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THE APPLICABILITY OF THE PARTNERS FOR CHANGE OUTCOME MANAGEMENT SYSTEM FOR PSYCHOTHERAPY IN SOUTH KOREA: EXPLORING KOREAN THERAPISTS' EXPERIENCES

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THE APPLICABILITY OF THE PARTNERS FOR CHANGE OUTCOME MANAGEMENT SYSTEM FOR PSYCHOTHERAPY IN SOUTH KOREA: EXPLORING KOREAN THERAPISTS' EXPERIENCES

DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Education
at the University of Kentucky

By

Sang-hee Hong
Lexington, Kentucky

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2020

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ABSTRACT OF DISSERTATION

THE APPLICABILITY OF THE PARTNERS FOR CHANGE OUTCOME MANAGEMENT SYSTEM FOR PSYCHOTHERAPY IN SOUTH KOREA: EXPLORING KOREAN THERAPISTS' EXPERIENCES

The introduction of psychotherapy approaches to another culture may require adjustments, such as cultural adaptation (Benish, Quintana, & Wampold, 2011; Griner & Smith, 2006). Unique features of a specific cultural group, such as a native language and traditional cultural values may interfere with new approaches. Although a client feedback system, the Partners for Change Outcome Management System (PCOMS; Miller, Duncan, Sorrell, & Brown 2005) has been established as an evidence-based treatment approach with clients in the United States, little has been examined on its utility in Korean psychotherapy. Therefore, the aim of this study was to investigate the applicability and utility of PCOMS for psychotherapy in South Korea. Specifically, Korean psychotherapists' experiences of deciding whether or not employing PCOMS and its implementation were analyzed with thematic analysis. The analysis generated four themes: implementation; the benefit of PCOMS; barriers to utilization; and background factors. Discussion of the study's findings and the implication for the practice, training, and research are provided.

Keywords: systemic client feedback, the Partners for Change Outcome Management System, Korean psychotherapy, cultural adaptation of psychotherapy, thematic analysis

Sang-hee Hong

04/21/2020

Date

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CHAPTER 1: INTRODUCTION TO PARTNERS FOR CHANGE OUTCOME MANAGEMENT SYSTEM (PCOMS)

Does effective psychotherapy in one culture also work for clients in another culture? Given that certain approaches are being used around the world, universal effects of psychotherapy seem to exist; however, it is difficult to assume that all approaches are equally applicable to clients from any cultural background. As multiculturalism in psychotherapy emphasizes that clients' cultural contexts should be considered in psychotherapy (American Psychological Association, 2002), meta-analytic research also indicates that culturally adapted psychotherapy is more effective for racial and ethnic minorities (Benish, Quintana, & Wampold, 2011; Griner & Smith, 2006). Therefore, when using specific therapy orientations and techniques, a therapist needs to be careful to assess effects on specific clients.

One psychotherapy process that has been known to be effective for clients in the United States, but has not been examined with Korean clients, is systematic client feedback. Monitoring client feedback in a systematic way has been established as contributing to successful psychotherapy in the United States (e.g., Lambert & Shimokawa, 2011; Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Schuman, Slone, Reese, & Duncan, 2015). Systematic client feedback, also called routine outcome monitoring (Boswell, Kraus, Miller, & Lambert, 2015), refers to the session-by-session collection of critical information about the client's levels of psychological distress and life functioning using a formal assessment (Lambert & Shimokawa, 2011). Utilizing measures to assess symptom alleviation or therapy outcome of clients is not novel in psychotherapy. However, systematic client feedback is different because formal

measures are utilized every therapy session so that a therapist and a client can incorporate assessment results into their work immediately after administration (Duncan, 2011).

There are two major benefits of systematic client feedback. First, systematic client feedback can improve psychotherapy by informing clinical decision-making, helping a therapist make client-guided decisions (Duncan, 2011; Macdonald & Mellor-Clark, 2015). Research results have indicated that therapists often overestimate success and underestimate failure of therapy outcomes (e.g., Chapman et al., 2012; Walfish, McAlister, O'Donnell, & Lambert, 2012). While these misjudgments may negatively influence premature termination and therapy outcomes, systematic client feedback can provide information from clients in every session so that a therapist can adapt approach and treatment plan (De Jong et al., 2014).

The second advantage of systematic client feedback is that it allows therapists to keep track of clients' progress. Therapists often fail to keep track of clients' changes, which provide therapists with the crucial information in planning and evaluating therapy. Oftentimes, the acknowledgement of even the slightest progress can reassure clients that they are improving (Youn, Kraus, & Castonguay, 2012). Moreover, a meta-analysis study indicated that systematic client feedback has more effect on clients who are not benefitting in early treatment than those on a more expected and desirable track of progress, resulting in reducing the risks of treatment failure (Shimokawa, Lambert, & Smart, 2010). Additionally, as a tool to monitor client progress in psychotherapy, client feedback systems utilize normative data that guide therapists to potentially better treatment outcomes.

Currently, there are several client feedback systems. They include the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE; Barkham et al., 2001), the Outcome Questionnaire System (OQ System; Lambert et al., 1996), the Partners for Change Outcome Management System (PCOMS; Miller et al., 2005), the Treatment Outcome Package (TOP; Kraus, Seligman, Jordan, 2005), among others. Each client feedback system mentioned above has adequate empirical support with its strengths and weaknesses (Boswell et al., 2015). Furthermore, in the United States, only the OQ System and PCOMS have been investigated through the use of randomized clinical trials (Duncan & Reese, 2015) and are included on the Substance Abuse and Mental Health Service Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices (SAMHSA, 2017). PCOMS will be further examined in the following section.

PCOMS and Its Utility around the World

PCOMS is comprised of two 4-item visual analogue scales: The Outcome Rating Scale (ORS; Miller & Duncan, 2000) and the Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2002). Respondents complete the ORS and SRS items by marking on 10-centimeter lines (visual analogue scales), and each item is scored to the nearest millimeter. The total scores of the ORS and SRS each range from 0 to 40 with higher scores indicating better outcomes. Adapted from an outcome monitoring measure with sound psychometric properties, the Outcome Questionnaire-45.2 (OQ-45.2; Lambert et al., 1996), the ORS is a global distress measure that assesses the level of functioning in individual, interpersonal, social, and overall domains (Miller & Duncan, 2000). The SRS is a therapeutic alliance measure developed using Bordin's (1979) definition of

alliance (i.e., relational bond, agreement on goals, and agreement on tasks) and Gaston's (1990) emphasis on the agreement between the therapist and the client on how people change in therapeutic alliance (Duncan et al., 2003). The SRS assesses therapeutic alliance in four areas: therapist-client relationship, goals and topics addressed in a session, approach and method the therapist employed, and overall work with the therapist (Duncan et al., 2003). Since PCOMS is based on the common factors of psychotherapy and not a specific therapeutic orientation, it can be integrated with any therapeutic approach (Duncan, 2012).

PCOMS can positively affect therapy process. Originally, PCOMS "started from everyday clinical practice and a desire to privilege the client in the psychotherapy process" (Duncan & Reese, 2015, p. 392). Specifically, PCOMS can lead clients to engage in therapy by inviting them to open up about their level of functioning and experiences during each therapy session. Considering that one of the reasons therapists do not prefer using outcome measures during therapy sessions is practical barriers, such as time (Hatfield & Ogles, 2004), PCOMS offers a feasible tool to improve therapy given the brevity of the measures and ease of use.

In addition, therapists can employ a social justice perspective and ultimately improve their work with clients from diverse backgrounds by using PCOMS (Duncan & Reese, 2015). Duncan emphasized that the belief in the value of the client's perspective and in clients as proactive participants is a necessity in administering PCOMS (2011). Specifically, the ORS helps to contextualize clients' psychological distress in their lives instead of pathologizing their symptoms (Duncan & Reese, 2015). The SRS makes it a norm for clients to discuss their preferred ways of interacting and working with their

therapists. In short, PCOMS leads therapists to ongoing self-examination, sharing power with clients, and giving voice to clients, all of which bring about enhancements of social justice in therapy (Goodman et al., 2004; Minieri, Reese, Miserocchi, & Pascale-Hague, 2015).

Most of all, PCOMS promotes better therapy outcomes. Results from randomized clinical trials (RCTs) have indicated that PCOMS benefits clients in various types of therapy, including individual, group, and couple therapy (e.g., Anker, Duncan, & Sparks, 2009; Reese, Norsworthy, & Rowlands, 2009; Slone, Reese, Mathews-Duvall, & Kodet, 2015). In addition, results of benchmark studies, although varying to some extent, suggested that therapy utilizing PCOMS for diverse clientele, such as youths (Kodet, 2019), the economically underprivileged (Reese, Duncan, Bohanske, Owen, & Minami, 2014), and parolees (Grossl, 2016) is as beneficial as treatment efficacy in RCTs.

PCOMS, originally created in the United States, has been translated into diverse languages, and its applicability and utility in other countries has been examined. Currently, PCOMS has been translated into 23 languages, including Arabic, Chinese, Dutch, French, German, Greek, Russian, Spanish, and Slovak (Heart and Soul of Change, 2017). The ORS and SRS have been found to generate reliable and valid scores in Australia (Campbell & Hamsley, 2009), the Netherlands (Hanfkenscheid, Duncan, & Miller, 2010), and Norway (Anker, Duncan, & Sparks, 2009), which are Western and White-dominant societies. Despite the increasing number of languages in which PCOMS has been translated, only a small number of countries have tested the utility of systematic client feedback (Anker et al., 2009; She et al., 2018), providing little information on the benefit of PCOMS for clients from diverse cultural backgrounds.

Therefore, the purpose of this study was to examine the applicability of systematic client feedback for Asian clients, particularly clients in South Korea. Psychotherapy in South Korea has developed by accepting various Western theories, and therapeutic approaches widely used in the United States have been found to benefit Korean clients (Bae et al., 2003). Given this, it seems reasonable to infer that systematic client feedback would also be beneficial to Korean clients. Simultaneously, without cultural considerations, PCOMS may not be as effective in South Korea as in the United States. For example, authoritarian culture in Korea (Joo, 2006) may negatively affect using systematic client feedback for Korean clients because PCOMS encourages an egalitarian relationship between a therapist and a client. To investigate the impact of these seemingly incompatible factors on the utility of PCOMS in South Korea, the experiences of Korean psychotherapists who have used PCOMS will be explored.

In addition, perspectives of Korean psychotherapists who did not utilize PCOMS after obtaining training will be explored to examine considerations for cultural adjustment of PCOMS. Using thematic analysis, themes from Korean psychotherapists' experiences and perspectives shed light on whether or not PCOMS can be a beneficial tool with Korean clients, when it is effective or not effective, and any cultural adaptations that should be considered within an Asian/Korean context. Although not including the clients' perception can limit the understanding of the utilization of PCOMS, therapists' perceptions provide a good starting place for understanding the clinical utility of client feedback being part of the psychotherapy process. The results provide preliminary insights about subgroups of Asian clientele (i.e., those from East Asian countries) who share similar cultural values with Koreans'. In the following section, the characteristics

of psychotherapy in South Korea will be discussed to explore potential benefits and limitations of PCOMS for Korean clients.

