

Therapists' confidence in their theory of change and outcomes

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Abstract

Previous research has sought to understand what therapist characteristics contribute to positive outcomes for clients. It is widely accepted knowledge that the alliance between the therapist and client is a significant contributing factor to client outcomes. With that said, few studies have examined specific characteristics within the therapist themselves that may contribute to client success, regardless of the therapeutic model being used. Using data from a sample of therapist-trainees at a large, midwestern institution, this study sought to explore therapist confidence in their theory of choice and its potential impact on client outcomes. Findings suggest that those clients who have therapists with greater confidence in their theory are less likely to terminate treatment prematurely or without agreement. These findings have the potential to inform the curriculum for training programs to focus more on developing confidence in the chosen theory.

KEYWORDS

alliance, premature termination, therapist characteristics, therapist confidence

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INTRODUCTION

The purpose of this article is to explore the associations between therapists' confidence in their theory of change, their alliance with clients, and termination status. Recently, there has been a call in the literature to understand how therapists contribute to the process of therapy (Blow & Karam, 2017; Blow et al., 2007; Laska et al., 2014). That is, what characteristics make for an effective couple and family therapist (CFT)? Evidence suggests that therapeutic alliance between the therapist and client contributes the majority of the variance in outcomes (i.e., Friedlander et al., 2018), but we know little about what characteristics within a therapist are associated with that alliance. There is also a strong debate across psychotherapy fields about model-specific effectiveness versus common factors in effective therapy more generally (cf. Sprenkle & Blow, 2004).

The characteristics of a therapist that might influence the ability to develop an alliance and to successfully terminate with clients are also important for training programs. In the CFT field, training includes learning about theories used by therapists, including the classic theories based on systems theory (i.e., structural family therapy, strategic therapy) as well as more postmodern theories (i.e., narrative, solution-focused, etc.). Most clients, however, do not really care about what model is being used, they just want to "feel" better. Models of therapy, for the most part, are important for the therapist. The more adherent therapists are to evidence-based models the more effective they are (cf. Holder et al., 2018; Wampold, 2001). It may also be the case that the more confident the therapist is in the theory being used, the more able they are to develop working alliances with clients, and the more effective they can be. The purpose of this study was to explore how therapists' confidence in their theory of choice was associated with therapeutic alliance and termination status.

Therapeutic alliance

Therapeutic alliance has been shown to be one of the most influential factors for treatment outcomes (i.e., Friedlander et al., 2018). The definition of the therapeutic alliance comes from the classic work of Bordin (1979) who suggested that the alliance with the therapist (individual therapist) consisted of three factors, bonds (or trust), tasks, and goals. The more the client perceives that they can trust the therapist and agrees with the tasks and goals of treatment, the more likely there will be a positive outcome. In CFT, the alliance is more complex because typically the therapist needs to create an alliance with the individual members of the couple or family, family members need to perceive that their counterparts are also allied with the therapist, and the family members need to be allied with the therapist as a group (Friedlander et al., 2018; Pinsof & Catherall, 1986). Friedlander et al. (2006) also suggest that family members need to be allied with each other and have a shared sense of purpose in the therapy. Meta-analyses reviewing the association between alliance in CFT and retention and outcome have shown similar effect sizes to the meta-analyses reviewing the association between alliance in individual therapy and retention and outcome (Friedlander et al., 2018). Typically, this is a small to medium effects size ($d = 0.539$). Friedlander et al. (2018) found Cohen's d of 0.62 demonstrating that stronger alliances were predictive of better outcomes in a meta-analysis of 48 studies of couple or family therapy.

