. Based on skill item ratings, the Friedman Test was used to identify how psychological models ranked overall within groups and the Kruskal Wallace Test was used to identify if differences existed on model ranks between groups. To determine if training is reflected in current practice, the Spearman rho was implemented to identify if correlations existed between the ratings of professionals' perceived familiarity with the five models under study at the end of their academic training and ratings from which of those models they currently most often draw therapeutic techniques.

Research Question 1

Based on frequencies, the top five skills rated most useful in aiding clients to successfully attain positive change through therapy by LPs, LCPs, LSCSWs, and MDs combined were as follows:

1. The skill rated most useful by the sample was *maintain positive therapeutic relationship*. This item ranked #1 for 67 participants, 64% of the sample.
2. The second most useful skill was *acquire understanding of the person via the therapeutic relationship*. This item ranked #2 for 25 participants, 24% of the sample.
3. The third most useful skill was *be able to perceive the world as the person does*. This item ranked #2 for 16 participants, 15% of the sample.
4. The fourth most useful skill was *teach problem solving skills*. This item ranked #3 for 12 participants, 11% of the sample.

5. The fifth most useful skill was *enhance personal growth through self-exploration and goal setting*. This item ranked #4 for 15 participants, 14% of the sample.

The skills rated least useful in aiding clients to successfully attain positive change through therapy were as follows:

1. *Assist person in alleviating need for medication* rated least useful. It ranked #15 and #14. It ranked #15 by 34 participants, 33% of the sample, and ranked #14 by 22 participants, 21% of the sample.
2. *Uncover the hidden meaning of the person's overt behavior and assist person in medication management* rated second least useful. Both items ranked #14 by 15 participants, 14% of the sample each.

Research Question 2

Models of which the most useful skills were representative were determined by considering from which discipline those skills were designed based on model specific theory. Of the top five most useful skills, three were from the Humanistic model, one was from the Psychodynamic model, and one was from the Cognitive model. The most useful skill, *maintain positive therapeutic relationship*, was developed based on the precepts of the Humanistic model. The second most useful skill, *acquire understanding of the person via the therapeutic relationship*, was based on the Psychodynamic model. The third most useful skill, *be able to perceive the world as the person does*, was based on the Humanistic model. The fourth most useful skill, *teach problem solving skills*, was based on the Cognitive model. The fifth most useful skill, *enhance personal growth through self-exploration and goal setting*, was from the Humanistic model.

To observe which models offered the most useful skill techniques in general, The Friedman Test determined item ratings which were collapsed (3 items per model) to obtain mean ratings for all models (Table 1), $\chi^2(4) = 50.86, p < .001$, for LPs; $\chi^2(4) = 46.64, p < .001$, for LCPs; $\chi^2(4) = 35.54, p < .001$, for LSCSWs; and $\chi^2(4) = 18.71, p = .001$, for psychiatrists. The composite ratings were then ranked (Table 2). Models consistently ranked the same across all groups except psychiatrists. For LPs, LCPs, and LSCSWs the Humanistic model rated most useful, followed by the Cognitive, Psychodynamic, Behavioral and Psychopharmacological models, respectively. Psychiatrists also rated the Humanistic model most useful, but the Pharmacological model was rated second most useful, followed by the Cognitive, Psychodynamic, and Behavioral models, respectively. Indeed, results of the Kruskal Wallace Test confirmed no significant differences between model rankings of groups except where psychiatrists rated the Behavioral model significantly less useful, $H(3) = 8.04, p < .05$, and the Psychopharmacological model significantly more useful, $H(3) = 16.47, p < .01$.

From which models did professionals *claim* to most often draw therapeutic techniques in current practice? Crosstabulations revealed the majority of LPs (60%), LCPs (70%), and LSCSWs (74%) rated the Cognitive model as that from which they most often derive techniques, while most MDs (93%) rated the Psychopharmacological model as the one most often employed. The Behavioral and Humanistic models were ranked those of which skill techniques were least often derived. A mere 5% of the sample reported favoring the Behavioral model and only 9% of the sample reported most often drawing techniques from the Humanistic model.