CHAPTER 2: SELECTED LITERATURE REVIEW ON PSYCHOTHERAPY IN SOUTH KOREA AND PCOMS

In order to evaluate the utility of PCOMS for Korean clients, aspects that best demonstrate Korean psychotherapy are explored. Specifically, the history, development, theories and approaches, and treatment outcomes of psychotherapy in South Korea are reviewed in this section. Then, the effects of PCOMS with clients from the Unites States and a couple of other countries are examined. Finally, potential strengths and weaknesses of using PCOMS with Korean clients are evaluated.

History and Current State of Psychotherapy in South Korea

Compared to Western societies, the concept of psychotherapy is relatively new in South Korea. It has been established as an independent professional field since Western psychotherapy, mainly psychoanalysis, was introduced to Korean psychiatrists back in the 1930s for the first time (Rhi, 1988). Later, in the 1950s, clinicians started to practice psychotherapy (Bae, Joo, & Orlinsky, 2003). Before Western psychotherapy was imported, psychological disorders in Korea were treated by folk-medicine practitioners and spiritual or religious healers, such as shamans, Buddhist monks, Tao priests and Confucian scholars (Jeong, 2015; Joo, 2006; Rhi, 1988). In addition, individuals often consulted with authority figures in their family, extended family, and community, based on a belief that the elderly were wise, knowledgeable, and therefore respectable (Kim, Atkinson, & Umemoto, 2001). Due to the traditional ways of addressing mental disorders, psychotherapy in Korea has tended to be incident-focused, authoritarian, and short-term (Joo, 2006).

Since the late 1950s, counseling psychology has been established as a unique professional field in South Korea. Literature addressing the history of counseling psychology in South Korea suggests that counseling workshops for junior-high and high-school teachers, offered by American education delegates in 1957, were the first meaningful events in the development of this field (Jeong, 2015; Ryu & Park, 1998). Therefore, counseling and guidance in middle and high schools mainly constituted the field of counseling psychology in South Korea during this time (Lee, Suh, Yang, & Jang, 2012; Park & Hwang, 2008). One of the most representative academic organizations of counseling, the Korean Counseling Psychological Association (KCPA), was founded in 1986 as one division of the Korea Psychological Association after having been a part of the division of Clinical Psychology for 22 years (KCPA; 2016). In addition, the first counseling center at a Korean university was founded in 1962, and the first graduate counseling psychology program was founded in the early 1970s (Lee et al., 2012).

There has been rapid growth in the field of psychotherapy over the past 50 years in South Korea (Joo, 2006). Since the KCPA first certified six counseling psychologists in 1973, the number of certified professionals has drastically increased. Currently, there are more than 800 private counseling institutions and more than 17,000 counseling professionals in various mental-health fields (Han & O'Brien, 2014). The expansion of the number of professionals has occurred mainly because more and diverse professionals have become involved in the field of psychotherapy (e.g., social workers, developmental psychologists, experts in child and family studies, art therapists, and religious therapists), and more organizations for different professionals have opened accordingly. Additionally, increased social issues associated with mental health concerns, such as high

suicide rates, an extremely competitive educational atmosphere for adolescents and emerging adults, economic letdown, increasing unemployment rates, and intergenerational conflicts, have led to the need for more professional help (Joo, 2006; Lee et al., 2012).

Despite the rapid growth in the field of psychotherapy, further tasks remain unaddressed. First, the qualifications of therapists are not systemically regulated (Bae, Joo, & Orlinsky, 2003; Lee et al., 2012; Park & Hwang; 2008). Because there is no national licensure system for psychotherapists, there are two competing certification systems offered by the KCPA and the Korean Counseling Association, an organization for therapists with a background outside of psychology (Park & Hwang, 2008).

Currently, Korean national licensure in mental health includes psychiatrists, clinical psychologists, mental-health social workers, and counselors for youth (Joo, 2006). Furthermore, underqualified psychotherapists can start a private practice without any oversight from associations or the Korean government. Consequently, the current lack of government licensure for psychotherapists impedes therapists, as their professional identities provide a misleading impression that they are not as professional as other mental-health practitioners that have government licenses. In addition, the lack of unified licensure leaves trainees puzzled about the procedure for becoming a licensed practitioner. Most worrisome is that clients feel challenged when seeking a qualified therapist or when filing complaints about inadequate therapy services. Lastly, the fees for psychotherapy are not reimbursed by health insurance (Lee et al., 2012). Therefore, individuals are likely to avoid seeing therapists, even when necessary, due to the financial burden.

Theories and Orientations of Psychotherapy and Treatment Outcomes

Therapeutic approaches in South Korea reflect the West-influenced history of psychotherapy. Major theories in Korean psychotherapy include psychodynamics/psychoanalysis, cognitive behavioral therapy, humanistic therapy, and gestalt therapy, which demonstrate heavy reliance on Western theories with few cross-cultural considerations of Korean psychotherapy (Bae et al., 2003; Jang, 1999; Park & Hwang, 2008). Also, various treatment modalities established in Western countries, particularly in the United States, have continued to be introduced to Korea and found effective for Korean clients, such as dialectical behavior therapy (Jin & Son, 2013; Linehan, 2007), and acceptance and commitment therapy (ACT; Hayes & Smith, 2010; Joo & Son, 2015). Although outdated to some extent, Bae et al. (2003) suggested that the most popular therapeutic orientations were psychodynamics/psychoanalysis followed by humanistic and cognitive behavior approaches in South Korea using a limited number of therapists ($N = 123$).

Culturally adaptive psychotherapy in South Korea has remained vague with few research findings. Approaches based on Korean traditional philosophy, such as Confucianism, Taoism, and Buddhism have also developed to better serve the Korean clients' needs, but their outcomes have rarely been examined using empirical research methodologies (Lea, Yang, & Seo, 2007). Scholars and practitioners have criticized that most therapists in South Korea utilize Western psychotherapy theories without examining their cultural applicability (Jang, 1999; Yun, 2007). After analyzing interviews with Korea humanistic psychotherapists, Joo et al. (2007) indicated that Koreans have a tendency of being emotionally driven and that cognitive or analytic approaches are not

effective for them. However, empirical research to investigate what should be done for culturally adapted interventions, and if they work for Korean clients, is scarce. In their qualitative study to explore Korean psychotherapy, Lea et al. (2007) found that Korean psychotherapists are not sure about the differences between Korean and Western psychotherapy and further research is necessary to explore them.

However, treatment outcome research using empirical data in South Korea indicates that various Western therapeutic approaches are effective for diverse clients and their concerns. For example, a meta-analysis on adolescent clients indicated that humanistic and cognitive behavioral group therapy (Hong, Yim, & Kim, 2001) and gestalt group therapy (Kim & Kim, 2016) benefited Korean adolescent clients. Another meta-analysis on workplace stress reduction interventions indicated that cognitive behavioral therapy, art therapy, transactional analysis, mindfulness, ACT, reality therapy, and an integrative approach benefitted adult clients (Wang, Cheon, & Hong, 2016). For couple therapy, interventions based on a Satir model, reality therapy, rational emotive behavioral therapy, solution-focused therapy, and other approaches have been used and also found to be effective (Kim & Yang, 2012). However, as discussed in the paragraph above, outcome studies did not explicitly address if cultural adaptations were employed in their interventions.

In order to provide a brief picture of contemporary outcome studies in South Korea, RCT studies published from 2014–2017 in two major psychotherapy journals in South Korea (i.e., *The Korean Journal of Counseling and Psychotherapy* and *Korean Journal of Counseling*) are presented in Appendix A. Overall, research findings indicate that various therapeutic interventions originated from Western societies were beneficial

to address psychological distress in Korean clients. It was also notable that all interventions were conducted in group settings while no study used individual psychotherapy, which show that there may be an unfavorable environment for collecting data from individual therapy. While a few studies did not identify the employed theoretical approaches, their results indicated that an integrative approach combining cognitive, emotional, and behavioral bases for specific issues (e.g., a smartphone addiction intervention) was utilized. Focusing more on clinical issues and less on therapeutic approaches may reveal that psychotherapy in South Korea tends to employ a problem-focused approach.

Clients in South Korea

Given that the great proportion of therapy outcome variance is explained by client factors (Wampold, 2001; Wampold & Imel, 2015), it is crucial to investigate characteristics of Korean clients to understand Korean psychotherapy. Research on the characteristics of Korean clients emphasizes the significance of relational issues and stigmas attached to receiving mental health services among Korean clients (Jang, 1999; Joo, Lee, & Joo, 2007; Lea et al., 2007). In South Korea, relational difficulties often stem from cultural values of familism, hierarchism, and harmony in relationships, which are influenced by Confucianism and other traditional Asian philosophies (Lee, Suh, Yang, & Jang, 2012; Park, Shim, & Lee, 2014). These relational values can manifest when Korean clients perceive therapists as authoritative figures and therefore have difficulty having open discussions, instead requesting therapists' guidance and advice. In addition, the importance of maintaining harmonious relationships and valuing interconnectedness instead of independence often prevents Korean clients from

disagreeing with their therapists even when necessary. In terms of familism, family members share a collectivistic identity and all of them tend to share the emotional and social consequences of achievements or misbehaviors of other members; therefore, Korean clients are likely to be reluctant to open up about concerns related to their family (Joo, 2009).

Negative stereotypes of mental health are also salient among Korean clients. In general, Koreans are reluctant to seek professional help to address mental health issues because of the cultural tendency to minimize psychological difficulties (Park & Hwang, 2008; Park & Seo; 2009). For example, Korean university students reported to prefer discussion with friends and family or keeping quiet when they have concerns, instead of seeking professional help (Oh & Kim, 2015). In addition, Koreans often prefer psychotherapists to psychiatrists or clinical psychologists in hospitals, as many individuals are concerned that medical records may negatively affect their social life (Joo, 2009). Koreans often perceive that psychological distress is shameful, thinking that it stems from personality flaws or a lack of willpower that should be independently resolved (Lee, 1997). Due to the barriers to admitting psychological distress, Koreans tend to experience somatic symptoms when suffering from psychological distress, as in "*Hwa-Byung*," a psychological syndrome characterized by symptoms of somatization and emotional distress, such as depression and anger, which is particularly prevalent among Korean middle-aged women (Lee, Wachholtz, & Choi, 2014).

However, it is also noteworthy that cultural values and negative perceptions about psychological difficulties have been changing in South Korea. While traditional cultural values, such as familism, interdependence, hierarchy, and harmony are influential, more

Western and individualistic ways of life have spread as Korean society has moved from an agrarian to industrial and capital-focused society over the past 50 years (Hyun, 2001). In addition, although Koreans tend to regard themselves as a homogeneous group, various sub-groups in Korea self-identify by their sexes, sexual orientations, generations, social statuses, geographical regions, and political stance, and they have different social identities and accordingly diverse cultural values.

Consequently, today's Korean clients cannot be considered a homogeneous clientele. Also, the Korean public's perception of psychotherapy seems to have become more positive. A study of Koreans who received psychotherapy (Park & Seo, 2009) indicated that they felt less stigma about seeking professional help and were more willing to seek future counseling. Moreover, Koreans have more opportunities to learn about the benefits of psychotherapy because there are a couple of famous television shows where real families or couples go to therapy and work through their conflicts. Consequently, the negative perceptions of psychotherapy may continue to subside as the Korean public becomes more exposed to psychotherapy and its benefits.

