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A SELF-ADMINISTERED INSTRUMENT FOR ASSESSING THERAPEUTIC APPROACHES OF DRUG-USER TREATMENT COUNSELORS

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ABSTRACT

In this article we describe the development and psychometric properties of a self-administered instrument for assessing drug-user treatment counselors' therapeutic approaches such as psychodynamic or interpersonal, cognitive-behavioral, family systems or dynamics, 12-step, and case management. We generated an initial pool of items corresponding to these five approaches and modified them based on expert ratings. We developed three sets of items. The first concerned the beliefs underlying each therapeutic approach. The second and third concerned the practices of each applicable approach within individual and group counseling, respectively. With the exception of case management, an approach that originated

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within social work and which is only applicable to individual counseling, the other four approaches are applicable, at least theoretically, to both individual and group counseling. Additionally, we included items that describe techniques used exclusively with groups (i.e., group techniques). Finally, we included some items that are not associated with any of the traditional approaches but which reflect the practical approach that drug-user treatment programs often take to both individual and group counseling (i.e., practical counseling). The initial instrument consisted of 17 subscales with a total of 76 items. This instrument was administered to 226 counselors from 45 drug-user treatment programs in Los Angeles County. Based on this data, we further refined these scales using confirmatory factor analysis to ensure both construct validity and discriminant validity. The final instrument consisted of 14 subscales with a total of 48 items.

Key Words: Therapeutic approaches; Counselors; Drug misuse; Construct validity; Reliability.

INTRODUCTION

The evaluation of treatment for substance misuse has traditionally focused on structural characteristics (e.g., modality and treatment length) and on client characteristics (e.g., demographics and drug use history). Although counseling is the major, and frequently the only, regimen within most treatment programs (McLellan, Woody, Luborsky, and Goehl, 1988; Hubbard et al., 1989), there has been relatively little research concerning the characteristics and practices of counselors (Hagman, 1994; Hser, 1995). The limited body of existing research focuses primarily on counselor demographic characteristics such as gender, age, and ethnicity (Hall, Hall and Sirin, 1996; Russell et al., 1996), personality characteristics such as self-efficacy and empathy (Carozzi, Bull, Eells, and Hurlburt, 1995), and sex-role attitudes (Schor, 1982). There is surprisingly little research concerning the assessment of therapeutic approaches of counselors in this field. Consequently, most of our current knowledge about therapeutic style and approach comes from literature on psychotherapy, psychological counseling, and social work. Because counselors are critical elements in drug user treatment, it is important to gain an understanding of their therapeutic beliefs and practices. Thus, the development of an instrument to assess

therapeutic beliefs and practices is crucial to the development of research focused on substance-misuser treatment and counselors.

Finney, Moos, and Humphreys (1999) studied two therapeutic approaches—cognitive-behavioral and 12-step—and evaluated the relationship between the proximal outcomes specified by these two approaches and the ultimate substance use outcomes. They observed that the modest cross-sectional relationships between these two sets of outcomes suggest that the theories on which 12-step and cognitive-behavioral substance-misuser treatments are based are not sufficiently comprehensive. The findings of this study suggest that assessment of therapeutic approaches is an important aspect of treatment evaluation.

The purpose of this study was to develop a self-report instrument for assessing drug-user treatment counselors' therapeutic approaches. We developed this instrument as part of a larger effort examining the effects of a wide variety of counselor characteristics, beliefs, attitudes, and behaviors on treatment effectiveness within drug-user treatment settings. Although our instrument cannot provide an objective measure of actual counseling behavior, it does represent an important first step in understanding the nature of drug-user treatment counseling.

Therapist Style Versus Therapeutic Approach

Einstein (1986) proposed that theoretically, at least, each therapy can be practiced in a variety of styles and manners depending on the goals, patient population, therapeutic parameters, and program policies. Beutler, Machado, and Neufeldt (1994) commented that it is important to differentiate between "therapist style" and "therapeutic approach" when evaluating the effects of counselors on treatment outcomes. Following Beutler and colleagues, we define therapist style as relatively idiosyncratic counselor characteristics and the fit between counselor and client. We define therapeutic approach, on the other hand, as the relatively formal characteristics associated with traditional schools of psychotherapy, psychology, or social work. In this study, our focus was on therapeutic approach. Therefore, in our instrument development, we generated items that corresponded to formal therapeutic approaches and to those commonly applied in substance-misuser treatment. In the next section, we briefly describe the six formal approaches that we assessed and their relevance to substance misuser counseling.