Table 1

Mean Ratings of Clinical Psychologists (LP), Licensed Clinical Psychotherapists (LCP), Licensed Specialist Clinical Social Workers (LSCSW), and Psychiatrists (MD) on Usefulness of Model Specific Therapeutic Skills

	Behavioral	Cognitive	Humanistic	Psychodynamic	Psychopharmacological
LP	3.70	2.64	1.73	2.79	4.14
LCP	3.57	2.60	1.67	2.92	4.25
LSCSW	3.48	2.38	1.90	2.98	4.26
MD	4.43	2.77	2.20	3.17	2.43

Table 2

Rank Placements of Model Specific Psychotherapeutic Skills According to Clinical Psychologists (LP), Licensed Clinical Psychotherapists (LCP), Licensed Specialist Clinical Social Workers (LSCSW), and Psychiatrists (MD)

	Behavioral	Cognitive	Humanistic	Psychodynamic	Psychopharmacological
LP	4	2	1	3	5
LCP	4	2	1	3	5
LSCSW	4	2	1	3	5
MD	5	3	1	4	2

Research Question 3

Based on frequencies, the three skills each group individually rated most useful were identified and differences considered. Results were as follows:

Rank #1. Maintain positive therapeutic relationship universally ranked the most useful skill for 22 LPs (63% of group), 20 LCPs (67% of group), 16 LSCSWs (64% of group), and 9 MDs (60% of group).

Rank #2. Acquire understanding of the person via the therapeutic relationship ranked second most useful for three of four groups, specifically, 9 LPs (26% of group), 10 LCPs (33% of group), and 5 LSCSWs (20% of group). In contrast, *evaluate person for medication need* ranked second most useful for 6 MDs (40% of group).

Rank #3. The rank for third most useful skill was more varied. The only similarity was between ratings of LSCSWs and MDs. *Evaluate person for medication need* ranked third most useful for 5 LPs (15% of group). *Gain insight into person via the study of his/her environment* ranked third most useful for 5 LCPs (17% of group). *Be able to perceive the world as the person does* and *teach problem solving skills* both ranked third for 3 LSCSWs (12% of group each). Likewise, *teach problem solving skills* ranked third most useful for 4 MDs (27% of group).

Research Question 4

Using the Spearman rho, calculations were performed on participant ratings of familiarity with five models of psychology at the time they first began to practice (based on pre-licensure and academic training) and ratings of from which models they currently most often draw therapeutic techniques to observe if correlations existed

between training and practice of professionals. Where significant correlations did not exist, individual participant ratings of models after training and in current practice were summed for each group and compared to determine the nature of disagreement between training scores (TR) and practice scores (PR). Lower scores meant greater familiarity with specific models after training and/or more frequent current use of model techniques in practice.

Clinical Psychologists. Significant correlations between training and practice of LPs were found with the Behavioral model, $r(29) = .43, p < .05$ and Humanism, $r(27) = .63, p < .01$. Training was also reflected in practice with the Psychodynamic model, $r(28) = .70, p < .01$. Non-significant correlations for this group existed within the Cognitive and Psychopharmacological models with correlations of .18 and .25, respectively. The TR for the Cognitive model was 75 with a PR of 57 and the TR for the Psychopharmacological model was 144 with a PR of 118, indicating training was lacking compared to current use of these models.

Licensed Clinical Psychotherapists. A significant correlation existed between training and practice in Humanism for LCPs, $r(26) = .44, p < .01$. Non-significant correlations were observed within the Behavioral, Cognitive, Psychodynamic, and Psychopharmacological models with correlations of .34, .34, .32, and .32, respectively. The TR for the Behavioral model was 70 with a PR of 87 and the TR for the Psychodynamic model was 93 with a PR of 107, indicating training was not reflected in current practice. The TR for the Cognitive model was 73 with a PR of 45 and the TR

for the Psychopharmacological model was 140 with a PR of 110, indicating training was lacking compared to current use of these models.

Licensed Specialist Clinical Social Workers. A significant correlation between training and practice for LSCSWs was found in Humanism, $r(17) = .48, p < .05$. Non-significant correlations for this group were found within the Behavioral, Cognitive, Psychodynamic, and Psychopharmacological models with correlations of .08, .34, .14, and .25, respectively. The TR for the Behavioral model was 48 with a PR of 63 and the TR for the Psychodynamic model was 61 with a PR of 80, indicating training was not reflected in current practice. The TR for the Cognitive model was 55 with a PR of 32 and the TR for the Psychopharmacological model was 89 with a PR of 72, indicating training was lacking compared with current use of these models.

Psychiatrists. Significant correlations were found between training and practice of MDs within the Behavioral model, $r(7) = .77, p < .05$, and the Cognitive model, $r(8) = .82, p < .05$. This group had non-significant correlations within the Humanistic, Psychodynamic, and Psychopharmacological models with correlations of .34, .60, and .21, respectively. The TR for the Humanistic model was 62 with a PR of 46 and the TR for the Psychopharmacological model was 26 with a PR of 18, indicating training was lacking compared with current use. The TR for the Psychodynamic model was 37 with a PR of 47, indicating training was not reflected in current practice.