Benefits of PCOMS in the United States and Other Western Countries

To investigate the potential benefits of PCOMS for Korean clients, existing PCOMS studies, of which the vast majority utilized the United States samples, were reviewed. Specifically, the advantages of using PCOMS included utilization of the measures with sound psychometric properties, feasibility, improvement of therapy outcomes, enhanced working alliance, and increased client retention (Duncan & Reese, 2015; Lambert & Shimokawa, 2011).

Reliability. Overall, research findings demonstrated solid psychometric properties of the ORS and SRS, even though these measures have a small number of items that threaten validity and reliability. First, the ORS has generated reliable scores with diverse samples. Coefficient alphas have been reported to be high with a range from .77 to .97 using U.S. samples (Bringhurst, Watson, Miller, & Duncan, 2006; Miller et al., 2003; Reese et al., 2013; Reese et al., 2009), and with a range from .83 to .91 in Norway (Anker, Owen, Duncan, & Sparks, 2010), the Netherlands (Hanfkenscheid et al., 2010), and Australia (Campbell & Hamsley, 2009).

The test-retest correlations of the ORS demonstrated that ORS scores were stable across time for U.S. samples with a few exceptions. Miller et al. (2003) reported test-retest reliability coefficients of .66, .58, and .49 between two consecutive scores obtained at the first through fourth administrations using a non-clinical sample ($N = 86$), which was significantly lower than the test-retest reliability of the Outcome Questionnaire 45.2 (OQ-45.2; Lambert et al., 1996). In contrast, a replication study using a non-clinical sample ($N = 98$) demonstrated that the correlations between the two consecutive scores at the first, second, and third administrations were .80 and .81 respectively, which were comparable with those of the OQ-45.2 (Bringhurst et al., 2006). However, the low test-retest reliability coefficients may indicate sensitivity of the ORS to a rater's changes, which was the original purpose of the ORS (Miller et al., 2003).

Reliability of SRS scores has also been established through internal consistency and test-retest correlations. Internal consistency coefficient alphas in studies using both clinical and non-clinical samples were high, ranging from .88 to .92 (Anker et al., 2009; Duncan et al., 2003; Reese et al., 2009; Reese et al., 2013). Duncan et al. found that the

internal consistency of the SRS was similar to that of the Revised Helping Alliance Questionnaire (HAQ-II; Luborsky et al., 1996), one of the widely used measures of alliance. Internal consistency coefficient alphas in studies using international clinical samples were high, ranging from .86 to .93 in Australia (Campbell & Hamsley, 2009) and the Netherlands (Hanfkenscheid et al., 2010).

Validity. Results of validity studies demonstrate sound validity of the ORS and SRS for the United States, Australian, and Dutch samples. Concurrent validity of the ORS using both clinical and non-clinical samples has been found to be adequate when calculating correlations with established measures, such as the OQ-45.2 (r = .53−.69; Bringhurst et al., 2006; Miller et al., 2003), the Symptom Checklist-90-Revised (Derogatis, 1992; r = .57; as cited in Reese, Toland, Slone, & Norsworthy, 2010), and Clinical Outcomes in Routine Evaluation (Barkham et al., 2001; r = .67; as cited in Reese et al., 2010). For an Australian clinical sample, Campbell and Hemsley (2009) reported moderate to strong correlations between the ORS and the sub-scales of the Depression Anxiety Stress Scale-21 (Lovibond & Lovibond, 1995; r = .54 –.76), Quality of Life Scale (Burckhardt & Amderson, 2003; r = .68), and Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965; r = .46 –.67). Hanfkenscheid et al. (2010) suggested that the discriminant validity of the ORS was adequate because of the lower correlation between overall ORS scores (throughout the first to tenth therapy sessions) and the Therapist Satisfaction Scale (TSS; Tracey, 1992; r = .22) with a Dutch clinical sample.

In terms of the SRS, its concurrent validity has been demonstrated as acceptable through correlations using established measures, such as HAQ-II (r = .48; Duncan et al., 2003). Duncan et al. also found that correlations between each SRS item and total HAQ-

II scores ranged from .39 to .44, indicating that the SRS, although ultra-brief, can assess therapeutic alliance similar to longer, research-oriented alliance measures. For an Australian clinical sample, Campbell and Hemsley (2009) found that the SRS scores correlated with the OQ-45 (r = .28) and the Working Alliance Inventory-12 (WAI-S; Tracey & Kokotovic, 1989; r = .58), with inter-subscale correlations that ranged from .37 (WAI-S Bond – SRS Relationship) to .63 (WAI-S Goal – SRS Approach). The SRS was found to be weakly correlated with self-esteem as measured using the RSES (r = .24) and was not correlated with self-efficacy, depression, or quality of life (Campbell & Hemsley, 2009).

Sensitivity to change. A feature of the ORS is its ability to monitor client change. Specifically, Miller et al. (2003) suggested that the ORS well reflects raters' changes because pre-post administrations of the ORS between the first and tenth sessions in a clinical sample were significantly different while those in a non-clinical sample over the same time period were not significantly different. Combined with the reliability of the ORS, the finding indicates that the ORS generates reliable scores, while it is sensitive to progress in clients receiving therapy.

Feasibility. The main purpose of developing the ORS and SRS was brevity and convenience, which increased substantial use of measures during therapy sessions (Miller et al., 2003). Oftentimes, therapists find it challenging to use outcome measures due to practical reasons, such as time and money (Hatfield & Ogles, 2004). Therefore, the extent to which a measure can be introduced, completed, and interpreted with little time and energy is a crucial advantage of PCOMS. Miller et al. (2003) found that compliance rates of the ORS increased while those of the OQ-45.2 dropped for a year, when they

were compared with the data of therapists at two mental health agencies who had a similar practice of introducing and mandating the ORS and the OQ-45.2, respectively. Although the study was limited to the use of the ORS, comparable results are expected with the SRS, which is as brief as the ORS.

Quality improvement strategy. PCOMS has been found to be effective in improving therapy outcome. Studies using RCTs indicated that PCOMS was beneficial for individual, couple, and group therapy (e.g., Anker et al., 2009; Reese et al., 2009; Schuman et al., 2015). A study including two RCTs at a university counseling center and a graduate training clinic with 74 clients, respectively, indicated that client feedback conditions led to significantly better outcomes more rapidly, compared to a non-feedback-condition in individual therapy (Reese et al., 2009). The findings of a study using 410 participants attending couple therapy at a community family counseling clinic in Norway demonstrated that a feedback condition yielded significantly better outcomes, nearly four times the rate of clinically significant change compared to a treatment-as-usual (TAU) condition (Anker et al., 2009). Anker et al. employed multi-level modeling to control a varying degree of therapist effects, attributing their results favoring a feedback condition over TAU to different treatment conditions. Another study with 46 couples, who had couple therapy at a graduate training clinic in the United States, also indicated that a feedback condition yielded significantly greater outcomes more rapidly, compared to a TAU condition (Reese, Toland, Slone, & Norsworthy, 2010).

For group therapy, one study conducted at a military treatment clinic with 263 active-duty male and female soldiers, who attended a substance abuse program, indicated that a feedback condition led to better outcomes reported by clients and others (i.e.,

therapists and commanders) when compared to those in a TAU condition (Schuman et al., 2015). Schulman et al. also reported that a feedback condition had nearly double the percentage of clients who made clinically significant change and a significantly lower percentage of clients who made no change. Another study with 84 clients who attended interpersonal process group psychotherapy at a university counseling center demonstrated significantly more improvement and better retention when compared to a TAU condition (Slone, Reese, Mathews-Duvall, & Kodet, 2015).

Along with RCTs, benchmark studies also have been used to evaluate PCOMS effect for underrepresented groups in naturalistic settings (Duncan & Reese, 2015). Reese et al. (2014) compared the effect size of treatment gains of depressed adults (*N* = 1,589) in a public behavioral health setting in the southwest of the United States to the aggregated effect size from RCTs. The findings indicated that treatment outcome using PCOMS for adults with depression was comparable to effect size estimates of RCTs with depressed clients in a feedback condition.

Another benchmark study using ethnically diverse youths, who were impoverished and with depression-associated diagnoses (*N* = 469), indicated that the outcome of psychotherapy using PCOMS in a public behavioral health setting for youths was comparable to clinical trials using intent-to-treat analyses (Kodet, 2019). Grossl (2016) evaluated the psychotherapy using PCOMS for parolees (*N* = 1,112), in a non-clinical range, referred by the criminal justice system in southeast of the United States and suggested that the treatment outcome was superior to that of TAU, although not equivalent with those of feedback conditions in RCTs using PCOMS.

However, one study suggested that PCOMS may have limited long-term effects (Rise, Eriksen, Grimstad, & Steinbekk, 2016). Rise and colleagues conducted an RCT with 75 outpatient participants in a mental health hospital in Norway and analyzed data from baseline and 6-month and 12- month follow-ups. The findings indicated that both feedback and non-feedback groups showed improvement and that the feedback condition exceeded the non-feedback condition only in ability to manage mental health problems. While Rise et al. did not provide any potential reasons for their findings, it could be that the unfavorable results for PCOMS were due to a small sample size, severity or kinds of mental illness of participants, or unidentified cultural characteristics of psychiatric hospitals in Norway. In order to clarify the factors that help treatment gains of systematic client feedback, further research is necessary.

Working alliance. The SRS, one measure of PCOMS, provides a formal tool to directly address working alliance by the regularly monitoring client perceptions of the client-therapist relationship, goals and topics addressed in therapy, therapist approaches or methods, and the overall of the therapy session (e.g., Duncan & Reese, 2015). The working alliance is known to predict treatment outcomes (Orlinsky, Rønnestad, & Willutzki, 2004); the SRS has also been found to predict treatment outcomes. For example, Duncan et al (2003) reported that second or third SRS scores were significantly correlated ($r = .29$) with last session ORS scores in their study to evaluate the psychometrics of the SRS using 100 cases from outpatients in a mental health agency.

In the case of a study of a Dutch version of PCOMS, with 126 Dutch outpatients in a mental health agency, findings indicated that SRS scores at the third administration significantly predicted ORS scores at the tenth administration, while first and second SRS

scores were not correlated with tenth session ORS scores (Hanfkenscheid et al. 2010). In addition, findings from a study with 250 couples (500 individuals) in Norway suggested that the SRS scores in first-session did not predict treatment outcomes while those in last-session did for individual and partner outcomes when controlling for pre-therapy functioning and the number of sessions (Anker, Owen, Duncan, & Sparks, 2010). Anker et al. (2010) also reported that the sub-sample of 118 couples who participated in at least four couple sessions showed that third-session alliance predicted reliable change. In conclusion, SRS scores in early sessions, despite mixed results, tends to predict the ORS score in later sessions and is a useful marker of treatment progress.

Client retention. PCOMS provides a tool to openly discuss a client's perception on treatment gains and cooperation with therapist; therefore, it can reduce premature terminations (Duncan, 2011). For example, Miller et al. (2006) reported that clients who completed the ORS, but not the SRS, in their intakes were three times less likely to have an additional session than those completed the SRS after observing 3,612 clients who had had telephone therapy, which was offered to employees in a company. An RCT conducted at a military treatment clinic with 263 active-duty male and female soldiers, who attended a substance abuse program, indicated that a feedback condition had a better retention rate than a TAU condition did (Schuman et al., 2015).