Although the field of CFT has refined the definition of therapeutic alliance to be more applicable to the CFT context, there has been little research into what characteristics of a CFT

therapist might explain the variance in alliances that are present. Psychotherapy research across modalities has found that empathy and collecting client feedback are demonstrably effective actions therapists can take to increase alliance (Norcross & Wampold, 2011). Norcross and Wampold (2011) concluded from a series of meta-analyses in a special issue on evidence-based therapy relationships, that the therapeutic relationship accounts for why clients improve at least as much as the particular treatment method. It is through the relationship that any particular model of therapy will be effective (Blow & Karam, 2017; Norcross & Wampold, 2011). Again, however, we do not know what characteristics of the CFT therapist would increase the probability of developing a strong alliance.

Termination status

Along with alliance, how clients terminate treatment is also important to attend to. Premature termination or treatment dropout in couple therapy is typically high (40%–60%; D'Aniello et al., 2021). It seems obvious that therapeutic alliance would be associated with treatment dropout. That is, if clients do not feel that there is a workable relationship with the therapist, they would be more likely to drop out. However, the evidence that alliance and termination status are associated is conflicting. Bartle-Haring et al. (2021) demonstrated that couple satisfaction was more associated with termination status than was alliance and alliance was not significantly associated with termination status, while other researchers have found an association between alliance and premature termination (Bartle-Haring et al., 2012; Friedlander et al., 2011; Tambling & Johnson, 2008). As much as therapist characteristics are associated with alliance, it would suggest that they would also be associated with termination status.

There is debate in the field about what constitutes treatment dropout. Some suggest that it is not attending a specified number of sessions: some use dropping out after the first session, and others suggest dropping out at or before the third session would constitute treatment dropout. The literature that supports the 3-session mark is based on the notion that the first few sessions of therapy are about assessment and diagnoses, and less about intervention, so those clients who drop out at or before session 3 have not really received treatment (Xiao et al., 2017).

There is also debate about what a successful termination is. Some say it is when the therapist and client agree that it is time to end the therapy, while others focus on distress reduction, or increases in satisfaction beyond a clinically distressed cut-off (Leichsenring et al., 2019). There is also some debate about whose perspective matters: clients' or therapists'. For the purposes of this study, we define premature termination as leaving without agreement at or before session 3, leaving without agreement after session 3, and successful treatment as ending with agreement (regardless of the number of sessions attended). We use the therapist's perspective for this determination.

Therapist confidence

Very little research exists about therapists' confidence in their theory of choice. Simon (2006) suggests that when a therapist becomes aware of his or her worldview and adopts a model of change that is congruent with this worldview, the therapist grows in confidence in his or her theory. This synergy, according to Simon (2006), will lead to effective treatment. Blow et al.

(2007) agree that a therapist's enthusiasm for a treatment approach is crucial for effective therapy. They further suggest that this enthusiasm leads to confidence, authenticity, and precision in the delivery of interventions. Eisler (2006) also suggested that confidence or enthusiasm for a theoretical approach is essential. "Doing something we are wholeheartedly committed to must surely be more effective than something we only half believe in..." (p. 330).

Blow et al. (2007) saw this as a somewhat narrow view of therapy in general, since the theory or approach the therapist uses also needs to include therapeutic alliance, which in turn means that the approach needs to fit with the clients' worldview as well. It may be the case, however, that when therapists are more confident in their theory of change and are able to use it easily, they are freer to develop a therapeutic alliance and freer to adapt to clients' unique needs. Blow et al. (2007) reviewed the literature about overall therapist effects and found that therapist effects are larger than the effects of different treatment models. They reported that therapists accounted for about 9% of the variance in the outcome which translates to an effect size of 0.60. The effect size for most differences between treatment models is 0.20.

What is less clear, however, is what it is about therapists that make them more or less effective. Erikson et al. (2017) examined training stage and experience (number of client contact hours and severity of case presentations) to see if these made a difference in therapist effectiveness at an on-campus clinic staffed by psychology graduate trainees, interns, postdoctoral psychologists, and licensed psychologists. They found that in a large sample of therapists and clients, therapist experience and training level had little effect on treatment outcome, with a slightly negative influence on the rate of change in clients. These findings support previous work that actually showed a negative influence of more experience. Therapists with more experience showed a slight decrease in outcomes (Goldberg et al., 2016).