In summary, LCPs and LSCSWs expressed greater familiarity with the Behavioral model after training and less utilization of the model's techniques in current practice, when ranked among five models offered. Behavioral training was reflected in

practice of LPs and MDs. In contrast, LPs, LCPs, and LSCSWs expressed greater use of the Cognitive model in practice and less familiarity with the model after training. Cognitive training was reflected in practice of MDs. Regarding the Humanistic model, training was reflected in practice of all groups except MDs. Psychiatrists expressed greater use of the Humanistic model in practice than familiarity with the model after training. All groups except LPs expressed more familiarity with the Psychodynamic model after training and less utilization of the model in current practice. All groups expressed less familiarity with the Psychopharmacological model after training than use of the model in practice. This result was surprising concerning MDs whom, one might expect, would receive extensive pharmacological training. Upon closer inspection of data, the researcher found that the offset was due to some MDs rating more familiarity with models other than the Psychopharmacological model when they first began to practice. For example, 33% of the group rated the Cognitive model and 20% rated the Behavioral model as those among which they were *most* familiar after training.

CHAPTER 4

DISCUSSION

Research Question 1

It speaks to the current condition of psychology's attempt to be an objective science that the two most highly rated psychotherapeutic skills involve human relationships and the third most useful skill is a therapist possessing an ability to perceive the world as the client does. Of the top five rated techniques, perhaps clinical outcomes from the Cognitive skill of teaching problem solving can best be scientifically measured. Yet, it only ranked fourth and just behind it in fifth place was the technique of enhancing personal growth through self-exploration and goal setting. Can phenomena of human relationships, perceiving the world as someone else does, and self-exploration be scientifically defined and measured *objectively*? Apparently, Harmon's (1962) assertion that scientific psychology leaves out the "inner man" as a focus of research and treatment is truer of research than treatment when it comes to psychotherapy. This may help to explain Bachar's (1998) finding that psychotherapy is a useful tool. In this era of scientific psychology, perhaps people really do receive "inner healing" with the help of therapists continuing to practice techniques rooted in Humanism.

The job security of psychiatrists seems in tact considering the recent push of health care providers to place mental health care ultimately under the control of psychiatrists (Stone, 1995), and, the findings of this study that the majority of

professionals viewed alleviating a client's need for medication as the worst thing a therapist could attempt to do compared with 14 other skill choices that were offered.

Research Question 2

Based on the ratings of clinical psychologists (LPs), licensed clinical psychotherapists (LCPs), licensed specialist clinical social workers (LSCSWs), and psychiatrists (MDs) in the state of Kansas, of five models studied, the Humanistic model offers the most useful skill techniques in aiding clients to successfully attain positive change through psychotherapy. Even medically trained psychiatrists, whose main psychotherapeutic function is medication management (Aldrich, 1993), rated the humanistic concept of a positive therapeutic relationship as most conducive to successful therapy. Yet, less than 10% of professionals claimed the Humanistic model as their main source of skill technique. Reflecting current trends reported by Robins, Gosling, and Craik (1998), the Cognitive model was *perceived* by the majority of professionals to be the model of choice. In essence, in spite of the current push to mold psychology into a more objective, scientific discipline (Richardson, Fowers, & Guignon, 1999), and despite what they *think* they practice, according to professionals in the state of Kansas, it is the Humanistic model that offers the most useful techniques to promote positive outcomes with psychotherapy.

Although they were not the highest rated skills, the Cognitive techniques of teaching problem solving and replacing negative thoughts with positive thoughts were both found to be useful. Similarly, the influence of Sigmund Freud as reported by Kanekar (2001) and Newstead (1983) must not be ignored as professionals ranked

skills based on the Psychodynamic model as third most useful for bringing about positive change in clients. The findings of Robins, Gosling, and Craik (1998) that behavioral methods are still utilized in psychotherapy were not well supported by this study, as the Behavioral model ranked next to last for LPs, LCPs, and LSCSWs, and least useful for MDs.

There were conflicting results involving the Psychopharmacological model. While LPs rated assessing clients for medication need as the third most useful skill they employ and the sample collectively rated alleviating a client's need for medication as the least useful skill, assisting the client with medication management rated second least useful overall. Furthermore, consistently, the Pharmacological model ranked least useful for LPs, LCPs, and LSCSWs. This conflict warrants further research. Obviously, based on the findings of this study, doctoral-level practitioners utilize aspects of the model, but do LPs, LCPs, and LSCSWs find drug therapy "useful" or do they simply tolerate it because they have no choice with the prominence of pharmacology as a therapeutic tool in modern mental health treatment? Do non-medical practitioners neglect to rate Psychopharmacology higher in model ranks due to lack of confidence in this area or, perhaps, a lack of credentialing to exercise control of client medicinal use?