A clinical training tool. Therapists can benefit from PCOMS in training (e.g., Duncan & Reese, 2015; Sparks, Kisler, Adams, & Blumen, 2011). For example, PCOMS can provide a structured and practical framework for trainees using any therapeutic approach, in order to establish early comfort and confidence (Sparks et al., 2011). Also, regularly monitoring client progress and the working alliance can highlight strengths

and/or weaknesses of a trainee, providing data to which trainees can refer for their development. Research results also support the benefit of PCOMS for therapists in training. Specifically, Reese et al. (2009) investigated 28 therapists in training in either a feedback condition or a non-feedback condition for one academic year; findings indicated that that trainees who used PCOMS with clients discussed the data in supervision improved more than those who did not. In addition, they suggested that trainee self-efficacy was correlated with treatment outcomes only for trainees who used PCOMS, inferring that consistent feedback on therapist performance through systematic client feedback becomes a substantial base for linking their perceived capability to actual outcomes in therapy. In addition, findings from a study by Grossl et al. (2014), using 44 trainees, indicated that trainees who utilized PCOMS reported significantly greater satisfaction in supervision than those who did not, while no significant difference existed in terms of supervisory working alliance. As such, PCOMS is likely to facilitate trainee development and supervision satisfaction.

PCOMS in South Korea

Potential benefits. Given the selected literature reviewed above, PCOMS is likely to benefit Korean therapists and clients in several ways. Firstly, therapists in South Korea have an opportunity to utilize a new therapy technique, systematic client feedback, which has not been introduced yet. Measures of systematic client feedback, such as the Outcome Questionniare-30 (OQ-30; Thompson, 2004) and Outcomes in Routine Evaluation-Outcome Measure (CORE-OM; Barkham et al., 2001) have been validated using Korean samples. However, Korean researchers (i.e., Korean OQ-30: Sohn & Yoo, 2012; Korean CORE-OM: Kim & Wang, 2016) have focused on creating valid and

comprehensive outcome measures rather than utilizing a therapeutic technique of regular discussion on client progress and cooperation between a therapist and a client. Therefore, the introduction of PCOMS (or another outcome monitoring system) to South Korea, with an emphasis on features of a clinical intervention, is needed because it offers the potential to improve therapy outcomes.

Secondly, PCOMS offers an efficient tool with which a therapist and a client can discuss progress of the client and their interactions in therapy, possibly improving treatment outcomes. Given the brevity of the ORS and the SRS, they can be administered quickly in each session, while still providing crucial clinical data, without spending too much time on completing, scoring and interpretation. In addition, as the ORS does not address diagnoses, Korean clients will likely benefit from discussing their concerns using their personal frames of reference instead of fitting their experiences into a diagnostic system. In South Korea, using diagnostic terms is likely to be less beneficial, particularly because health insurance does not cover psychotherapy; therefore, not discussing diagnoses-related topics while utilizing the ORS may lower a client's resistance to seeking professional help due to pervasive stigmas attached to mental disorders.

Thirdly, PCOMS can potentially improve the therapeutic alliance by fostering collaboration between the therapist and the client, directly addressing ruptures in therapeutic relationships (Duncan & Reese, 2015). Research using Korean clients indicates that collaboration between clients and therapists reduces initial dropouts, and eventually improves therapy outcomes (Lee & Cho, 2010; Oh, 2011; Yun & Yoo, 2016). Therefore, Korean clients can benefit from PCOMS, which facilitates therapist-client

cooperation based on regular and transparent monitoring of client distress and therapeutic alliance. Furthermore, Korean clients tend to expect their therapists to be directive, which stems from a culture of deference for authority figures (Kim et al., 2001). Joo and colleagues (2007) suggested that even humanistic therapists need to be flexible in order to make direct interventions when necessary, based on qualitative analyses of data from experienced Korean humanistic therapists. However, a few studies on Korean clients and therapists suggest that therapists' directiveness can negatively affect the client's level of resistance, and that effectively addressing clients' high passivity and dependence on therapists at the initial phase of therapy is key to bringing about improved outcomes (Joo & Park, 2105; Kim, Kwon, Han, & Sohn, 2008). Therefore, the use of the SRS will likely lead to regular evaluation of the client's expectations about therapists, timely interventions to improve therapeutic relationships, and eventual enhanced therapy outcomes.

Lastly, PCOMS can offer a great tool for trainees to improve their clinical ability in addressing clients' expectations and therapeutic alliance. Addressing client dissatisfaction is one of the most challenging tasks likely to threaten therapists' confidence and efficacy for trainees (Oh, 2011). In addition, Korean cultural norms value harmony in relationships, which can impair therapists' ability to address relational difficulties in therapy. PCOMS, particularly the SRS, can be a beneficial formal instrument for new Korean therapists who want to learn how to invite clients to discuss their relational experiences and negotiate client expectations, regardless of their therapeutic approaches. Moreover, Korean trainees can utilize the PCOMS data to

analyze their current clinical strengths and weaknesses and discuss how to improve them in supervision.

Considerations. Clinical interventions need to be modified for clients from diverse backgrounds (Constantine, 2002; Griner & Smith, 2006). Therefore, without considering Korean culture and values that may affect the practice of PCOMS, Korean clients may not benefit from PCOMS. First, due to Korean social norms highlighting respect for authority figures and harmonious relationships (Kim et al., 2001), SRS scores may not correctly reflect Korean clients' subjective experiences in therapy. In addition, the use of the SRS may not facilitate open discussion, particularly about negative experiences in therapy. Therefore, Korean psychotherapists may need to spend more time educating clients about the SRS, discussing their hopes and concerns so that they feel able to share their expectations and experiences in therapy sessions. For example, a therapist may discuss Koreans' tendency of not opening up about their negative feelings and thoughts in interpersonal relationships in order to normalize engagement in such behaviors and let clients know that such feedback will not impair their therapeutic outcomes. Further, considering that Reese et al. (2013) suggested that SRS scores were not correlated with client social desirability in the United States, empirical studies should be conducted to investigate the potential effect of Korean cultural norms on the administration of PCOMS.

Another potential concern in using PCOMS with Korean clients includes that the four questions of the ORS may not fully represent the areas of clients' psychological disturbances. The ORS is comprised of four questions about the level of functioning: "individually (personal well-being)", "interpersonally (family, close relationships)",

"socially (work, school, friendships)", and "overall (general sense of well-being)." However, considering that relational issues in family and social contexts are of importance among Korean clients (Jang, 1999; Joo et al., 2007), having one question about an interpersonal area may misrepresent the clients' subjective experience of psychological distress. Therefore, additional questions about interpersonal functioning or family life may help identify and evaluate Korean clients' psychological distress. Otherwise, it would also be helpful to check with clients if they have issues that they did not mark on the ORS in order to ensure that the format of the ORS is suitable in revealing clients' levels of functioning.

In addition, a few ORS and SRS items may have slightly different meaning from the original intention when introduced to Korean clients via verbatim translation. For example, *individually (personal well-being)* on the ORS may not be specific for Korean clients, who are likely to have stronger collective identities than individual identities. In the case of the Chinese ORS, Lee translated *individually (personal well-being)* on the ORS as 身心健康 (physical and psychological health) because Chinese clients tend to report somatic symptoms when they struggle with psychological distress (personal communication, September 9, 2016). As such, adjustment of the measures based on cultural aspects in South Korea should be considered instead of simply relying on word-for-word translation.

Purpose of Study

The aim of the current study was to investigate the applicability and utility of PCOMS to Korean psychotherapy. Specifically, experiences of Korean therapists who utilized PCOMS with their Korean clients were explored to examine their thoughts and

experiences of using PCOMS with their clients in South Korea. Therapists are the ones who decide whether to use specific therapeutic approaches and techniques; therefore, investigating their experiences can aid in understanding the applicability of PCOMS in Korean psychotherapy. Also, in-depth analysis of therapists' experiences can shed light on how Korean culture affects the utilization of PCOMS in South Korea, identifying possible cultural adaptations when using PCOMS with Korean clients.

Research questions. The main research questions to guide the present study were as follows: What were the experiences of Korean therapists when they used PCOMS with their clients? What contributes to Korean therapists' belief that PCOMS is or is not applicable to Korean clients? What modifications, if any, are needed for the use of PCOMS with Korean clients?

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

Design Overview

In order to explore Korean therapists' experiences of using PCOMS with Korean clients, the ORS and SRS were introduced to Korean psychotherapists. The introduction of PCOMS to Korean therapists was comprised of providing Korean-adapted versions of the ORS and SRS and training. Then, participants for this study were recruited among Korean therapists who attended PCOMS training. The interviews were recorded and analyzed using thematic analysis. Thematic analysis is one of the most widely used qualitative research methods to identify, analyze, and describe repeated themes (Braun & Clarke, 2006; Willig, 2013). It is particularly useful to investigate research areas that do not have existing research, and where there is a specific need to learn about specific phenomena, as in the research topic of this study.

Adaptation of the ORS and SRS

The procedure of scale adaptation included translation, back-translation, and verification with slight variations (e.g., Borsa, Damásio, & Bandeira, 2012; Brislin, 1970). The author followed these steps to adapt the English ORS and SRS into Korean versions. Throughout the adaptation process, eight people, both within and outside of the field of psychology, participated in order to reduce the linguistic and cultural biases (Borsa et al., 2012; Hambleton, 2005). First, the ORS and SRS were translated into Korean; three people were involved for each measure. It was comprised of three steps: a draft, reviews of the draft, and integration of the draft and reviews. For the ORS, a bilingual Korean counseling psychologist made a draft, a bilingual Korean clinical psychologist reviewed it, and the author reviewed and integrated the input. For the SRS,

the author made a draft, and then a bilingual Korean counseling psychologist, and a bilingual Korean not associated with psychology reviewed it. Finally, the author synthesized this input as well. At this stage, all suggestions from those involved in the translation procedures were employed, and when they recommend changes that differed from one another, the author made final decisions, considering the potential impact of each suggestion.

The notable modifications in the first stage of adaptions were as follows. The items on the ORS, which are written in adverb forms (i.e., *individually*, *interpersonally*, *socially*, and *overall*) were translated into nouns (i.e., individual aspects, interpersonal aspects, social aspects, and overall aspects), in order to make the ORS less informal for Korean clients, who perceive the noun phrase as more formal, professional, and, therefore more reliable. For the SRS, the anchors for the *Approach or Methods* item, *The therapist's approach is not a good fit for me* and *The therapist's approach is a good fit for me* were translated into past tense so that clients understand that the need to respond in terms of what they worked on with their therapists. It does not sound natural in Korean if the item uses present tense, as in the English version.

On the other hand, the author did not follow some suggestions from other reviewers. For example, the person who reviewed only the SRS suggested a word, 회기 (session) of *Session Rating Scale* is not commonly used among lay people and it would be better to use 상담 (counseling), instead. The author did not follow this suggestion as it is likely to cause confusion with the Outcome Rating Scale, which has been translated into 상담 결과 평가 척도 (counseling outcome rating scale).