Cologon et al. (2017) found that the reflective functioning of the therapist (the ability to conceptualize, identify, and understand mental states of self and others) was positively associated with treatment outcomes. Odyniec et al. (2019) showed that when trainees have more professional self-doubt, their clients do not show the same change as when trainees have less professional self-doubt. Shamoon et al. (2017) discuss several therapist factors that might relate to treatment outcomes including managing anxiety but provide no empirical evidence to suggest that those better at managing anxiety have clients who have better outcomes. Therapist expectations have also been examined, similar to client expectations. When therapists have higher expectations that clients can change, their clients show better outcomes (Connor & Callahan, 2015). Therapist expectations explained 7.3% of the variance in whether or not clients experienced clinically significant change.

Current study

For the current study, we hypothesize that therapists who perceive that they use their theory of change consistently and are confident that the theory allows them to work with diverse problems and diverse clients, will develop higher alliances and terminate treatment with agreement more often. We use a sample of clinicians in training at an on-campus training clinic. The study was designed so that therapists were surveyed about their confidence in their theory of change once per semester over the course of the time that they saw clients at the

training clinic. Confidence changed over time. Thus, confidence in the theory of change became a time-varying covariate to predict alliance for couple members and the probability of terminating without agreement at or before session 3, after session 3, or of terminating with the agreement.

METHODS

Sample

Clients

The clients were couples seeking treatment at the on-campus training clinic. There were 118 couples who were, for the majority, of different-sex couples (97.9%). The demographics of the couple members can be seen in Table 1. The average length of the current relationship was 5.53 years (SD = 5.03) ranging from 1 to 28 years. About 60% of the couples did not have children, with 13.7% having one child, and 26% having two or more children.

TABLE 1 Client and therapist sample demographics.

	Male partners (n = 118)	Female partners (n = 118)	Therapists (n = 16)
Age (years) (SD)	31.4 (9.33)	29.21 (8.35)	30.0 (6.44)
White (%)	78.0	78.1	50.0
African American (%)	14.0	12.4	18.8
Asian/Asian American (%)	4.0	6.2	12.5
Multiracial (%)	3.0	3.1	12.5
Hispanic (%)	4.0	7.0	0
Education level			
High school/GED (%)	19.4	9.0	
Some college (%)	24.0	24.3	
College (%)	26.0	35.0	
Graduate/professional (%)	20.0	21.0	
Working on CFT Master's (%)			6.25
With CFT Master's working on PhD (%)			31.25
Other Master's working on PhD (%)			6.25
Straight through (%)			56.25

Abbreviations: CFT, couple and family therapist; GED, General Educational Development.

Therapists

There were 16 therapists who had seen between 1 and 23 clients in the sample. The majority were female (two males). The other demographics of the therapists can be seen in Table 1. The program in which the therapists were enrolled accepts students from undergraduate programs to obtain a master's or a PhD and accepts students with a master's degree in CFT, as well as related fields. The program encourages students to select a theory of change that fits the best for them. Of the 16 therapists in the sample, some used symbolic experiential (4), some used a Bowen Family Systems approach (4), some narrative or solution-focused (2), some contextual family therapy (2), and some emotion-focused therapy (4). Students provide therapy in the on-campus clinic between 2 and 4 years. Thus, some of the therapists in the sample completed the confidence questionnaire up to six times. To determine their confidence level at the time of seeing the client, we used the confidence score closest to the date of the intake for the client. Some therapists only completed the confidence questionnaire one or two times, even though they were seeing clients at the clinic beyond when they completed the confidence questionnaire the last time. We used their last score on the confidence questionnaire for all clients who were seen past the last time the therapist completed the confidence questionnaire. It is possible that their confidence increased or decreased in the interim, so the confidence scores are approximations.