Therapeutic Approaches

Because so little is known about drug-user treatment counselors' therapeutic approaches, we generated a pool of items that described psychotherapeutic beliefs and techniques. We describe our item generation method in the "Method and Results" section that follows. We included items representing only the most commonly used approaches. These are: (a) the psychodynamic or interpersonal approach, (b) the cognitive-behavioral approach, and (c) the family systems or dynamics approach (Bongar and Beutler, 1995; Nystul, 1993). We also included items pertaining to the 12-step approach. This approach has its origins in alcoholic self-help groups but has spread to the larger substance-misuser treatment community. All four approaches (i.e., psychodynamic, cognitive-behavioral, family systems, and 12-step) are applicable, at least theoretically, to both individual and group counseling.

We also developed items that pertain to case management, an approach that originated within social work and one that is only applicable to individual counseling. Additionally, we included items that describe techniques used exclusively with groups (i.e., group techniques). Other researchers seeking to describe the substance misuser counselors' treatment styles have used similar taxonomies (e.g., Davidge and Forman, 1988; Rotgers, Keller, and Morgenstern, 1996).

Psychodynamic Approach

The psychodynamic approach is actually a set of approaches that are generally concerned with unconscious processes that motivate thought and behavior (Freud, 1924). Some psychodynamic theorists view substance misuse as the result of unresolved, and usually unconscious, conflicts (e.g., Leeds and Morgenstern, 1996; Levin, 1995; Wurmser, 1995) or as a defense mechanism (McDougall, 1989; Miller, 1994). Our initial item pool included items that concerned both defenses and unconscious motivation.

Cognitive-Behavioral Approach

The cognitive-behavioral approach makes use of techniques that derive from two models of human behavior: the behavioral model and the cognitive model. Although counselors need not practice cognitive and behavioral techniques in conjunction, they frequently do. Many researchers have proposed that cognitive-behavioral techniques are well-suited to

substance misuse counseling (e.g., Miller and Hester, 1986; Morgan, 1996). For instance, Lovejoy and colleagues (1995) reported that cocaine misusers benefit from the highly structured nature of cognitive-behavioral techniques. In this study, we assessed cognitive-behavioral orientation by determining if counselors teach their clients cognitive and behavioral skills for avoiding drug use situations that are high-risk situations.

Family Systems Approach

Family system theorists argue that psychological distress is frequently rooted in familial problems (Clarkin and Carpenter, 1995; Kaslow and Celano, 1995). For this reason, family systems therapists argue that it is more effective to treat the entire immediate family rather than just the "identified patient" (e.g., McKay, 1996). There is some evidence that family therapy may be an effective form of substance misuser counseling. For example, family therapy has both relatively high retention (Liddle and Dakof, 1995) and compliance (McCrady and Epstein, 1996) rates among substance misusers. As with psychodynamic therapy, there are multiple approaches to family therapy. In our study, we did not assess the degree to which counselors advocate any particular approach to family counseling. Our focus was to assess the extent to which counselors engage family members in general.

12-Step Approach

The 12-step approach derives from the techniques espoused by Alcoholics Anonymous (AA). Not only do many substance misuser treatment programs encourage their clients to participate in 12-step meetings, but many programs have also incorporated the tenets of this approach into their practices (Nowinski, 1996; Wallace, 1996). The hallmarks of the 12-step approach are the beliefs that: (1) substance misusers are powerless over alcohol and/or other drugs, (2) substance misusers learn by listening to the experiences of other substance misusers, (3) recovery from substance misuse can only be achieved through total abstinence, and (4) recovery occurs through spiritual growth (Wallace, 1996). Although in wide use by drug-user treatment counselors, there is scant literature on how the 12-step approach is actually incorporated into drug treatment counseling.

Case Management Approach

Case management is a far more proactive approach than are the other approaches. According to Godley, Godley, Pratt, and Wallace (1994), case management is comprised of six integral functions: (a) assessment, (b) planning, (c) linking (e.g., referring clients to community resources), (d) monitoring, (e) advocacy (e.g., representing clients' needs to governmental and community agencies), and (f) support (e.g., provision of concrete services such as food stamps). In our instrument, we measure the extent to which counselors provide such case management services for their clients.

Group Techniques

This approach is characterized by interactions among group members, as well as, between clients and counselors. Counselors interpret group process (i.e., the interactions among group members) as indicative of clients' habitual interpersonal styles. Within counselor prescribed guidelines and limits, client group members provide feedback to each other regarding the acceptability of behavior and accuracy of social perceptions. Groups within substance-misuser treatment programs sometimes address highly specific issues such as anger management and bereavement. The majority of these groups, however, focus on how clients handle interpersonal problems. This focus on interpersonal issues developed because many practitioners have come to believe that much of substance misuse is rooted in interpersonal deficits (Khantzian, Golden, and McAuliffe, 1996).