The second step was back-translation. Two Korean bilinguals, one having a master's degree in counseling psychology and the other not associated with counseling psychology, translated the Korean ORS and SRS into English. Then, an American counseling psychologist, who specializes in training and research on PCOMS, reviewed the back-translated ORS and SRS comparing them with the original versions. The review suggested that the back-translation was comparable with an original version and recommended reconsidering a word (*happiness*) in the back-translated ORS for *wellbeing* in the original version. Accordingly, *wellbeing* in the ORS was translated into 건강 및 안녕감 (health and a sense of wellbeing) instead of happiness. 'Health' was added because the word 'wellbeing' is not commonly used in the Korean public and may not be fully understood by clients.

Reviews by two experts were then performed. The author developed the Korean ORS and SRS by synthesizing feedback from all previous stages. Two Korean counseling psychology doctoral students, who have conducted therapy both in Korea and the United States for eight to nine years, assessed the semantic and cultural equivalence of the English and the use of a 5-point scale, ranging from 1 (*very different*) to 5 (*very similar*). The raters rated the similarity of the items and anchors of English and Korean versions with 4s or 5s on all items, suggesting alternative words to improve them. Therefore, subtle modifications were made at this stage, too. For example, a new postposition (a grammatical feature in Korean language that follows verbs affecting tense and nuances of a sentences) was employed to make it sound more natural for the first sentence of the Korean SRS directions. It is challenging to accurately describe this particular modification because Korean and English languages have different linguistic

features; however, it was similar to a shift from “with respect to” to “about.” The English and Korean ORS and SRS are attached in Appendix B.

Training

Korean psychotherapists who were interested in learning new therapy techniques were recruited. Specifically, the author contacted her acquaintances in the field of psychotherapy in South Korea, explained the purpose of this study, and checked if they would like to obtain PCOMS training. They were also requested to share the information of training with other psychotherapists who may find PCOMS interesting. Training was offered 10 times, in a didactic format by the author, with a minimum of 41 attendees between July 2017 to July 2018. At the beginning of each training session, the author informed the context of the training and a plan to recruit research participants who were willing to utilize PCOMS and share their experience. The training included providing the theoretical background of PCOMS, outcome research evaluating PCOMS, the potential benefit of using client feedback systems in Korea, the administration steps of PCOMS, and role-playing the use of PCOMS with a client.

At the end of training, attendees were asked for feedback and to ask questions. For example, several attendees were concerned that clients would likely find it difficult to be honest on the SRS because it asks them to raise their concerns about therapy and potentially confront their therapists. Some attendees suggested specific ways to improve the format and translation of the Korean ORS and SRS. Later, these questions and feedback were reflected in the research interview protocol. Also, the author requested trainees to leave their contact information if they were interested in participating in this study. In case the author had already obtained their contact information when arranging

training sessions, she verbally asked permission to contact them for recruitment. The contact information of 30 trainees was obtained. Training lasted one to one and half hours in attendees' offices and public cafés. After training, attendees were provided with the Korean ORS and SRS, as well as a script of mock sessions showing an example of introducing and first administration of PCOMS.

Data Collection

Procedure. For the current study, permission was granted by the IRB for data collection between February 2018 and February 2019. Korean psychotherapists who received PCOMS training were recruited by emails, texts, and phone calls collected at the time of training. A criterion for research participation was implementation of PCOMS with at least one client and no prerequisite, such as a record of treatment progress, was requested. A purposeful selection technique (Patton, 2002) was used to include diverse therapists, in terms of professional characteristics (e.g., gender, therapeutic orientations, work experiences, and work settings), so that variant information could be collected. Ten therapists responded agreeing to participate in an interview. The author did not follow up trainees who did not respond, as some trainees who left their contact numbers appeared hesitant. Instead, a couple of trainees who seemed quite interested in this study but did not respond were re-contacted; they reported that they did not employ PCOMS after the training. To gather further information to address the research question about Korean therapists' perceptions of the applicability of PCOMS to Korean clients, two therapists who did not implement PCOMS were also included to explore their decision-making processes. The time between training and interviews ranged from 6 months to 17 months.

A total of twelve participants were recruited. An adequate sample size in qualitative research is ultimately a matter of judgment and experience (Sandelowski, 1995). For this study, two criteria were considered: saturation and a ratio of a sample size to the number of the population. Saturation is a concept for another qualitative research method, grounded theory, a point where no more new categories are developed from newly collected data (Glaser & Strauss, 1967). The themes from the last interview were consistent with the prior ones, so the data from 12 therapists meet the criterion of saturation. In addition, a sample size constituting 30% (12 therapists) of the population (40 Korean therapists who obtained PCOMS therapists) seems representatively plausible.

Participants. Twelve Korean therapists who obtained PCOMS training participated in this study. Ten implemented PCOMS and two did not. Their age ranged from 34 to 63, and 92% of participants were female. Years of practice ranged from 1 year 9 months to 25 years. Practice settings were private practice, university counseling center, company counseling center, and community center. Theoretical orientations employed by participants were diverse, including feminist therapy, gestalt therapy, cognitive behavioral therapy, psychodynamics, and integrative approach. The number of clients with whom therapist participants implemented the ORS and SRS ranged from zero to 18, and the number of sessions they administered the ORS and SRS ranged from zero to 25. Details of demographic information are provided in Table 2.

Interview. Interviews were conducted through in person, phone, or Skype depending on participants' preferences and the geographical distance between the author and participants. A questionnaire (Appendix C) on demographic and professional information was emailed out so that participants were able to complete it before

interviews. Participants received a Korean consent form via email before interviews as well. Then, interviews were conducted individually with each participant. The author utilized a semi-structured interview protocol (Appendix D) that includes open-ended questions on therapists' experiences of using PCOMS, moments that stood out, and participants' thoughts on the benefit and drawbacks of using PCOMS with Korean clients. The questions were also designed by reflecting the feedback from the attendees in PCOMS training sessions in mind. At times, the protocol was adapted based on previous interviews to reflect the new information that emerged. For example, a question on whether a participant administers psychological tests was included after the second interview, as it seemed to reflect a context of employing PCOMS.

Interviews ranged from 45 minutes to an hour and a half. When additional data collection was necessary from specific participants, follow-up questions were sent via email. All the interviews done in person, phone, or Skype were audio recorded after verbally obtaining informed consent from participants. The recordings were kept on a password-protected flash drive. Participants were awarded a gift card of 10,000 Korean won (approximately 10 dollars) as a token of gratitude.

Interview transcription. After each interview was completed, it was transcribed verbatim by the author. All transcripts included both verbal and non-verbal responses. For example, interruption, short pauses, and long silence of participants were recorded so that the context of verbal responses could be revealed. Because all interviews were conducted in Korean, they were transcribed in Korean. The quotes which constituted initial codes and themes, were translated into English by the author so that quotes were available to an English-speaking reviewer who became a part of data analysis.

Data Analysis

As qualitative research is usually conducted in a recursive way (Braun & Clarke, 2006), data analysis began upon the first interview being completed, and subsequent data collection and analyses were conducted in a parallel manner. Analysis procedures followed the steps suggested by Braun and Clarke (2006): familiarizing oneself with your data, generating initial codes, searching themes, reviewing themes, and defining and naming themes. The author conducted the analysis, and a faculty member in counseling psychology, who is an expert on PCOMS reviewed themes to ensure that the analysis, mainly conducted by the author, aptly reflected interview transcripts.

Familiarizing oneself with data. The author listened to audio-recorded interviews to transcribe them and then read completed transcripts multiple times, searching for meaning and patterns in terms of the research questions. Also, the author kept a journal to record ideas on potential coding themes while reading and re-reading transcripts as Braun and Clarke (2006) suggested.

Generating initial codes. Initial themes of transcripts were then produced. Interesting and salient phrases were underlined and given short descriptions. Because there is no existing theory about introducing therapy techniques to another culture, all themes produced were based on interview data. They were organized using an Excel spreadsheet. The themes of different participants' transcripts were compared so that consistent themes could be used for similar contents. To increase credibility and trustworthiness of initial codes, a Korean counseling psychologist reviewed initial codes and this input was reflected.

Searching themes. After initial coding was completed, the author started to group initial codes by comparing and contrasting them. These groups of initial codes yielded sub-themes, and then abstract themes were created based on similar sub-themes. Sub-themes and themes were generated using an Excel spreadsheet as well.

Reviewing themes. The author then reviewed themes to ensure their accuracy by using two levels of reviewing (Braun & Clarke, 2006). First, the author read all extracts for each theme and considered whether there was a coherent pattern or not. Then, themes were reassessed in terms of their relationship with the complete data set. For example, the author considered whether each theme contributed to the understanding of therapist experiences or not. At this stage, themes for extracts and a table of themes were reviewed by an American counseling psychologist, who specializes in training and research on PCOMS. The author and the reviewer discussed different perspectives on themes, and results of the discussion were incorporated into themes.

Defining and naming themes. The author then "defined and refined" (Braun & Clarke, 2006, p. 92) themes created from previous stages. Specifically, the author reviewed whether each theme had its own scope and content, and if all the themes were properly exclusive to one another. Additionally, themes were edited to have concise, impactful, and easy-to-understand verbiage.

Table 2.
Participant demographics

ID Number	Age	Gender	Years of Practice (years/months)	Practice Setting	Number of Clients[a] (range of session numbers[b])	Therapeutic Orientations
A	48	Female	18/0	Private practice	18 (1-3)	Internal family systems, somatic experiencing, drama therapy, and feminist therapy
B	38	Female	7/9	Private practice	10 (1-10)	Gestalt therapy and object relations therapy
C	34	Female	9/7	Company counseling center	3 (4-15)	Integrative
D	36	Female	8/0	Private practice	1 (9)	Feminist therapy and psychodynamics
E	38	Female	3/9	Private practice	4 (9-23)	Gestalt therapy, object relations therapy and somatic experiencing
F	56	Female	1/9	Community center	7 (3-15)	Feminist therapy and integrative orientation
G	40	Female	10/5	Company counseling center	2 (12-21)	Gestalt therapy
H	38	Female	4/1	University counseling center	1 (8)	Feminist therapy and cognitive behavioral therapy

Table 2. (continued)

I	49	Female	10/0	Private practice	3 (12-25)	Feminist therapy and psychodynamics
J	63	Female	25	University counseling center	2 (1-6)	Feminist therapy
K	53	Male	25	Private practice	N/A	Psychoanalysis
L	42	Female	3/4	Private practice	N/A	Eclectic including psychodynamics

Note. All participants were Korean. Number of clients[a] = the number of clients with whom participants administered the ORS and SRS. Range of session numbers[b] = actual number of sessions wherein participants administered the ORS and SRS.

CHAPTER 4: RESULTS

Themes constructed from interviews of Korean psychotherapists are implementation, the benefit of PCOMS, barriers to utilization, and background factors. Sub-themes and relevant quotes, which compose these themes, are provided in the following section. Themes, subthemes, and the number of participant therapists who endorsed them are indicated in Table 3.

Implementation

Participants decided whether to implement PCOMS after they obtained training. Ten participants out of 12 employed PCOMS. With respect to a therapist's implementation of PCOMS, six subthemes were constructed: expectations of PCOMS, selection of clients, preparation for administration, administration according to the PCOMS manual, adjustment to administration, and plan for future use.