Procedures

The data for this project came from a larger ongoing data collection at the on-campus training clinic. Clients were informed of the opportunity to participate in research during their intake session. If they elected to participate, they were offered a \$20 reduction in their first session fee. The clinic operates on a sliding fee scale based on income and the number of dependents. At the time of the data collection, this was between \$10 and \$180, with the average fee at about \$20. All clients completed an intake questionnaire that included demographic questions, relationship satisfaction and commitment questions, and depressive symptoms questions. When clients agreed to research, they completed a research intake questionnaire that included items on differentiation in the relationship, trauma experiences, stress items, and emotion regulation items. They also completed after-session questionnaires that included their satisfaction with the treatment received, progress, relationship satisfaction and commitment, and therapeutic alliance items. These were distributed to clients after sessions 1–8. The session-8 questionnaire included the items from the research intake again.

Clients were randomly assigned to a condition in which they and their therapist did not review their after-session data (treatment as usual) and a condition in which they and their therapist reviewed their after-session data at the next session, in the form of graphs. Previous research has shown that the outcome of treatment did not vary based on condition (Bartle-Haring & Vanbergen, 2021).

Instruments

Therapist confidence

We used a newly developed instrument by the first author to assess therapist confidence. As it was newly developed, we performed a two-level exploratory factor analysis (EFA) to determine

if the original 15 items could be combined into a single score or if there were more than one factor. In the analysis using *Mplus*, the intraclass correlations of the items (i.e., how nonindependent the item scores were clustered in the therapist) ranged from 0.20 to 0.55. As these were not as high as expected, we treated all scores on the items as independent and performed the EFA without clustering. Although a four-factor model fit better than a one-factor model, the first factor in all tests was consistent and contained the same six items. These items were about the consistent use of the theory of change: for example, “when I think about my philosophy of change, I can easily apply it to my own situation and interaction,” and “In the moment when an intervention is required, I can rely on my theory of change to guide my therapeutic interventions.” The full set of items in the original along with the six items (in bold) used can be seen in Appendix A. The six items had a Cronbach's alpha of 0.87.

Therapeutic alliance

To assess the alliance with the therapist from the clients' perspective, we used the couple version of the Working Alliance Inventory (Horvath & Greenberg, 1989; wai.proffhorvath.com). This scale includes items on bond, items on goals, and items on tasks for self in relation to therapist, perception of the partner in relation to therapist, and the perception of how both partners interact with the therapist. For this study, we used both partners' assessments of how both partners as a unit interact with the therapist and used all items as a single score for the male partner and for the female partner. We used the scores from session 2 (or from 3 if session 2 was missing) given that we wanted to include couples who had terminated at or before session 3. The internal consistency reliability for the couple alliance subscale was 0.88.

Relationship satisfaction

As previous research has indicated that a couple's levels of satisfaction at the beginning of therapy are associated with the alliance (Bartle-Haring et al., 2021) and therapy outcomes (Roddy et al., 2020) we used data on relationship satisfaction at intake as “controls” in our analyses. The assessment of relationship satisfaction was one item that asked the participant to rate how satisfied they were with the relationship on a scale from 1 to 10.

Termination status

As stated above, we used therapists' rating of termination. Clients either (1) ended with agreement, (2) left without agreement (client let the therapist know they were not returning to treatment), or (3) no-showed (client did not attend a session and was unable to be contacted thereafter). We combined “left without agreement” and “no-showed” and created two dropout groups; (1) those who dropped out at or before session 3 and (2) those who dropped out after session 3. Those who ended with agreement could have done so before session 3 but were still considered as being in the “ended with agreement” group. Therapists completed a termination note in which they recorded the clients' reason for leaving. We used these termination data to determine termination status.