There were two phases of instrument development: item generation and scale refinement. Therefore, we present separate sections on the methods and results for each of these two phases.

METHOD AND RESULTS: ITEM GENERATION PHASE

A clinical psychologist knowledgeable about drug-user treatment wrote brief descriptions of the three major psychotherapy approaches (i.e., psychodynamic, cognitive-behavior, and family systems), the 12-step model, and group techniques. An experienced social worker wrote the description of the case management approach. For each therapeutic approach, we generated three sets of items—one for beliefs, one for practices in individual counseling, and one for practices in group counseling. Because case management is, as described above, an exclusively individual approach, there were no group practice items for case management. Similarly, there

were no individual practice items for group techniques. Finally, counselors in the pretest suggested that we add several items. Although none of these are specific to any of the six approaches, they do reflect the practical approach that drug-user treatment programs often take to both individual and group counseling. Using these items we formed scales for measuring practical counseling in individual and group settings.

A panel of 13 nationally recognized experts in drug misuser treatment and psychotherapy who published extensively in this area of research rated each of the resulting 74 items. Using a 5-point Likert scale, the experts rated each for the degree to which it was associated with the six approaches and practical counseling. Using these ratings we eliminated items that were not good indicators of an approach. Additionally, we adopted several items that panel members suggested. The final first phase instrument consisted of a total of 76 items. In summary, we created a total of 17 preliminary subscales during the item generation phase. These were: (a) psychodynamic beliefs, individual practices, and group practices, (b) cognitive-behavioral beliefs, individual practices, and group practices, (c) family systems beliefs, individual practices, and group practices, (d) 12-step beliefs, individual practices, and group practices, (e) case management beliefs and individual practices, (f) group techniques, and (g) practical counseling individual practices and group practices. We list items for all 17 preliminary subscales in Appendix A. In the next section, we describe our second phase of instrument development, scale refinement.

METHOD: SCALE REFINEMENT

Participants

We administered the 17 preliminary scales to 243 counselors from 45 drug-user treatment programs in Los Angeles County. As indicated above, this effort was part of a larger study concerned with the effects of a wide variety of counselor characteristics, beliefs, attitudes, and behaviors on treatment effectiveness within drug-user treatment settings. Table 1 shows the demographic characteristics of the counselors. Over half of the respondents were female (55%). Forty-two percent were white, 32% were African-American, and 15% were Hispanic (e.g., Mexican/Mexican-American, Puerto Rican, other Hispanic/Latino); about 5% were Asian/Pacific Islanders (e.g., Cambodian, Filipino, Asian Indian, Hawaiian, Japanese, Chinese, Korean, Laotian, Samoan, other Asian), and the remaining 6% were mixed ethnicity, or refused to specify. The participants had a mean age of 42 (standard deviation [SD] = 10) and had 15 years of education

Table 1. Selected Demographic Characteristics of Counselors ($N = 226$)

Variable	Frequency	Percent	Mean	SD
Age			42	10
Sex				
Male	102	45		
Female	124	55		
Race				
White	95	42		
African-American	72	32		
Hispanic	34	15		
Asian/Pacific Islander	11	5		
Multi-Racial/Other	14	6		
Education (y)			15	3

(SD = 3). Most had at least some post secondary education (63%), but less than half the sample were college graduates (42%) and only 11% had graduate degrees. On an average, these counselors have been working in the substance-misuser treatment field for 7 years and in their current program for 4 years. About 33% of the counselors had obtained a drug user or alcoholic treatment certificate/license and 30% were currently working on obtaining a certificate. About 11% of the counselors had obtained a general mental health certificate/license and 33% were working on obtaining a certificate.

Procedure

To be eligible to participate in the study, counselors must have: (1) worked at the program for at least 3 months, and (2) either carry a caseload or run treatment groups. Using our eligibility requirements, the 45 programs identified a total of 241 counselors for participation. We invited all eligible counselors to participate. Key senior researchers held meetings with counselors at each of the 45 study sites. During the meetings, we explained the purpose of the study, the role of counselors in the study, and our study eligibility criteria. Surveys were distributed at these meetings and mailed back by the counselors after they completed the survey. We also informed counselors that their responses would be confidential. We paid each counselor $25 for completing the survey. Counselors who were not willing to complete the survey were free to refuse participation in the study. Two

hundred twenty-six counselors responded to the survey, a 93% response rate. Data collection was conducted during the period of December 1994 through December 1995. The counselors rated all items using 7-point Likert scales. For the belief subscales, they rated their level of agreement with each item (1 = strongly disagree, 7 = strongly agree). For the practice subscales, they rated the level of emphasis they placed on each technique (1 = none, 7 = very high).