Research Question 3

Despite differences in professional disciplines, there were more commonalities in skill preferences of practitioners than might have been anticipated. Ratings of all four professional groups agreed that a positive therapist/client relationship is the most helpful therapeutic tool of 15 choices, and, ratings agreed that learning from the

process of that relationship is the second most useful tool for three of four groups.

Regarding pharmacy, LPs and MDs alike valued assessment for medication need as an important part of therapy, and LCSWs and MDs agreed that teaching problem solving skills is a highly useful technique. However, some rating differences did exist. For example, LCPs may be more inclined to learn about a client by studying his/her environment than other groups, while LCSWs may more often attempt to perceive the world as the client does to promote successful therapy.

As clinical psychologists considered evaluating a client for medication need the third most useful skill they employ (MDs rated it second most useful), perhaps the question is not whether or not clinical psychologists *should* prescribe, but rather, how soon it can happen. Aside from helping to secure psychologists' place among treatment competitors, prescribing privileges would allow psychologists to treat illnesses in need of medication that they are, evidently, already diagnosing. Perhaps the greatest obstacle to psychologists obtaining in depth pharmaceutical training and prescribing privileges is based less on their lack of general knowledge of medicine, as described by Pies (1991), than it is on the maintenance of power and privilege currently held by doctors of medicine.

Research Question 4

Based on discrepancies between training and practice of professional groups surveyed for this study, suggestions are offered toward the improvement of academic training for mental health professionals. For example, of the purely psychological models offered (Psychopharmacology excluded), Behaviorism fared so poorly in

ratings one could ponder why B-Mod courses are still even offered, let alone required by some institutions. Behavioral courses might be replaced with Cognitive courses, as three of four groups expressed a lack of Cognitive training compared to current use of the model. Interestingly, Humanistic training was reflected in practice of all groups of professionals except psychiatrists. They reported a lack of training compared to current use of the model. Thus, schools of medicine would serve their students of psychiatry well to provide courses in Humanistic theory and practical training in Humanistic technique. In contrast, three of four groups expressed more familiarity with the Psychodynamic model than use of Psychodynamic technique in practice. Yet, the model ranked third for overall usefulness. Therefore, while the value of the model must not be denied, these findings suggest an overabundance of curriculum in Psychoanalytic theory, which may attest to the lingering influence of the model's founder, Sigmund Freud.

Of five models studied, Psychopharmacology is the only one professionals collectively expressed a lack of training in compared to current use. Apparently, academic institutions have yet to catch up their curriculum with the current use of medication as a psychotherapeutic tool in the field. In the end, it is psychotherapeutic clients who suffer a loss due to psychotherapists being expected to incorporate pharmacology in practice, while they lack access to in depth pharmacological training and credibility. Furthermore, is it not indeed imperative to the well-being of society that persons in need of mental health treatment receive the best possible care?

This study would be enriched with the inclusion of an open-end question of

professionals requesting their views on how psychotherapy might be improved and in what direction they see the field moving. For instance, addressing issues of religion and spirituality were mentioned on surveys as useful aspects of effective therapy, although they were not included as skill items.

Conclusion

Results of this study support the assertion of Humphreys (1996) that psychologists need to re-envision training and practice of clinical psychologists if they wish to keep up in a competitive treatment market. For example, results showed therapeutic techniques of the Humanistic model are more beneficial to promoting positive change in clients, compared to four other prominent treatment models. However, in the field, few practitioners claimed to adhere to the model. One problem is the lack of a clear-cut method of defining Humanistic concepts in scientifically acceptable, objective terms, thereby, Humanistic practices are harder to “justify” to the scientific community and health care payers. Still, in the best interest of mental health clients and society in general, is it not crucial that treatment providers recognize and expand on what works best in improving a human experience, whether or not it fits the mold of traditional science? For instance, one could ponder the positive impact for addiction treatment if commonly utilized Behavioral, or more recent Cognitive-Behavioral, treatment programs were replaced with Humanistic techniques, considering alcoholics’ low response rate to professional treatment reported by Emrick (1987), and the findings of this study that Behaviorism is one of the least favored psychotherapeutic models for bringing about positive change in clients.