Data analysis

Along with preliminary analyses to describe the sample and the numbers of clients in each termination status group, we used multilevel modeling in *Mplus* to test our hypotheses. Multilevel modeling allows the analyst to take into account the nested aspect of the data. For our purposes, clients were nested in therapists. Multilevel modeling equations are referred to as level 1 or within-level equations and level 2 or between-level equations. For our purposes, the within-level is the client level and we are assessing how therapist confidence influences client alliance and termination status while accounting for a therapist.

$$\text{Outcome} = \text{Intercept} + b_1(\text{P1 satisfaction}) + b_2(\text{P2 satisfaction}) + b_3(\text{Therapist confidence}).$$

The between-level equation included therapist sex as a “placeholder” to create the cluster for a therapist. Thus, clients were clustered in therapist and therapist confidence was a time-varying covariate. This means that therapist confidence may be different for some clients depending on when the client was seen during the therapist’s time at the clinic.

$$\text{Intercept} = \text{intercept} + g_1(\text{therapist sex}).$$

We used HLM 7.03 (Raudenbush et al., 2013) to determine the amount of variance that could be attributed to the therapist level, as *Mplus* does not easily provide this information in the output.

RESULTS

Preliminary analyses

In a one-way analysis of variance (ANOVA) using termination status as the factor and number of sessions as the outcome, there were significant differences, $F(2, 100) = 13.33$; $p < 0.001$, in the number of sessions attended (as we expected). For those in the dropout at or before session 3 ($n = 28$), the average number of sessions was 1.96 ($SD = 0.744$) with a range from 1 to 3. In the group that dropped out after session 3 ($n = 43$), the average number of sessions attended was 7.07 ($SD = 4.37$) with a range from 4 to 24. For those in the ended with agreement group ($n = 32$) the average number of sessions was 12.25 ($SD = 12.85$) with a range from 1 to 67. There were 15 couples for whom there was no termination data. For the most part, this was because these couples were still in treatment.

We used a repeated-measures ANOVA to compare partners’ alliance scores at session 2 among the termination status groups. There were no significant differences between partners or among the termination status groups. This suggests that, on average, alliance at the second session did not significantly vary among termination status groups. For the male partners, their average alliance score was 5.82 ($SD = 0.858$). The average alliance score for female partners was 5.86 ($SD = 0.815$).

Therapist confidence scores ranged between 3.17 and 5.0 with a mean of 4.32 ($SD = 0.504$). This suggests that therapists rated their consistent use of theory highly for the most part. On average, there were 2.5 scores for therapist confidence for each therapist with a range between one and four. When therapists had multiple scores on confidence their scores tended to increase (see Table 2).

Two-level model with the alliance as the outcome

We hypothesized that when therapists are more confident or use their theory of change more consistently, they would be able to form a stronger alliance with clients. In the two-level model with alliance as the outcome, none of the predictors at level 1 (satisfaction and therapist confidence) were significantly predictive of alliance scores. Therapist sex at the second level was predictive of alliance for both male and female partners. As sex was coded as 0 for female and 1 for male, the results suggested that when the therapist was male, both partners perceived that the couple had a better alliance with the therapist. As there were only two male therapists, this needs to be interpreted with caution. From the results of an unconditional model (no predictors), the therapist contributed about 10.7% of the variance to the overall variance in alliance scores. The results of the two-level model in *Mplus* can be seen in Table 3.

Two-level model with termination status as outcome

We hypothesized that therapists who are more confident in or use their theory of change more consistently would be more likely to end therapy with agreement. The results of the two-level model using termination status as the outcome can be seen in Table 4. An unconditional model using HLM demonstrated that about 9.6% of the variance in termination status could be attributed to the therapist. However, therapist confidence was a significant predictor of termination status in the level 1 equation (estimate = 0.974; $p = 0.009$). Therapist sex was not a significant predictor in the level 2 equation. Using the thresholds estimated in *Mplus* for the first two categories of termination status (dropout at or before session 3, dropout after session 3) and the significant predictors, we calculated the probability of each termination status by therapist confidence at the mean and at one standard deviation above and below the mean. These probabilities can be seen in Figure 1. As can be seen, as confidence increases, the probability (the y -axis) of dropping out at or before session 3 decreases, while the probability of ending with agreement increases. For example, the figure shows that therapists who score 1 standard deviation below the mean on the confidence measure (diagonal line filled bar) have clients with a 40% probability of dropping out at or before session 3, a 55% probability of clients dropping out after session 3, and about a 5% probability of clients ending with agreement. Therapists with scores one standard deviation above the mean (square filled bar) on confidence have clients with about a 14% probability of clients dropping out at or before session 3, a 65% probability of clients dropping out after session 3, and a 20% probability of clients ending with agreement. The probability of dropping out after session 3 remains fairly stable across the levels of confidence, though there is an increase in the probability with increasing confidence. This suggests that when therapists