Expectations of PCOMS. Six participants reported they had positive or negative expectations of PCOMS before administration. Two participants reported they were motivated to administer the ORS and SRS, as they expected the measures to benefit clients. They sounded less hesitant to start administering PCOMS compared to the participants who did not report positive expectations of PCOMS. On the contrary, four participants reported they had a preconception about negative effects of PCOMS, which became barriers to implementation. Specific concerns were as follows: filling out the ORS and SRS with a therapist's presence may cause unnecessary tension; repeating the same measures would make clients careless; a therapist has to deal with pressure to meet client's satisfaction; regular administration would limit therapy time; the ORS would not lead clients to addressing their concerns; and the SRS may make clients be critical of a

therapy relationship. Due to these negative expectations, two participants ended up not implementing PCOMS.

Selection of clients. Five participants decided with whom to administer PCOMS. The criteria of participants were based on their professional and personal judgment. Some participants employed PCOMS for clients who seemed to benefit from it. For example, participant therapists considered PCOMS beneficial when clients seemed to struggle with self-expression or self-assertiveness, or there were significant power differentials between a therapist and a client.

On the contrary, clients were excluded when participants inferred that PCOMS would be less helpful due to client characteristics (e.g., clients who were capable of communicating their needs or who exhibited impaired intellectual functioning) or a therapist's sense of impeded capability to administer PCOMS. For example, therapist C, who works at a human resources (HR) department of a company, stated she did not recommend PCOMS to clients occupying higher positions in her organization who came across as judgmental or who required quick solutions. One of the steps of PCOMS administration is openly discussing results, which this therapist found challenging with these particular clients. Furthermore, a couple of participants stated they were afraid that clients might decline PCOMS, which at times did happen. Participants identified that their hesitation stemmed from the lack of research findings to support the benefit of PCOMS for Korean clients and their inexperience of administering PCOMS.

Administration according to the PCOMS manual. All the participants who implemented PCOMS reported they followed through with PCOMS instructions given by the researcher. For example, participants introduced the ORS and SRS in their first

therapy sessions, invited clients to ask questions about the two measures, administered them every session, measured clients' responses immediately, and discussed noticeable results and a trend of scores with clients.

Adjustment to administration. Although all participants reported they followed through with PCOMS instructions, they also reported various partial adjustments when they administered it. These adjustments included not administering the ORS and SRS every session, administering the ORS at the end of a session, having clients fill out the ORS alone, not measuring client responses immediately, and not keeping track of total scores.

One of the significant adjustments that participants made was not administering the ORS and SRS every session. Since regular monitoring of client feedback is one of the major aspects of PCOMS, administering the ORS and SRS every session is a crucial component. However, therapist participants did not or were not able to administer them every session due to various reasons: participants had to deal with other priorities within limited time for therapy (e.g., dealing with a client's safety concerns or addressing a new topic that arose toward the end of a session), the ORS and SRS felt redundant as participants verbally checked-in and received feedback about therapy, or participants perceived using the same measures weekly did not lead to meaningful information. While the ORS and SRS are known for brief administration and one therapist participant acknowledged their briefness as a strength, most participants reported that these measures took five to 15 minutes, which they perceived as not a small portion out of a one-hour therapy session; therefore, the ORS and SRS at times ended up not being administered.

> The measure for the end of a session (the SRS) was missed at times as I didn't have enough time. … I was able to give the SRS to clients when they were ready

> to wrap up. But they sometimes started a new topic 10 to 15 minutes before wrapping-up, they continued on that topic, and I had another client to see right after, so I was not able to administer the SRS. (Therapist E)

Another significant adjustment was how participants measured client responses and used results. Three participants reported they did not score client responses using a ruler immediately after the clients completed it, as prescribed by the PCOMS manual. Reasons for not scoring them included easy guessing of scores with a brief look at client responses. Also, seven participants reported they did not keep track of the total scores. Some of them said they were not fully aware of this step while the others stated they did not have time to manage total scores. It should also be considered that total scores of the ORS and SRS may not provide as much information to participants as those in the United States since their cut-off scores have not been validated with a Korean population and thus have not been available to participants.

Plan for future use. All ten participants who implemented PCOMS were asked whether they would continue utilizing PCOMS. Out of the 10 participants, five participants stated they were going to continue utilizing PCOMS, four decided to discontinue, and one said she was going to keep utilizing the ORS and not the SRS. Participants who were going to continue PCOMS appreciated the benefit of PCOMS, while participants who discontinued believed they did not benefit from it or wanted to stop getting stressed from extra work due to PCOMS administration.

The Benefit of PCOMS

Participant therapists reported positive experiences when they implemented PCOMS, which affected various dimensions of therapy. Under this theme, four sub-themes were constructed: accelerating data gathering, providing a structure, facilitating

the therapy process, and better therapist-client relationship. Other benefits that a small number of participants reported are summarized as well.

Accelerating data gathering. Nine participants, who implemented PCOMS, reported they gained various information quickly through using the ORS and SRS. Although the ORS is intended to monitor client functioning and the SRS measures the client's experience and satisfaction in therapy, therapists were able to collect more information beyond the measures' original purpose within a limited time. The information participants gleaned through administering the ORS and SRS included a client's traits, strengths, weaknesses, needs, wants, relational patterns, perspectives, inner change process, and progress.

Participants pointed out that items on the ORS and SRS were likely to help a therapist collect crucial information directly. For example, therapist H described a moment when she noted a client's decreased result of an ORS item, "Interpersonally (Family, close relationships)," and the client brought up a conflict with a family member. Therapist J noted a client offered feedback on how the client perceived the therapist due to an SRS item directly asking about the therapy relationship on the SRS.

Participants reported not only ORS and SRS results themselves but also a client's reactions or attitude toward these measures provided data about the client. Therapist B stated that a client with compulsive personality traits and another with histrionic personality traits exhibited different reactions to the ORS and SRS, which enhanced her understanding of these clients. Therapist E described a client whose motivation for therapy was reflected in her attitude toward completing the ORS and SRS:

> I had one client who had fluctuations in therapy. Sometimes she came to therapy with eagerness, and other times she came 20 minutes late or even forgot the

> session. She was similarly inconsistent when she filled out the ORS and SRS. There were times when she completed the ORS and SRS thoroughly and there were other times when she seemed careless about doing this and gave it to me without saying anything. (Therapist E)

Providing a structure to therapy. Five participants reported the ORS and SRS provided a structure to therapy, which benefited both the therapist and client. Since the ORS and SRS are administered every session, clients can assume what they are supposed to do at the beginning of therapy sessions. Participants noted that the structure given by the ORS and SRS benefited clients, particularly with high anxiety. Therapist G stated one of the clients with social anxiety liked being given ORS and SRS paper copies, as he was nervous about not knowing what to do at the beginning of sessions. In respect to the benefit for a therapist, one participant reported she became mindful about starting a new therapy session when getting the ORS and SRS paper copies ready and taking a brief look at prior results.

Facilitating the therapy process. Eight participants reported that the ORS and SRS facilitated the therapy process by helping clients increase their abilities to reflect on and communicate their experiences, which is essential to client work. Specifically, participants reported the ORS and SRS assisted clients with improving self-exploration, self-awareness, self-expression, self-acceptance, and self-reflection, gaining new perspectives, and becoming empowered. Therefore, some participants inferred that the ORS would benefit passive and unexpressive clients who struggle with these abilities.

There seem to be two main factors for PCOMS facilitating mental abilities for the therapy process. Firstly, ORS and SRS items seemed to model for clients what to explore and what to communicate. For example, Therapist B reported four items of the ORS provided a client with a frame of reference to view and communicate one's concerns;

therefore, the therapist stated she found the ORS beneficial to clients struggling with identifying thoughts and feelings. Secondly, to clients, the ORS or SRS results laid out on paper what is to likely appear more objective than the “data” in their mind. Because ORS and SRS results seem more objective, it is difficult for clients to deny them. Therapist G described a situation wherein the ORS provided a client with a different lens to view one’s presenting problems due to the perceived objectivity:

> PCOMS seemed to benefit clients with depression. One of my clients … thought that he was always depressed and that things were horrible for him every day in the past week. However, after he filled out the ORS, he could see he was doing okay in some areas, and he was not in other areas. It helped him see himself as he was. His responses showed that things were not that horrible. The benefit for my client was that he was able to see how he was doing with less distortion by filling out the ORS. (Therapist G)

Participants also noted the ORS helped clients with setting therapy goals. By exploring the ORS results, participants reported that clients were able to identify areas where they were doing fine, and where they were not, which guided the client to identify a focus of therapy. Therapist B stated that, when comparing and exploring the results of different ORS items with one client, it helped the client decide which topic needed attention in therapy.

Better therapist-client relationship. Six participants reported an improved therapy relationship due to PCOMS administration. Participants noted that the SRS administration encouraged clients to communicate their perception of therapy, which helped both parties be on the same page and deepened the therapy relationship. Participants also described that conversations over client feedback on therapy and therapist led to a genuine therapy relationship. A participant described a moment when she brought up a lower score on the SRS, and she and her client had a frank conversation:

> The result of "Approach or Method" of the SRS went down by 0.3 centimeters. I asked my client to share what led to the result. The client said, "It may be about me," and frankly shared her experience. I said, "It really works for our relationship when you open up about how you felt like this. It helps me know how you felt. Thank you for being honest with me and trusting me." After this interaction, the client seemed to be making progress gradually… It was a crucial moment. My messages, like "it really matters to me to know how you feel. I would not be offended by your feedback. Focusing on your experience is what matters the most here." seemed to be conveyed to the client. (Therapist E)

Other benefits. There were other benefits that only a small number of participants noted. First, Therapist C reported the ORS and SRS were brief, and Therapist F stated the layout of the ORS and SRS was simple, both of which led to undemanding administration. Second, one participant suggested that the ORS and SRS were beneficial for therapy as part of an employee assistant program. Therapist G stated features of PCOMS, such as being strength-based and solution-focused, seemed to align with the intention of employee assistant programs. This therapist also suggested that documenting ORS and SRS results would benefit therapists who needed supporting material for termination of therapy or client progress.

Barriers to Utilization

Participants reported challenges during PCOMS administration, which at times led participants to uncertainty about the effect of PCOMS. These experiences were labeled as barriers to utilization, and there were nine subthemes: stable results, concerns with items, the impact of client characteristics, difficulty exchanging genuine feedback, unfamiliarity, lack of time, few benefits, inaccurate reflection of client experience, and other barriers. Also, other types of barriers that only a couple of participants indicated were provided.

Stabilized results. Eight participants reported that PCOMS was not informative when the ORS and SRS scores were constant. They stated that they did not know how to deal with when PCOMS results were stable. Participants also reported they doubted whether these results were accurate reflections of a client's functioning or therapy experience. Some participants inferred that stable results were caused by frequent administration, which made some clients careless. In the case of consistently high SRS scores, some participants inferred that clients might have been amiable to therapists due to social desirability:

> The second client was interpersonally adept and said he liked everything about therapy. He always gave a high rating on each item (of the SRS). He was like, "I absolutely love therapy." So, I wasn't sure if the SRS was working for him. (Therapist G)

It is not rare that scores of the ORS and SRS are stable. A therapist needs to explore what this means, identify a client's need, and try alternative approaches if needed (Duncan, 2011). However, participants were unsure about what to do, presumably due to lack of experience and ongoing supervision or consultation regarding PCOMS administration. It is also notable that cut-off scores for a Korean population were not available, so interpretation of scores was limited.