Perhaps the best competitive edge psychologists could secure for themselves among treatment providers would be to perfect the “art” of psychotherapy. If psychological researchers would spend less time on striving for scientific treatment method and more time on the scientific measurement of positive outcomes brought about with Humanistic therapy, perhaps psychologists could better defend the treatment of “inner man” with less pressure to conform to hard science. For instance, this study could be repeated with consumers of psychotherapy as the sample to obtain their views on which of the 15 skill items they find most useful. After all, beyond the hubbub of the science vs. philosophy debate, in the long run, people will seek out and purchase what best fills their needs. Ultimately, it is consumers of a product who determine its market value.

Some might argue that without justifiable scientific methodology, psychotherapy is no different than, for example, talking to a friend. Admittedly, most people probably do feel a sense of relief just by telling someone about their problems. However, it can also be argued that there is a considerable difference in feeling better for the moment after expressing problems to a friend and actual treatment of those problems by a trained professional. Why should psychologists accept a professional disposition “less than” physicians simply because they treat unobservable phenomena, rather than the physical body? Are human mind, emotion, and relationship less important than physical conditions in determining quality of human life? Based on the results of this study, Humanism is important to bringing about positive change in clients of practitioners in the fields of psychology and social work, as well as medicine.

REFERENCES

- Aldrich, C. K. (1993). Psychiatry in 2001. *Family Practice*, 37, 323-328.
- American Board of Psychiatry and Neurology, Inc. (2002). *What is an ABPN Board-Certified Psychiatrist?* Retrieved July 24, 2003, from <http://www.abpn.com>
- American Psychological Association (2002). *About clinical psychology*. Retrieved July 24, 2002, from <http://www.apa.org/divisions/div12/about.shtml>
- Bachar, E. (1998). Psychotherapy--an active agent: Assessing the effectiveness of psychotherapy and its curative factors. *Israel Journal of Psychiatry and Related Sciences*, 35, 128-135.
- Ban, T. A. (2001 May). Pharmacotherapy of mental illness--a historical analysis. *Progressive Neuropsychopharmacol Biological Psychiatry*, 25, 709-727.
- Bibeau, T. (1994, May). The dark side of psychiatric drugs. *USA Today (Magazine)*, 122, 44.
- Bohart, A. C. (1995). The person centered therapies. In A. S. Gurman & S. B. Messer (Eds.), *Essential psychotherapies* (pp. 85-127). New York: The Guilford Press.
- Bohart, A. C., & Tallman, K. (1996). The active client: Therapy as self-help. *The Journal of Humanistic Psychology*, 36, 7-31.
- Dewan, M. J. (1992). Adding medications to ongoing psychotherapy: Indications and pitfalls. *American Journal of Psychotherapy*, 46, 102-110.
- Dilman, I. (1994). Ten answers for psychoanalysis. *Philosophy*, 69, 353-364.
- Druck, A. (1989). *Four therapeutic approaches to the borderline patient: Principles and techniques of the basic dynamic stances*. Northvale, NJ: Jason Aronson.

- Emrick, C. D. (1987). Alcoholics anonymous: Affiliation processes and effectiveness as treatment. *Alcoholism: Clinical and Experimental Research, 11*, 416-423.
- Freeman, A., & Reinecke, M. (1995). Cognitive therapy. In A. S. Gurman & S. B. Messer (Eds.), *Essential psychotherapies* (pp. 182-225). New York: The Guilford Press.
- French, L. (1987). Victimization of the mentally ill: an unintended consequence of deinstitutionalization. *Social Work, 32*, 502-505.
- Harman, W. W. (1962). The humanities in an age of science. *Main Currents in Modern Thought, 18*, 75-83.
- Healy, D. (2002). *The creation of psychopharmacology*. Cambridge, MA: Harvard University Press.
- Holinger, P.C. (1989). A developmental perspective on psychotherapy and psychoanalysis. *American Journal of Psychiatry, 146*, 1404-1423.
- Horvarth, P. (1987). Demonstrating therapeutic validity versus the false placebo-therapy distinction. *Psychotherapy: Theory, Research, Practice, Training, 24*, 47-51.
- Humphreys, K. (1996). clinical psychologists as psychotherapists: history, future, and alternatives. *American Psychology, 51*, 190-197.
- Illinois Self-Help Coalition (FAQ) (2001). Retrieved January 25, 2003, from <http://www.selfhelp-illinois.org/faq.html>
- Jacobs, M. (2000). Psychotherapy in the United Kingdom: Past, present, and future. *British Journal of Guidance and Counseling, 28*, 451-466.