TABLE 2 Therapists' confidence scores over time.

Time (n)	Mean	SD	Range
1 (17)	4.23	0.514	3.17–5.00
2 (6)	4.27	0.60	3.5–5.00
3 (9)	4.35	0.493	3.83–5.00
4 (5)	4.56	0.448	4.0–5.00

TABLE 3 Results of the two-level analysis for therapeutic alliance.

Variable	Estimate (SE)
Intercept of male partner alliance	5.419 (1.50)*
Male partner satisfaction	0.087 (0.059)
Female partner satisfaction	0.034 (0.037)
Therapist confidence	-0.085 (0.305)
Therapist sex	0.616 (0.142)*
Intercept of female partner alliance	5.439 (1.51)*
Male partner satisfaction	0.071 (0.057)
Female partner satisfaction	0.001 (0.047)
Therapist confidence	-0.014 (0.325)
Therapist sex	0.729 (0.159)*

* $p < 0.05$.**TABLE 4** Results of the two-level analysis for termination status.

Variable	Estimate (SE)
Threshold for dropping out at or before session 3	3.448 (1.45)*
Threshold for dropping out after session 3	5.347 (1.54)*
Male partner satisfaction	0.003 (0.097)
Female partner satisfaction	0.083 (0.086)
Therapist confidence	0.974 (0.371)*
Therapist sex	-0.400 (0.791)

* $p < 0.05$.

are using their theory more consistently, their clients are more likely to stay beyond session 3, but not necessarily end with agreement. Therapists with less confidence in their theory of change or who are less consistent in their use of the theory have a much lower probability of clients ending with agreement than therapists with more confidence (5% vs. 20%, respectively).

DISCUSSION

Our results from this study indicate that while therapist confidence in their theory of choice was not associated with alliance with clients, it was associated with termination status. As therapists' consistency in the use of their theory as well as their confidence in the theory overall increased, so did the probability of ending treatment with agreement. Those therapists who had higher confidence levels were less likely to have clients drop out before session 3. While we were surprised to find that therapist confidence was not associated with alliance at all, we found it interesting that clients were more likely to stay in treatment if their therapist was more confident in their theory. This leads us to turn to what we already know about therapist factors influencing termination and consider how our findings might inform further study and implications for therapist training programs.