Analytical Approach

We conducted two sets of analyses. First, we applied confirmatory factor analysis to evaluate and refine these scales using the EQS program (Bentler, 1995). We then calculated descriptive statistics and reliability α coefficient for each of the final scales.

Many research studies have used confirmatory factor analysis to determine the construct validity of instruments/assessments (De Weert-Van Oene, De Jong, Jorg, and Schrijvers, 1999; Erford, Peyrot, and Siska, 1998; Mueller, Lambert, and Burlingame, 1998) and have found useful results. The confirmatory factor analysis (CFA) allows the examination of the internal consistency among items of a scale. A scale is internally consistent if items designed to measure the same construct have high factor loadings on the same factor. A factor, or latent construct (e.g., the scale) has adequate construct validity if conceptually related measures conform to the theoretical underlying structure. A scale has discriminant validity if items yield high factor loadings on their theoretically derived scale but not on other scales.

We tested two CFA models with each scale predicting its proposed manifest indicators or items. In the first CFA model, we allowed all latent constructs to intercorrelate freely. These analyses tested the adequacy of the proposed measurement model (factor structure) and the relationships among the latent variables. Because our main interest is to establish the discriminant validity of the scales, we did not allow complex factor loadings and correlations among error residuals. Complex factor loadings allow two or more latent variables to predict measured variables. Correlated error residuals account for relationships between measured variables not fully captured by their hypothesized latent variables. Researchers frequently include these relationships because they improve model fit. In the second CFA model, we assumed a higher order construct underlying all relevant scales. Because it is reasonable to expect that scales may share a general counseling factor, we also tested this two-level model. Again, we allowed no correlated error residuals. Finally, to further understand the consistency

between beliefs and practices among these counselors, we used CFA to calculate the correlations between corresponding scales within the therapeutic beliefs and counseling practices.

We evaluated the closeness of the hypothetical model to the empirical data through goodness-of-fit indexes including the χ^2/degrees of freedom ratio, and the Comparative Fit Index (CFI) (Bentler, 1990). The CFI ranges from 0 to 1 and is based on the improvement in fit of the hypothesized model over a model of complete independence among the measured variables. Values of 0.9 and higher are desirable and indicate that the hypothesized model is able to reproduce 90% or more of the covariation in the data (Bentler and Stein, 1992).

RESULTS: SCALE REFINEMENT

Confirmatory Factor Analysis

The preliminary confirmatory factor analysis, which included all 76 items from the initial instrument, had generally poor fit statistics. Because items in the psychodynamics scale either did not load on the theoretically derived scale or were related to items on other scales, these items and the scale were dropped. We also dropped items that had low loadings on their respective scales. With these changes to the model, the fit indexes improved substantially. In the final models, all items loaded significantly ($p < .001$) on their respective latent factors. Table 2 presents the factor loadings for the one-level CFA models. Although the χ^2 tests were all significant, the CFI for all the models were higher than .90 (i.e., .92 for therapeutic belief, .92 for individual practices, and .93 for the group practices). We report the correlations among the scales within beliefs, individual practices, and group practices in Table 3.

Table 4 presents the results of the second-order CFA with a higher-order construct underlying all relevant scales. The CFI for these models was .91 for therapeutic belief, .92 for individual practices, and .92 for the group practices. Although the model fit results were similar to those without the higher-order construct, the results of this second-order CFA have clearer scale structure. These results indicated reasonably high construct validity (i.e., items have high factor loadings on their theoretically derived scales) and discriminant validity (items loaded only on their theoretically derived scales). According to Reise, Widaman, and Pugh (1993), it is important to use more than one fit index and "no CFA model should be accepted or rejected on statistical grounds alone: theory, judgement, and persuasive

Table 2. Factor Loadings in Confirmatory Factor Analysis for Belief, Individual Practice, and Group Practices

	Factor Loadings					
	Belief		Individual Practices		Group Practices	
1. Cognitive-behavioral approach	Item 4	.55	Item 33	.73	Item 9	.71
	Item 8	.67	Item 36	.60	Item 14	.71
	Item 10	.79	Item 40	.77	Item 19	.56
	Item 12	.60	Item 44	.85		
	Item 47	.61				
	Item 52	.71				
2. Family systems	Item 2	.43	Item 34	.54	Item 5	.51
	Item 5	.39	Item 42	.88	Item 11	.64
	Item 13	.61	Item 50	.71	Item 16	.47
			Item 54	.51		
3. 12-step approach	Item 9	.59	Item 25	.82	Item 3	.86
	Item 11	.70	Item 32	.64	Item 21	.86
	Item 14	.58	Item 41	.59	Item 27	.41
			Item 49	.74		
4. Case management	Item 6	.58	Item 29	.39		
	Item 15	.78	Item 37	.83		
	Item 16	.74	Item 45	.84		
5. Group techniques					Item 26	.38
					Item 28	.79
					Item 29	.73
6. Practical counseling			Item 24	.40	Item 7	.56
			Item 30	.44	Item 18	.69
			Item 46	.69	Item 24	.51

All correlation coefficients were significant at $p < .001$.

argument should play a key role in defending the adequacy of any estimated CFA model'' (p. 554).