- Johnson, E. L., & Sandage, S. J. (1999). A postmodern reconstruction of psychotherapy: Orienteering, religion, and the healing of the soul. *Psychotherapy: Theory, Research, Practice, Training, 36*, 1-15.
- Jones, J. V., & Lyddon, W. J. (2000). Cognitive therapy and empirically validated treatments. *Journal of Cognitive Psychotherapy, 14*, 337-345.
- Kanekar, S. (2001). Fin-de-siecle ranking of important psychologists by a sample of undergraduate students enrolled in history of psychology. *Psychological Reports, 89*, 650.
- Kansas Behavioral Sciences Regulatory Board (2002). Retrieved December 14, 2002, from <http://www.ksbsrb.org>
- Kansas State Board of Healing Arts (2002). Retrieved January 25, 2003, from <http://www.ksbha.org>
- Kelley, P. (1995). Integrating narrative approaches into clinical curricula: addressing diversity through understanding. *Journal of Social Work Education, 31*, 347-357.
- Kendall K. C., & Hammen, C. (Eds.) (1998). *Abnormal psychology: Understanding human problems* (2nd ed.). New York: Houghton Mifflin Company.
- Knaudt, P. R., Conner, K. M., & Weisler, R. H. (1999). More research needed to determine effectiveness of alternative therapies. *Outcomes & Accountability Alert, 4*, 7.
- Lazar, S. G. (1997). Epidemiology of mental illness in the United States: An overview of the cost effectiveness of psychotherapy for certain patient populations.

Psychoanalytic Inquiry, 4-16.

Le Figaro (1992). Retrieved January 25, 2003, from

www.maudkristen.com/lefigaro1.htm

Lieberman, F. (1987). Psychotherapy and the clinical social worker. *American Journal of Psychotherapy*, 41, 369-383.

Lindfors, O., Hannula, J., Aalberg, V., Kaarento, K., Kairainen, M., & Pylkkaenen, K. (1995). Assessment of the effectiveness of psychotherapy. *Psychiatria Fennica* 26, 150-164.

Mahoney, M. (1991). *Human change processes*. New York: Basic Books.

Malony, H. N. (1998). Counseling body/soul persons. *International Journal for the Psychology of Religion*, 8, 221-242.

Mann, R. L. (1998). *Sacred healing: Integrating spirituality with psychotherapy*. Nevada City, CA: Blue Dolphin Publishing, Inc.

Mentally ill not warned about drug side-effects (2001). *The Lancet*, 358, 1076.

Mills, N. (1995 Summer). Technology and culture. *Social Research*, 4, 1119-1126.

Moore, F. (2002, November 27). Putting Freud on the couch: There's no escaping influence of the father of psychoanalysis. *The Associated Press*, p. C5.

Moriarty, K., Alagna, S., & Lake, R. (1984). Psychopharmacology: An historical perspective. *Psychiatric Clinics of North America*, 7, 411-433.

Moss, M.E. (1992). Sigmund Freud. *Great Thinkers of the Western World*, 414-420.

National Association of Social Workers (2002). *Professional development*. Retrieved August 8, 2002, from <http://www.naswdc.org>

National Coalition on Health Care and Institute for Healthcare Improvement (1998).

Improvement of health care with best practice. Retrieved January 26, 2003,
from http://kuuc.chair.ulaval.ca/english/fiche_pratiques.php?idPratique=12

Newstead, S. E. (1983). Perceived importance of famous psychologists. *Bulletin of the British Psychological Society*, 36, 239-241.

Phares, E. J., & Trull, T. J. (1997). *Clinical psychology* (5th ed.). Pacific Grove, CA: Brooks/Cole Publishing Company.

Pies, R. W. (1991). The “deep structure” of clinical medicine and prescribing privileges for psychologists. *The Journal of Clinical Psychology*, 52, 4-8.

Plato (1961). Socrates' defense (apology). In E. Hamilton & H. Cairns (Eds.), *The complete dialogues of Plato* (p. 15). Princeton: Princeton University Press.

Reed, J. (1989). Mechanical man: John Broadus Watson and the beginnings of behaviorism. *Science*, 244, 1386-1388.

Research Randomizer (1997). Retrieved January 26, 2003, from <http://www.randomizer.org>

Resnick, R. J. (1997). A brief history of practice--expanded. *American Psychologist*, 52, 463-468.

Richardson, F. C., Fowers, B. J., & Guignon, C. B. (1999). *Re-envisioning psychology: Moral dimensions of theory and practice*. San Francisco: Jossey Bass Inc..