Probability of Termination Status by Therapist Confidence

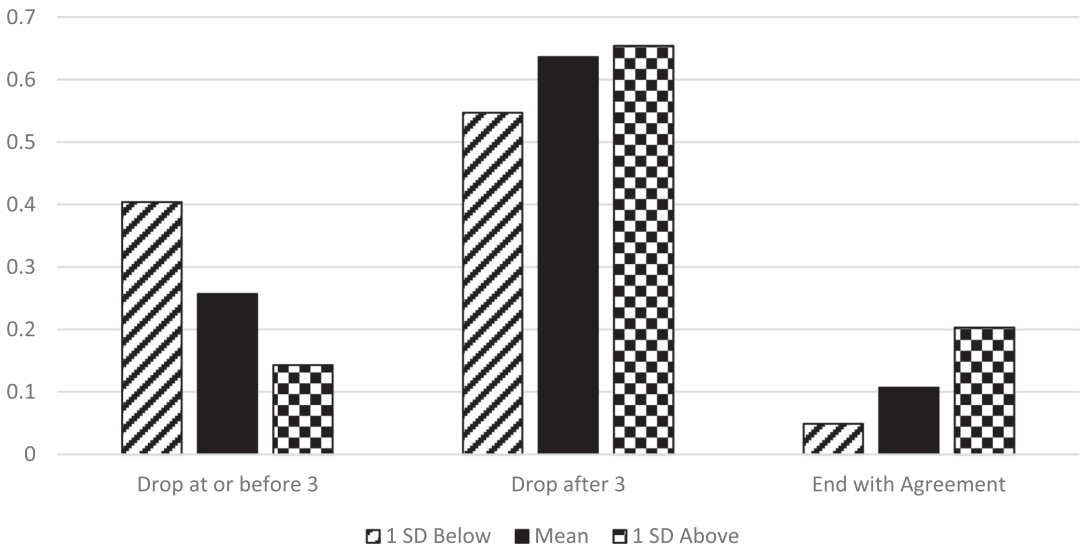


FIGURE 1 Probability of termination status by therapist confidence

Common factors in therapy models and therapists

Research shows that common factors across models of therapy are proving to be more important for client outcomes than the actual theory itself (D'Aniello, 2015; D'Aniello & Perkins, 2016). As CFT training programs begin to encourage more integrative approaches to therapy, researchers have identified the importance of punctuating the influence of common factors in treatment across models such as client factors, therapist factors, the therapeutic alliance, hope, common interventions, therapist allegiance to their model, and feedback (Karam et al., 2015). While these common factors highlight a variety of facets of the therapeutic process, including therapist factors, they do not touch on the importance of the confidence the therapist has in their theory in addition to their allegiance to the specific theory.

Adherence to theory could be conceptualized as strictly following what the theory guides. However, confidence, in theory, may indicate a deeper level of experience from the therapist themselves—essentially that the theory they are using has brought some sort of change in their life. If therapists have confidence in their theory of change, they may have been influenced personally by that theory or may have experienced a significant shift in their worldview because of that theory. Because of this personal change (or self-of-the-therapist work), they are better able to apply it to the clients that they work with. Training programs should consider the degree to which theory is combined with self-of-the-therapist's work, and should assist trainees in applying the theory to themselves.

Blow and Karam (2017) note the importance of focusing on building core therapeutic abilities for therapist-trainees to enhance confidence and reduce anxiety. While the complexities of specific models and interventions are important to understand, these scholars make the point that therapists who possess a certain level of confidence in themselves and their abilities are more likely to achieve good outcomes in treatment. They identify a number of core therapist characteristics to be focused on in training programs: adaptability, projecting hope

and confidence, patience and pacing, self-reflection and insight, curiosity, humor, and sensitivity. Our findings further this list by suggesting that while therapists should be confident in their ability to help clients, they should also be confident in their theory of choice and its ability to produce good outcomes. Gurman (2011) punctuates this point by arguing that treatment outcomes in couple therapy require the person of the therapist to “fit” with their theoretical orientation. One might infer that this “fit” is best achieved through confidence and competence in the theory.

Adherence to model

Importantly, this study did not focus on the effects of any specific therapeutic model on dropout and alliance. Rather, it focused more holistically on the therapists' confidence—particularly in their individual theory of change. Although different mechanisms could explain how therapists' confidence in theory and dropout are related, one potential theory could be that those therapists who have more confidence in their theory are better able to create a coherent and collaborative treatment plan with the client. The ability to create a clear treatment plan in collaboration with the client has been associated with dropout repeatedly, showing to be an important factor when considering treatment outcomes and dropout (Friedlander et al., 2011; Scamardo et al., 2004). Therapists who have more confidence in their selected theory may be better able to collaborate with clients and adjust their theory to the needs of the client.