The impact of client characteristics. Eight participants reported that certain kinds of client characteristics did not lead PCOMS to yield the best outcomes. For example, participants found PCOMS did not work well for clients that have a tendency of pleasing others, struggling with high anxiety or other types of psychological distress, denying their concerns, lacking clear therapy goals, or being reactive to numeric outcomes. Participants also reported that desirable aspects of clients minimized the benefit of PCOMS. For example, they stated that clients with high functioning or self-

reflection capability seemed to not fully benefit from PCOMS because it was supposed to improve these components.

Difficulty receiving genuine feedback. Six participants reported they had difficulty receiving frank feedback, which seems to go against the intended benefit of PCOMS. The difficulty stemmed from both clients and therapists. Specifically, the participants indicated that their clients seemed to struggle with giving feedback to a therapist, particularly negative feedback with the therapist being present. Participant B noted that her client never gave her lower ratings on the SRS and that it did not feel genuine. Some participants stated a couple of clients even declined to fill out the ORS and SRS; participants inferred that clients might have wanted to avoid any negative consequences or awkwardness after giving unpleasant feedback. Regarding factors of therapists, a participant reported a doubt that she would not receive objective feedback from clients who were critical or judging. The other participant noted that she was afraid that she may hurt a client's feelings in the process of exchanging feedback.

Concerns with items. Five participants found some clients had difficulty grasping some items of the ORS or SRS. These difficulties seemed to stem from translation, categorization based on a different culture, or breadth of items. Two participants noted some of their clients struggled to understand the meaning of the item "Individually (Personal well-being)" of the ORS. The Korean translation of the item was slightly adjusted to "Individual aspects (personal health and sense of well-being)" because well-being is normally used in academic or commercial areas but is not a common term among lay people; however, participants indicated there were still clients

who struggled to understand it. Other participants noted that the categorization of the ORS did not fit with some clients' experiences.

> A client found "Interpersonally" and "Socially" overlapping. … A client who felt friends or people from their schools closer than their family members seemed torn between these two items, pondering which one to take for which group. (Therapist A)

Lastly, some participants stated items were not specific enough, and that some items overlap, which led clients to be confused. As the literature on often PCOMS indicates, participants reported some clients perceived the item "Overall (General sense of well-being)" of the ORS overlapping with the other items.

Unfamiliarity. Five participants expressed difficulties due to unfamiliarity with administering PCOMS and managing the results of the ORS and SRS. For example, participants felt stressed by implementing a new technique before they became used to it, forgot to keep track of scores on a given table, or felt awkward bringing paper copies into a therapy room. A participant attributed the difficulty to her own personality traits.

> I am low on novelty seeking. I know some therapists tend to employ new theories or techniques right after they learn them. However, I normally stick with what I am used to, so it feels challenging to try new things in therapy. (Therapist C)

Lack of time. Five participants indicated that PCOMS administration led to a lack of time. Although the ORS and SRS were brief, participants found regular monitoring by using them took substantial time to the extent of feeling limited. Particularly, participants reported they sometimes did not spare time to administer SRS or explore its result at the end of a session since it took more time than they thought, or clients rushed to leave. Due to these experiences, some participants reported they did not administer the ORS and SRS every session or even discontinued the utilization.

Few benefits. Four participants shared that there were not many perceived benefits in using PCOMS. Specifically, they reported that they were not always able to see instant effects or obtain informative data, which led them to question whether or not they should continue with PCOMS. Two participants indicated administering PCOMS every session did not seem to yield benefit. One participant stated that she stopped utilizing PCOMS due to a lack of benefit.

Inaccurate reflection of client experience. Four participants noticed results of the ORS and SRS did not accurately reflect the experiences of some clients. One participant found that ORS scores dropped while following conversations revealed there was no substantial change over the past week. Another participant found that ORS scores were stable, while the following conversations revealed something significant happened. One participant noted that her client's ORS result increased after several sessions when she made aware the client still had concerns to be addressed in therapy. A participant noted that ORS results of clients who deny their struggles tend not to be an accurate representation of client functioning.

Other barriers. There were other kinds of difficulties a small number of participants encountered. A participant reported that she did not like using paper copies, as it was not eco-friendly and causing difficulty managing documentations. Two other participants noted the ORS and SRS led clients to take a cognitive approach, which made it difficult for them to focus on their emotions.

Background Factors

Participants indicated personal, professional, or cultural backgrounds that affected PCOMS administration. Background factors included four subthemes of Korean culture, use of verbal feedback, utilization of psychological tests, and work setting of a therapist.

Korean culture. Eight participants reported they noticed Korean cultural values that would be likely to limit the benefit of PCOMS. First, participants noted that respect of professionals as authority figures or an emphasis on harmony in relationships seemed to make it difficult for clients to provide genuine but challenging feedback to therapists:

> I once recommended a book on Koreans' psychological features to you. The book said Koreans had a tendency of treating authority figures like their fathers or respectable teachers. Koreans seem to expect their therapists to be an individual they can look up to or feel like family members. … I was certainly able to sense that expectation of my clients. So, it seemed that they were not used to filling out a rating form regarding an individual they would depend on or feel connected… (Therapist C)

Second, a participant inferred that social pressure to provide positive feedback on customer satisfaction surveys would create barriers for honest responses when completing the SRS. The pressure became prevalent a decade ago when commercial service providers started to collect client feedback through customer satisfaction surveys. The pressure often comes from service providers, who will eventually be evaluated by their employer based on client feedback. Therefore, Korean people tend to be pressured to give only positive feedback to service providers even if the service is poor. A participant exhibited concerns that their clients would have the same impression of the SRS, believing they are supposed to provide only positive feedback.

Third, Korean clients have a tendency of wanting to address symptoms in a direct manner along with a short-term and solution-focused approach. Because the PCOMS

does not directly address client symptoms, a participant inferred clients might perceive the ORS and SRS unhelpful. Fourth, a participant noted a culture of excessive ratings or evaluations, which fuels a competitive environment in Korean society. Therefore, she claimed that the administration of PCOMS with ignoring the context of excessive ratings is likely to reinforce social messages normalizing judgment and competition. Lastly, a participant noted that Korean clients tended to report their level of functioning more positively to look okay to therapists; therefore, he inferred that ORS results might not be an accurate representation of client functioning.

Use of verbal feedback. Six participants indicated that they were verbally monitoring clients' functioning and soliciting feedback on therapy before employing PCOMS. Some participants stated that they verbally solicited feedback on a regular basis, such as at the beginning and at the end of each session or three times throughout the course of therapy. A participant stated, based on his therapeutic approach, psychoanalysis, that he openly discussed the therapy relationship when necessary. These participants indicated PCOMS did not make a huge difference to their therapy practice. Simultaneously, a few participants noted they learned how to improve their verbal feedback:

> According to the feminist therapy approach that I use, therapists don't ask their clients about how they felt toward their therapist every session. I normally ask my clients about how the session went for them. I usually ask clients to share their therapy experiences with me when terminating. However, this measure (the SRS) has an item about therapy relationship so I was able to recognize what my clients think about the relationship with me. My way to ask about therapy sessions do not necessarily reveal a client's perception of the therapy relationship. So, it was beneficial. (Therapist J)

Utilization of psychological tests. Eight participants reported they either do not administer psychological tests or administer them just once per client. Therefore, all

participants who responded about psychological tests were unfamiliar with administering the same measure repeatedly to monitor treatment outcomes, which is a major feature of PCOMS. One participant noted she was willing to employ PCOMS due to an interest in administering psychological tests.

Work setting of a therapist. Two participants who were working at HR departments as therapists noted their work environments affected their PCOMS administration. One participant reported that due to her heavy workload, including developing new psychoeducational programs, she was not afforded the time to master how to effectively utilize PCOMS. She further indicated she was not sure about the effect of PCOMS when she was supposed to employ other structured techniques and pieces of worksheets according to the orientation of her work setting. The other participant reported that free counseling services, a part of employee welfare, seemed to result in clients' high satisfaction and high SRS results in general.

Summary of Findings

The interviews with Korean therapists who employed PCOMS (n = 10) and who did not after obtaining PCOMS training (n = 2) revealed their decision-making processes of implementing PCOMS and experiences of administering the ORS and SRS. Participants indicated various details regarding their expectations of PCOMS, selection of clients, preparation for administration, administration according to the PCOMS manual, adjustment to administration, and plan for future use. Participants reported what they found beneficial from PCOMS administration. They indicated the ORS and SRS accelerated data gathering, provided a structure to therapy, facilitated the therapy process, and improved the therapist-client relationship. Simultaneously, participants faced

barriers to utilization of PCOMS due to difficulty addressing stable results, concerns with items, the impact of client characteristics, difficulty exchanging genuine feedback, unfamiliarity of PCOMS, lack of time, inaccurate reflections of client experience on the ORS and SRS, and other challenges. Lastly, background factors, including Korean culture, use of verbal feedback, utilization of psychological tests, and work setting of the therapist, were noted by participants.

Table 3.
Summary of Themes

Themes	Sub-themes	Number of therapists
Implementation	Expectation of PCOMS	6
	Selection of clients	5
	Administration according to the PCOMS manual	10
	Adjustment to administration	10
	Plan for future use	10
The benefit of PCOMS	Accelerating data gathering	9
	Providing a structure	5
	Facilitating the therapy process	8
	Better therapist-client relationship	6
	Other benefits	3
Barriers to utilization	Stabilized results	8
	The impact of client characteristics	8
	Difficulty receiving genuine feedback	6
	Concerns with items	5
	Unfamiliarity	5
	Lack of time	5
	Few benefits	4
	Inaccurate reflection of client experience	4
	Other barriers	3
Background factors	Korean culture	8
	Use of verbal feedback	6
	Utilization of psychological tests	8
	Work setting of a therapist	2

CHAPTER 5: DISCUSSION

The findings of this study indicate that Korean therapists' experiences regarding PCOMS included the domains of implementation, benefits of using PCOMS, barriers to utilization, and background factors. The experiences demonstrate that factors regarding employing PCOMS in psychotherapy within another culture spread across personal, professional, and cultural domains. In this chapter, discussion of these factors, the implications for practice, training, and research, and strengths and limitations are provided.

Expectations of Therapists

The expectations of therapists played a significant role in the implementation of PCOMS. Potential challenges that therapists anticipated affected their willingness to employ PCOMS. For example, findings of this study indicate therapist participants were concerned about the negative impact of regular monitoring due to repeating the same measures each session, the client's difficulty giving feedback to the therapist, time burden, and focus on the therapist not the client, specifically due to the SRS.

In fact, research on systemic feedback indicates that it is not unusual for therapists to fear negative consequences before PCOMS implementation (Boswell et al.,2015; Youn et al., 2012). For Korean therapists, given the lack of clinical or research evidence supporting that PCOMS benefits Korean clients, it is reasonable and necessary to be cautious about employing this new therapy process. In addition, lacking a professional culture of regularly monitoring therapy outcomes further keeps Korean therapists from anticipating the benefit of PCOMS. Since these negative expectations are likely to keep

therapists from employing PCOMS, it seems significant to identify therapist expectations and address them proactively within PCOMS training.