Robins, R. W., Gosling, S. D., & Craik, K. H. (1998). Psychological science at the

crossroads. *American Scientist*, 310-313.

Rodenhauser, P. (1992). Psychiatry residency programs: trends in psychotherapy supervision. *American Journal of Psychotherapy*, 46, 240-249.

Sabin, J. E. (1995). Psychotherapy and managed care (part 1). *Harvard Mental Health Letter*, 11, 4-8.

Sammons, M. T., Sexton, J. L., & Meredith, J. M. (1996). Basic science training in psychopharmacology. How much is enough? *The American Psychologist*, 51, 230-234.

Sandler, J. (1988). Psychoanalytic technique and "analysis terminable and interminable." *International Journal of Psychoanalysis*, 69, 335-345.

Seligman, M. E. (1995). The effectiveness of psychotherapy: The Consumer Reports study. *American Psychologist*, 50, 965-974.

Seligman, M. E., & Levant, R. F. (1998). Managed care policies rely on inadequate science. *Professional Psychology: Research and Practice*, 29, 211-212.

Shilo, A. M. (1995). The relationship of personal orientation to individualism-collectivism, gender, and age to preference for an individual or collective approach in counseling. *Dissertation Abstracts International Section A: Humanities and Social Sciences*, 551 (7-A), 1832.

Siepmann, M., & Kirch, W. (2001). Psychopharmacotherapy in the 20th century. *Wien Med Wochenschr*, 151, 397-402.

Sneider, W. (1990). The prehistory of psychotherapeutic agents. *Journal of Psychopharmacology*, 4, 115-119.

- Stone, A. A. (1995). Psychotherapy and managed care: the bigger picture. *Harvard Mental Health Letter*, 11, 5-8.
- Stone, E. (1992). Off the couch. *New York Times Magazine*, 142 (December 6), pp. 50, 52-53, 78-79.
- Szasz, T. (1998a). Discretion as power: In the situation called "psychotherapy." *British Journal of Psychotherapy*, 15, 216-228.
- Szasz, T. (1998b). The healing word: its past, present, and future. *The Journal of Humanistic Psychology*, 38, 8-13.
- University of California (December 2000). *Psychopharmacology Update*, 11, 4.
- University of Kansas (2002). *The required courses*. Retrieved January 26, 2003, from www.psych.ukans.edu/clinical_psychology.htm
- Wallerstein, R. S. (1991, Fall). The future of psychotherapy. *Bulletin Menninger Clinic*, 55, 421-423.
- Watson, J. B. (1913). Psychology as a behaviorist views it. *Psychological Review*, 20, 158-177.
- What is a psychologist? (2002). *Psychological Networks*. Retrieved December 8, 2002, <http://www.psychnetworks.com/psychol.html>
- Wolitzky, D. L. (1995). The theory and practice of traditional psychoanalytic psychotherapy. In A. S. Gurman & S. B. Messer (Eds.), *Essential psychotherapies* (pp. 12-54). New York: The Guilford Press.
- Wood, S., Belar, C. D., & Snibbe, J. (1998). A comparison of computer-assisted psychotherapy and cognitive-behavioral therapy in groups. *Journal of Clinical Psychology in Medical Settings*, 5, 103-115.

APPENDICES

- A. Survey
- B. Cover Letter
- C. Informed Consent Document
- D. Approval to Use Human Subjects
- E. Demographics Page

Appendix A: Survey

Instructions: Based on your experience in the field, please rate the following therapeutic skills from those which you have observed to be most useful to those that are least useful in helping clients/patients to attain positive change with psychotherapy. Rank the most useful skill as 1, following numerical order to the least useful skill which will be ranked 15. Consider every item before beginning to mark rankings.

- ___ maintain positive therapeutic relationship
- ___ teach person to emulate behavior that is desirable in others
- ___ use homework assignments to change behaviors
- ___ be able to perceive the world as the person does
- ___ provide insight toward resolution of inner conflict
- ___ assist person in alleviating need for medication
- ___ enhance personal growth through self-exploration and goal setting
- ___ evaluate person for medication need
- ___ uncover the hidden meaning of the person's overt behavior
- ___ teach problem solving skills
- ___ replace negative thoughts with positive thoughts
- ___ gain insight into person via the study of his/her environment
- ___ acquire understanding of the person via the therapeutic relationship
- ___ guide person to resolution by questioning person
- ___ assist person in medication maintenance

Appendix B: Cover Letter

Hello,

My name is Carla Wade, a graduate student at Emporia State University, Emporia, Kansas. For my master's degree in clinical psychology, I am conducting a study designed to obtain your views regarding various therapeutic skills. Results from this study will be used to analyze the practices of professionals involved in mental health treatment.