Implications for training and therapists

The results of this study suggest that training programs should focus on helping trainees with their understanding of theories of change and helping them to identify one or more theories that they will integrate and use consistently. Part of the training in CFT needs to focus on how the clinician thinks, not just on what a clinician does “in the room.” The first author is passionate about theory and how it should lead therapists in their decision-making. The results of this study suggest that when trainees believe they can use their theory consistently, that is, when they can apply it to various contexts and it helps them in determining their next move in treatment, their clients are more likely to stay in treatment longer and more likely to end with agreement. Established clinicians may already know that when they are using their theory of change more consistently that they get better outcomes, however, it seems that the field encourages therapists to use different theories depending on the presenting concern (i.e., see national exam questions). The results of this study would suggest that that might be problematic for therapists.

Limitations and future research

This project was not without its limitations. A larger sample of clients, as well as assessments of outcomes, would have provided more power to the study both statistically and conceptually. Having more male therapists in the sample would have also provided a more diverse sample of therapist-trainees. Using this same confidence instrument with seasoned therapists and understanding how confidence in the theory of change changes over time with more experience would also be an

important next step in this area of research. In addition, although our results appear to show a direct association between confidence and termination status, it is possible there could be some unexplored third variable associated with both that we have not yet discovered. Finally, the confidence scores used were those closest to when the client contacted the clinic and the therapist had completed the confidence scale. Therapists' confidence in their theory of change, especially during training, may change more rapidly, and during the course of working with a particular client. It may be necessary to assess therapist confidence more often to understand how it is related to client outcomes (alliance, termination status, and improvement in the presenting concern).

In essence, these findings indicate the importance of instilling confidence in new therapists through their training by providing them ample opportunity to conceptualize using their theory of choice through extensive supervision and practicum opportunities. In addition to conceptualization, programs should encourage trainees to explore different theoretical approaches to find their best "fit" and develop a belief in the tenets of their theory. Common factors research indicates the importance of self-of-the-therapist in producing effective outcomes. Our results suggest that a therapist must believe in the effectiveness of their theory in addition to being competent in its techniques and interventions. This may come through their own individual experiences of changing through their theory of choice. Future research should focus on therapists' confidence in their theory of choice and training programs should provide ample opportunity for students to conceptualize using their theory and grow confidence in its ability to create change both in themselves and their clients.

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APPENDIX A

Therapist confidence items

In thinking about your theory of change or the way that you feel most comfortable doing therapy, please rate how much you agree with the following statements:

1. When I think about my philosophy of change, I can easily apply it to my own situation and interaction.

2. When I think about my own family of origin, I can easily see how my philosophy of change can be applied to their interaction.

3. I have difficulty applying my philosophy of change to situations that my friends describe.

4. With clients with varying symptoms (i.e., depression, substance abuse, anxiety disorders) I can change my philosophy to meet their needs.

5. My philosophy of change applies to all problems/complaints that my clients bring to treatment.

6. When clients present me with an individually oriented problem, I can change my philosophy of change to an individually oriented therapy theory.

7. Using my philosophy of change, all problems or all client concerns can be viewed as relational.

8. I have not settled on one particular theory of change, I continue to explore which one(s) fits me the best.

9. Since evidence-based practice is so important, I revise my theory of change if a new research article suggests that a particular theory works best with a particular symptom or particular population of clients.

10. Even though I'm not settled on one particular theory of change, I've noticed that I tend to think the same way about clients and their concerns.

11. I've noticed that I use different techniques/interventions with different clients, but still tend to think about them and their concerns in the same way.

12. To say that techniques and theory of change are two different things confuses me.

13. I can conceptualize about my cases from my theory of change pretty consistently.

14. After I have used my theory of change to conceptualize about a case, I usually know what intervention/technique I will use in the next session.

15. In the moment when an intervention is required, I can rely on my theory of change to guide my therapeutic interactions.

Bolded items are those used in the current study and were consistently found to cluster into a single factor in the EFA.