Correlations Between Corresponding Scales Within the Therapeutic Beliefs and Counseling Practices

The 12-step approach had the best correspondence between belief and practices ($r = 1.00$ for individual and $r = .83$ for group). In general, all

Table 3. Correlations Among Latent Constructs

	1	2	3	4	5	6
1. Cognitive-behavioral approach		.51	.38	.94		
2. Family systems	.49, .83		.45	.48		
3. 12-step approach	.52, .35	.45, .47		.34		
4. Case management	.41, —	.45, —	.41, —			
5. Group techniques	—, .58	—, .64	—, .47	—, —		
6. Practical counseling	.76, .75	.55, .71	.53, .42	.55, —	—, .85	

Above diagonal: correlations among latent constructs for the therapeutic belief; below diagonal: first entries are for the individual counseling practice and second entries are for the group practice.
—, not hypothesized in the model.
Note: all correlations were significant at $p < .001$.

corresponding scales between beliefs and counseling practices were highly ($p < .001$) correlated (cognitive-behavioral: individual, $r = .40$; group, $r = .44$; family systems: individual $r = .46$; group $r = .64$). The only exception was case management ($r = .12$).

Descriptive Statistics and Reliability Alpha for the Final Scales

We report the descriptive information for the final scales in Table 5. As indicated above, we dropped the psychodynamic approach scales. Of the remaining scales, the individual practice scales were the most reliable and the group practice scales were the least reliable. Cronbach αs for all but one of the individual practice scales fell at or above .70. By contrast, only one of the group practice αs was above .70. The belief scales were moderately reliable; half of the αs fell above .70 and only one fell below .50. Interestingly, the practice and belief scales measuring the two traditional psychotherapy approaches (i.e., cognitive-behavioral and family systems) and 12-step were not uniformly reliable. For instance, although the family systems scale for individual practices had relatively high internal consistency, the corresponding beliefs and group practices scales were relatively unreliable.

Table 4. Factor Loadings in a Second-order Confirmatory Factor Analysis for Belief, Individual Practice, and Group Practices

	Factor Loadings					
	Belief		Individual Practices		Group Practices	
1.1 Cognitive-behavioral approach	Item 4	.55	Item 33	.72	Item 9	.70
	Item 8	.66	Item 36	.59	Item 14	.73
	Item 10	.79	Item 40	.77	Item 19	.55
	Item 12	.60	Item 44	.85		
			Item 47	.61		
			Item 52	.71		
1.2 Family systems	Item 2	.43	Item 34	.54	Item 5	.52
	Item 5	.44	Item 42	.88	Item 11	.63
	Item 13	.58	Item 50	.71	Item 16	.46
			Item 54	.51		
1.3 12-Step approach	Item 9	.62	Item 25	.82	Item 3	.86
	Item 11	.69	Item 32	.63	Item 21	.86
	Item 14	.56	Item 41	.59	Item 27	.41
			Item 49	.75		
1.4 Case management	Item 6	.58	Item 29	.39		
	Item 15	.78	Item 37	.83		
	Item 16	.74	Item 45	.84		
1.5 Group techniques					Item 26	.38
					Item 28	.78
					Item 29	.73
1.6 Practical counseling			Item 24	.40	Item 7	.57
			Item 30	.43	Item 18	.68
			Item 46	.70	Item 24	.51
2. General counseling factor						
Cognitive-behavioral approach		1.00		.78		.79
Family systems		.53		.65		.84
12-Step approach		.39		.65		.50
Case management		.93		.59		
Group techniques						.83
Practical counseling				.91		.94

All correlation coefficients were significant at $p < .001$.

Discussion:

We developed an instrument to measure therapeutic approaches among drug-user treatment counselors. Mainstream mental health and social service practitioners developed all of these approaches except for 12-step.