I will greatly appreciate it if you take the time to complete the survey and return it in the enclosed stamped, self-addressed envelope at your earliest convenience, no later than April 18, 2003. Your participation should only take about 15 minutes. You may obtain results from this study by providing an address in the space provided at the end of the survey. Your identity will be kept strictly confidential. If you have questions, please feel free to contact me at cjpsych@sctelcom.net. My thesis supervisor is Ken Weaver and his contact information is (620)341-5552 or weaverke@emporia.edu. Thank you so much for your time and your contribution.

Sincerely,

Carla J. Wade

Appendix C: Informed Consent Document

The Department of Psychology and Special Education at Emporia State University supports the practice of protection for human subjects participating in research and related activities. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time, and that if you do withdraw from the study, you will not be subjected to reprimand or any other form of reproach.

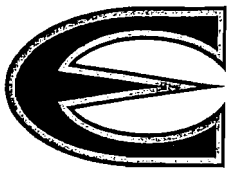
In this study you will be asked to rate therapeutic skills used in psychotherapy. Following this, you will be asked to complete some demographic questions about yourself. Participation should take no more than 15 minutes of your time. If you would like a copy of the results, please include an address on the space provided following the demographic questions. Any personal information obtained from you will be kept strictly confidential.

“I have read the above statement and have been fully advised of the procedures to be used in this project. I have been given sufficient opportunity to ask any questions I had concerning the procedures and possible risks involved. I understand the potential risks involved and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time without being subjected to reproach.”

Participant signature: _____

Date: _____

Appendix D: Approval to Use Human Subjects

**EMPORIA STATE UNIVERSITY**1200 Commercial
Emporia, Kansas
66801-5087620-341-5351
620-341-5909 fax
www.emporia.eduGRADUATE STUDIES AND RESEARCH
RESEARCH AND GRANTS CENTER
Campus Box 400

March 31, 2003

Carla Wade
4920 E Morris
Wichita, KS 67218

Dear Ms. Wade:

Your application for approval to use human subjects, entitled "Psychotherapeutic Skills Preferences of Licensed Psychologists, Licensed Clinical Psychotherapists, Lincensed Specialist Clinical Social Workers, and Psychiatrists," has been reviewed. I am pleased to inform you that your application was approved and you may begin your research as outlined in your application materials.

On behalf of the Institutional Review Board, I wish you success with your research project. If I can help you in any way, do not hesitate to contact me.

Sincerely,

Bill Stinson, Chair
Institutional Review Board for Treatment
of Human Subjects

pf

Appendix E: Demographics Page

Thank you for your participation in this project. Having ranked the items on the previous page, please take a moment to provide the following demographic information:

1) Age: _____

2) Sex: ___ Male ___ Female

3) Academic level: ___ master's ___ doctorate

4) Year of university graduation at current academic level: _____

5) Length of time in practice: _____

6) Setting where you primarily work (check all that apply):

- Academic
- Hospital
- Mental Health Center
- Private practice
- Other (specify) _____

7) Based on your pre-licensure academic and practical training, consider which psychological models you were familiar with when you first began to practice. Rank the following models according to which you believe you were *most* familiar with at that time, with 1 being the model of which you received the *most* exposure.

- Behavioral
- Cognitive
- Humanistic
- Psychodynamic
- Psychopharmacological
- Other (specify) _____

8) Based on your current practice, rank the following models according to which you *most often* draw your current therapeutic techniques, with 1 being the *most* influential.

- Behavioral
- Cognitive
- Humanistic
- Psychodynamic
- Psychopharmacological
- Other (specify) _____

* If you would like a copy of the results of this study, please give an address where you would like them

to be mailed.

e-mail: _____

Permission to Copy Page

I, Carla J. Wade, hereby submit this thesis to Emporia State University as partial fulfillment of the requirements for an advanced degree. I agree that the Library of the University may make it available for use in accordance with its regulations governing materials of this type. I further agree that quoting, photocopying, or other reproduction of this document is allowed for private study, scholarship (including teaching) and research purposes of a nonprofit nature. No copying which involves potential financial gain will be allowed without written permission of the author.

Carla J. Wade

Signature of Author

August 20, 2003

Date

**Psychotherapeutic Skill Preferences of Clinical
Psychologists, Licensed Clinical Psychotherapists,
Licensed Specialist Clinical Social Workers, and
Psychiatrists**

Title of Thesis

Loy Cooper

Signature of Graduate Office Staff Member

original