Table 5. Descriptive Statistics and Reliability Coefficients for Belief and Practice Subscales

Subscales	Mean	SD	α
Beliefs			
Cognitive-behavioral (4)	24.96	3.29	.73
Family systems (3)	15.48	2.90	.48
12-step (3)	15.54	3.80	.65
Case management (3)	18.57	2.66	.71
Individual practices			
Cognitive-behavioral (6)	36.20	4.88	.80
Family systems (4)	19.66	5.21	.73
12-step (4)	20.83	4.94	.77
Case management (3)	13.41	3.90	.70
Practical counseling (3)	18.95	2.11	.58
Group practices			
Cognitive-behavioral (3)	18.02	2.61	.67
Family systems (3)	15.59	3.23	.53
12-step (3)	14.80	4.00	.73
Group techniques (3)	17.57	2.89	.56
Practical counseling (3)	18.77	2.08	.55

The number in the parentheses indicates number of items in the scale.

Validity

The results of psychometric analyses indicated that the final subscales evidence adequate construct and discriminant validity. Specifically, in a confirmatory factor analysis, all items had high loadings on the constructs they were designed to assess (construct validity) but not on the other constructs (discriminant validity). Additionally, with only one exception (i.e., case management), all corresponding belief and practice scales were highly intercorrelated. This provides evidence for the convergent validity of our subscales. Our data do not permit us to determine whether this lack of correspondence among the case management scales is attributable to the quality of the scales themselves, counselor characteristics, program characteristics, or some combination of these factors. Interestingly, the mean on the case management belief scale was significantly higher than on the corresponding practice scales ($p < .001$). This suggests that although many counselors believe that the principles of case management are sound, they may not be able to apply these principles to their practices. This discrepancy

between beliefs about and practice of case management may be attributable to a variety of factors. Counselors may not have the requisite skills to effectively implement case management with their own clients. Programs may not provide adequate resources (e.g., staffing) for case management activities. It is also possible many program therapeutic orientations run counter to the principles of case management.

Reliability

The psychometric analyses also indicated that most of the subscales were reliable measures of counselors' beliefs about therapeutic approaches and their self-reported therapeutic practices. We assessed the internal consistency of each final subscale using Cronbach's α. With two exceptions (psychodynamic and family systems belief subscales), subscale αs were above Nunnally's (1967) proposed .50 minimal acceptable level and most were over .70. Although the obtained αs were generally in the low to moderately acceptable range, it is important to note that most of the subscales had only three items. Increasing the number of items per subscale would very likely have raised the scales' internal consistency. Given the large number of subscales, however, increasing the number of items per subscale would have greatly increased the level of respondent burden. The final 48-item instrument is sufficiently comprehensive to encompass all major techniques employed by drug-user treatment counselors in a wide variety of milieus without being overly burdensome.

One concern, however, is that the family systems and psychodynamic belief scales were unreliable. There may be several reasons. One reason could be that these scales actually were low on reliability. However, we derived items for both these scales from theory. Additionally, clinical experts assessed the face validity of the items. It could be that that these scales were unreliable because the approaches they described are not applicable to drug-user treatment counselors. Few drug treatment counselors have had extensive formal training in psychodynamic and family therapy techniques. Future research could assess the reliability of these two scales with counselors who have had training in these two approaches.

Study Limitations

This study does not provide any information regarding the effectiveness of the various approaches. Further, the present analysis does not provide any evidence regarding external validity. Future studies can explore the

external validity of the instrument either by surveying counselors with known specializations in specific therapeutic approaches, or by direct observational assessment by clinically trained professionals.

CONCLUSION

Traditionally, substance-misuser treatment counselors have been isolated from the mainstream of professional counseling and psychotherapy. Although substance misuser counseling has been characterized as having a specialized knowledge base, set of skills, and philosophy (Hagman, 1994), there is considerable overlap between the needs of individuals in mainstream counseling and those in drug-user treatment. Counselors involved in substance-misuser treatment have increasingly recognized the need for establishing practice standards and developing guidelines for the training, supervision, and credentialing of counselors. Establishing professional identity is an important issue for substance-misuser treatment staff and needs to be addressed. Although therapeutic approach may represent only one aspect of what constitutes high quality drug-user treatment, it is likely to be an important component of what counselors believe and ultimately practice. As such, counselors' therapeutic beliefs and approaches may determine how effective they are in helping their clients. A self-administered instrument, such as ours, can provide a relatively cost-effective measure of assessing drug-user treatment counselors' therapeutic approaches. We invite readers from various countries and cultures to carry out cross-cultural research in this important area.

APPENDIX A

Items in Therapeutic Belief, Individual Counseling Practices, and Group Counseling Practices

Therapeutic Beliefs

Psychodynamics/Interpersonal Approach

1. It is important to encourage clients to explore their feelings and examine their defense mechanisms
3. Drug misuse reflects an underlying unresolved conflict
7. It is crucial that counselors reveal little about their personal circumstances and keep sessions focused on clients

Cognitive-Behavioral Approach

4. Experiences from clients' everyday lives should be used as the basis for problem solving exercises and role-plays (F)
8. Clients must make the decision to take action by altering their problem behaviors outside the counseling session (i.e., in their daily lives) (F)
10. Treatment success depends on clients actively participating in their treatment (F)
12. An important goal of treatment is to master skills that will help maintain abstinence (F)
17. It is important to help clients to avoid unrealistic and destructive thoughts

Family Systems

2. Counseling will be most successful if it includes the client's family (F)
5. Clients' behaviors are best interpreted in terms of current family dynamics (F)
13. It is crucial for clients to explore and resolve interpersonal conflicts with family members (F)

12-Step Approach

9. Clients must accept that they have no control over their addiction and that recovery requires that they have faith in a higher power (F)
11. Clients must accept that they must reach out to recovering addicts (F)
14. The primary goal of treatment is to encourage clients to work the 12 steps (F)

Case Management

6. Treatment is most effective when it combines traditional counseling with providing concrete services (for example, social service and training programs) (F)
15. It is necessary to formulate a comprehensive individualized assessment of each client's situation, needs, and goals (F)
16. It is crucial to identify both the services that can satisfy client needs and the barriers that can hamper service delivery (F)
18. It is important to act as an advocate for your client by serving as a broker or mediator with service providers

Individual Counseling Practices

Psychodynamics/Interpersonal

28. Encouraging clients to break down defenses so as to understand their unconscious motivations
35. Making use of transference while being aware of possible countertransference
38. Encouraging clients to talk about their feelings
43. Using silences to encourage clients to continue talking or to give clients space
51. Avoiding giving direct advice to a client

Cognitive-Behavioral Approach

26. Giving homework assignments such as keeping a journal
33. Aiding clients in identifying cognitive and behavioral strategies that have been successful in avoiding drug misuse (F)
36. Helping clients to substitute healthy rewards (for example, socializing in a drug-free environment) for unhealthy ones (for example, drugs and alcohol) (F)
40. Teaching clients cognitive and behavioral skills to avoid drug use situations (F)
44. Teaching clients behavioral skills to avoid drug use situations (F)
47. Assisting clients in role-playing cognitive and behavioral skills to avoid drug use (F)
52. Aiding clients in identifying behavioral strategies that have been successful in avoiding drug misuse (F)

Family Systems

27. Encouraging clients to see drug use in the context of their families
34. Interpreting clients' family process (i.e., interactional style) (F)
42. Encouraging or requiring family members to participate in the treatment process (F)
50. Encouraging families to give their viewpoint about clients' disclosure or behavior (F)
54. Collaborating with a co-therapist or co-counselor in facilitating sessions with families and/or couples (F)

12-Step Approach

25. Articulating the 12 steps in counseling interactions (F)
32. Encouraging clients to reach out to other recovering addicts (F)
41. Encouraging clients' spiritual growth and spiritual well-being (F)

49. Interpreting clients' behaviors and feelings according to the 12 steps (F)
57. Disclosing personal information about yourself that might help clients in their recovery

Case Management

23. Helping clients to solve daily life-management problems
29. Acting as a problem solver for clients (F)
37. Advocating for clients (F)
45. Acting as a broker or mediator between clients and service providers (F)

Practical Counseling

24. Showing empathy and concern (F)
30. Developing rapport and trust (F)
46. Aiding clients in exploring alternatives when faced with a decision (F)
53. Explaining to clients that they need to work on other problems in addiction to substance misuse if they are to remain sober
56. Encouraging clients to get reconnected with their communities

Group Counseling Practices

Psychodynamics/Interpersonal

6. Encouraging clients to break down defenses so as to understand their unconscious motivation
12. Making use of transference while being aware of possible countertransference
13. Encouraging clients to talk about their feelings
17. Using silences to encourage clients to continue talking or to give clients space
23. Avoiding giving direct advice to a client

Cognitive-Behavioral Approach

4. Giving homework assignments such as keeping a journal describing the circumstances when feeling most "out of control"
9. Aiding clients in identifying cognitive and behavioral strategies that have been successful in avoiding drug misuse (F)
14. Teaching clients cognitive and behavioral skills to avoid drug use situations (F)
19. Assisting clients in role-playing cognitive and behavioral skills to avoid drug use (F)

Family Systems

5. Encouraging clients to see drug use in the context of their families (F)

11. Interpreting clients' family process (i.e., interactional style) (F)
16. Encouraging or requiring family members to participate in treatment process (F)
22. Encouraging families to give their viewpoint about clients' disclosure or behavior

12-Step Approach

3. Articulating the 12 steps in counseling interactions (F)
8. Encouraging clients to reach out to their recovering addicts
15. Encouraging clients' spiritual growth and spiritual well-being
21. Interpreting clients' behaviors and feelings according to the 12 steps (F)
27. Disclosing personal information about yourself that might help clients in their recovery (F)

Group Techniques

26. Collaborating with a co-therapist or co-counselor in facilitating sessions with families and/or couples (F)
28. Encouraging peer social support from recovering individuals (F)
29. Encouraging peer modeling of beliefs and behaviors (F)
30. Interpreting process between group members

Practical Counseling

2. Showing empathy and concern
7. Developing rapport and trust (F)
18. Aiding clients in exploring alternatives when faced with a decision (F)
24. Explaining to clients that they need to work on other problems in addition to substance misuse if they are to remain sober (F)
31. Encouraging clients to get reconnected with their communities

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(F) indicates that the item is included in the final scale.

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RESUMEN

En este articulo describimos el desarrollo y las propiedades psicometricas de un instrumento auto-administrado para evaluar enfoques terapéuticos tales como enfoques psicodinamicos o interpersonales, cognoscitivo-conductual, sistemas o dinámicas familiares, 12-pasos, y manejo de casos empleados por consejeros para el tratamiento de la drogadicción. Nosotros generamos un grupo inicial de preguntas correspondiendo a los cinco enfoques y las modificamos basándonos en las valoraciones de expertos. Desarrollamos tres grupos de preguntas. El primer grupo estaba relacionado con las creencias funamentales de cada uno de los enfoques terapéuticos. El segundo y tercer grupo estaban relacionados con las practicas de cada uno de los enfoques dentro de la consejeria individual y de grupo respectivamenta. Con la excepción del manejo de casos, un enfoque que se origino dentro del trabajo social y el cual únicamente tiene aplicación dentro de la consejeria individual, los otros cuatros enfoques se pueden aplicar, por lo menos teoréticamente, tanto a la consejeria individual como de grupo. Además, incluimos preguntas que describen las técnicas utilizadas exclusivamente con grupos (por ejemplo, técnicas de grupo). Finalmente, incluimos algunas preguntas que no están asociadas con ningún enfoque tradicional pero que reflejan el enfoque practico que los programas para la drogadicción frecuentemente toman para la consejeria individual y de grupo (por ejemplo, consejeria practica). El instrumento original consistía de 17 subclasificaciones con un total de 76 preguntas. Este instrumento fue administrado a 226 consejeros de 45 programmas en el Condado de Los Angeles. Basados en esta información, refinamos una vez mas las clasificaciones usando análisis de confirmación de factores para asegurar la validez de concepto y discriminativa. El instrumento final consistió de 14 clasificaciones con un total de 48 preguntas.

RÉSUMÉ

Dans le présent document, nous décrivons le développement et les propriétés psychométriques d'un autoinstrument. Cet autoinstrument sert à évaluer des approches thérapeutiques dans le traitement de la toxicomanie par des conseillers, telles que l'approche psychodynamique ou interpersonnelle, l'approche behavioriste cognitive, les systèmes ou dynamiques de famille, les 12 étapes et la gestion de cas. Nous avons produit un premier fonds commun d'éléments correspondant à ces cinq approches; ces éléments ont été modifiés suivant des évaluations faites par des spécialistes. Nous avons ainsi établi trois séries d'éléments. La première série touchait les convictions sous-jacentes à chaque approche thérapeutique. Les deuxième et troisième séries s'adressaient respectivement aux pratiques de chaque approche applicable dans le cadre de counselling individuel ou de groupe. À l'exception de la gestion de cas, une approche qui provient du milieu du travail social et qui ne s'applique qu'au counselling individuel, les quatre autres approches s'appliquent, du moins en théorie, autant au counselling individuel que de groupe. De plus, nous avons inclus des éléments décrivant les techniques utilisées exclusivement avec des groupes (techniques de groupe). Finalement, nous avons inclus certains éléments qui ne peuvent être associés à aucune des approches traditionnelles mais qui reflètent l'approche pratique qu'adoptent souvent les programmes de traitement de la toxicomanie autant pour le counselling individuel que de groupe (counselling pratique). Le premier instrument comprenaient 17 sous-barèmes pour un total de 76 éléments. Cet instrument a éléments. Cet instrument a été épouvé auprès de 226 conseillers répartis dans 45 programmes de traitement de la toxicomanie dans le Los Angeles County. En nous basant sur ces données, nous avons peaufiné ces barèmes en utilisant une analyse de corroboration des facteurs pour nous assurer de la validité de la construction mentale autant que de la validité discriminante. L'instrument final comportait 14 sous-barèmes pour un total de 48 éléments.

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