On the contrary, positive expectations of PCOMS, according to research and practice in the United States, facilitated the implementation of PCOMS. Some participants who anticipated the benefit of PCOMS were motivated to start PCOMS administration. Given the Korean history of importing psychotherapy from Western cultures, it is also reasonable to expect effective therapeutic techniques in Western countries to be beneficial for Korean clients. Therefore, exploring the positive expectations of therapists seems to be an approach to facilitate the application of PCOMS. Offering research findings that therapists in the United States tend to have positive experience after implementing systemic feedback (Youn et al., 2012), opposing their apprehension would benefit therapist, too.

Adjustments

When participants applied PCOMS to their Korean clients, they made various kinds of adjustments: not administering the ORS and SRS every session, having clients complete the ORS alone before a session, not measuring client responses immediately, or not keeping track of total scores. These adjustments were made for practical or clinical reasons rather than cultural ones, such as lacking time for the SRS at the end of sessions, dealing with other temporary priorities, or avoiding extra work that seems unnecessary. As Hatfield and Ogles (2004) suggested, practical barriers tend to affect therapists' attitudes toward systemic feedback to the extent where they slightly modify how to administer it. It is also notable that no adjustments were reported to address concerns regarding social desirability although therapist participants expressed them. It may

indicate that the participants were not able to create cultural adaptations and that they rather decided not to implement PCOMS. If this is the case, potential cultural adjustments would be discussed in PCOMS training including having clients complete the ORS and SRS without the therapist present which was tried in a study conducted in a Chinese counseling center (She et al., 2018).

Benefit

The findings of this study indicate that PCOMS could benefit Korean clients in various ways. The benefits categorized in this study were giving a structure, improving therapeutic alliance, facilitating the therapy process, and accelerating data gathering. Feasibility and the effectiveness in the context of employee assistance programs were also reported by therapist participants. These advantages seem to consistent with the benefit demonstrated in the existing literature (e.g., Anker, Owen, Duncan, & Sparks, 2010; Duncan & Reese, 2015).

Although many Korean therapists who obtained PCOMS training expressed concerns about its cultural fit, most of the therapist participants identified certain advantages when they put PCOMS into use. Particularly, therapist participants expected the SRS would not fit Korean traditional values regarding interpersonal relationships, but their experiences demonstrated that the SRS could contribute to increased therapeutic alliance.

So, how did some therapist participants gain this benefit despite interfering cultural values? It could be considered that PCOMS has a communicative feature (Duncan & Reese, 2015), which seems to provide an opportunity to discuss potential challenges. As the findings of this study regarding improved therapeutic alliance

demonstrate, the process of discussing the client's perceptions of treatment seems to promote the trust between the therapist and the client. Therefore, it seems crucial to help therapists see PCOMS as a communication tool leading to its aimed benefit.

Challenges

One theme from this study indicates that Korean therapists may encounter several kinds of difficulties when they employ PCOMS. The challenges identified in this study include stabilized results, the impact of client characteristics, difficulty receiving genuine feedback, concerns with items, unfamiliarity, lack of time, few benefits, and inaccurate reflection of client experience. These challenges are mostly attributed to three factors: lack of experience, cultural difference, and limitation of PCOMS. In terms of lacking experience, participants struggled when ORS or SRS scores did not change from session-to-session, or when their results seemed inaccurate. Although guidelines on how to address noticeable results were provided in their one-hour PCOMS training, it is challenging for therapists to effectively intervene as they are not used to PCOMS. In fact, unfamiliarity itself was identified as one of the challenges participants had.

In terms of cultural differences, it may be difficult for some clients to understand the meaning of "Individually (Personal well-being)" of the ORS or differentiate "Interpersonally (Family, close relationships)" and "Socially (Work, school, friendships)" of the ORS. As reported in the results chapter, the difficulty with these items stems from the fact that a concept of well-being is not common among lay Korean people and that Koreans build a relatively more intimate relationship at work, school, and social occasions. Given these cultural impacts, ORS items may benefit from being adjusted by recategorizing areas to assess client functioning, or therapists need conversations with

clients to figure out how to adapt ORS items to each client to reflect their level of functioning.

Lastly, the limitation of PCOMS can affect the challenges therapists encounter. For example, compared to psychological tests with more items, the ORS has only four items, and thus its items do not thoroughly cover various kinds of areas of client functioning at the symptom or problem-specific level. The pros and cons of the brevity of the ORS and SRS need to be addressed at training so that therapists can anticipate and address them when they implement PCOMS.

Impact of Cultures

The findings of this study indicate that cultures affect various levels of PCOMS administration, and these cultures include not only the unique social norms of Koreans but also the customary practice of a field of psychotherapy and the work setting wherein psychotherapy services are provided. Regarding social norms, the impact of Korean traditional values of respect for authority figures and avoidance of interpersonal conflicts (Lee, Suh, Yang, & Jang, 2012; Park, Shim, & Lee, 2014) were identified from the experiences of therapist participants. These traditional values may negatively affect SRS administration as Korean clients tend to believe their honest but challenging opinions about therapy sessions and therapists are perceived as impolite and disrespectful. Other than these traditional values, clients seemed to be affected by relatively modern social norms, such as giving only positive feedback to service providers, which also seem to prevent clients from giving honest feedback through the SRS.

As to the customary practice of Korean psychotherapy, the use of psychological tests to measure therapy outcomes is not common; therefore, participants questioned the

benefit of regular monitoring although they said PCOMS appeared beneficial at training. Workplace cultures also seemed to affect implementing PCOMS. For example, when a therapist and a client worked for the same hierarchical organization, wherein evaluation is a significant source of stress for employees, there were clients who declined PCOMS to avoid the pressure to give feedback to a professional. Also, when a therapist worked for an organization where documentation of clinical records or clinical case studies were less valued than seeing many clients and providing various kinds of therapy programs, the work environment was not favorable for the therapist administering PCOMS and managing the ORS and SRS results.

It is also notable that therapists could benefit despite interfering cultural values and practices of Korean society, as the findings of this study demonstrate. For example, while some therapist participants were concerned if social desirability would prevent genuine responses from their clients, they indicated that client responses were trustworthy and offered valuable information about therapy outcomes and the therapy relationships. Therefore, it seems crucial to balance acknowledging these background factors and their potential impact, while providing the potential means to address them.

Implications for Training, Practice, and Research

Given the findings of this study indicating the various factors that affect PCOMS implementation, it may be important that therapists receive training that helps them to anticipate potential factors that can influence implementation. The findings of this study demonstrate that these factors stem from a therapist, a client, and different levels of culture, and that their combination and effects vary. Therefore, PCOMS training in South Korea should include identifying potential factors, discussing the impacts of combination

of these factors, and developing strategies to deal with unhelpful influences. For example, one component of PCOMS training could be created to help therapists effectively address the impact of social desirability by discussing the client's perception of the ORS and SRS. Another component could be addressing the time burden. In addition to potential challenges, the factors causing benefit should be also discussed and strategies to utilize those factors should be developed at training. Informing benefits for Korean clients revealed in this study, although anecdotal, may help Korean therapists identify what facilitates advantages.

Second, supporting therapists who employed PCOMS with follow-up training or supervision should be considered. When therapists are reminded of strategies to deal with certain types of situations, they can better make use of PCOMS. As the effect of regular client feedback increased over time (Brattland et al., 2018), providing support through supervision and follow-up training seem to contribute to therapists continuing PCOMS implementation and experiencing enhanced benefit.

Lastly, research regarding PCOMS implementation with Korean clients should be continued. Since this study only examined the view of Korean therapists, studies on client experiences in South Korea will enhance the understanding of PCOMS implementation in cultures other than the United States. Further investigation of cultural fit seems essential. For example, the findings of this study indicate social desirability could interfere with PCOMS implementation; therefore, the replication of a study that examines social desirability in the United States (Reese et al., 2013) with a Korean sample will shed light on the impact of social desirability. Also, the research on validating the ORS and SRS for the Korean population by using correlations with other

Korean measures for treatment outcome and yielding normative data to create cut-off scores will complement knowledge on the applicability of PCOMS for Korean clients. The findings of the suggested studies will provide more information about PCOMS implementation with clients from diverse cultural backgrounds.

Strengths and Limitations

This study examines the experiences of Korean therapists who implemented PCOMS with Korean clients. The findings of this study provide variables, including culture, to consider PCOMS implementation in South Korea. This study seems to be a meaningful step in culturally adapting systemic client feedback by evaluating the acceptability of Korean psychotherapist who obtained PCOMS training. While previous research on PCOMS with culturally diverse clients has been conducted (e.g., Anker et al., 2009; She et al., 2018), it focused on treatment outcome or the psychometric properties of the ORS and SRS. The findings of this study uniquely shed light both on the outcome and the process of PCOMS administration with Korean therapists and their clients. In addition, although this study was conducted in Korean society, its findings seem to provide relevant information regarding PCOMS administration for Asian clients given similar cultural norms.

Lastly, as with other qualitative studies, this study captures the vivid and the diverse experiences allowed by a qualitative research methodology. Delineating specific experiences of Korean therapists provided an opportunity to understand the process of employing a new perspective and tool. Since the diverse ideas of Korean therapists who obtained PCOMS training were described, the finding of this study reflected different reactions of therapists from the same culture.

Some limitations affect the interpretation and generalizability of this study. First, the experiences of participants included unfamiliarity with PCOMS; therefore, the findings of this study reflect not only employing PCOMS in other cultures than the United States but also difficulties of less experienced therapists who used PCOMS. It was not feasible to find therapists experienced using PCOMS since it was not introduced to Korea before the training offered by the researcher. Therefore, the level of familiarity of therapists should be considered when interpreting the findings.

Second, the representativeness of participants is limited. Although the researcher made efforts to increase the size sample by recruiting diverse Korean therapists, it was challenging to compose a diverse sample in gender or work settings. Lastly, the results constructed by using thematic analysis would most probably demonstrate the experiences of the research participants the researcher was able to interview (Willig, 2013). Without further studies to test specific hypotheses, generalization of the findings of this study should be avoided.

Conclusions

This preliminary study investigated the applicability of systemic client feedback for Korean psychotherapy. The findings of this study shed light on various kinds of factors that may affect the process of implementing PCOMS with Korean clients. They also suggest potential benefits and challenges of PCOMS for the psychotherapy conducted in South Korea. This study highlights that Korean therapists and clients may gain benefits from systemic client feedback associated with better therapy outcomes, even though they may encounter challenges stemming from clients, therapists, cultures of the Korean society, and the professional field of psychotherapy. This study contributes to

illustrating the effect of implementing a new psychotherapy process, systemic client feedback, and identifying potential factors affecting the PCOMS implementation in South Korea. By investigating the specific variables identified in this study, further knowledge on the applicability of PCOMS to Korean psychotherapy will be generated and refined.

Appendix A

RCT Studies in South Korea from 2014 to 2017

Authors (year in published)	Approaches/ A focus of treatment (the number of sessions)	Participants			Outcomes
		Treatment group	Comparison group	Control group	
Kim (2017)	Unspecified: Group therapy to facilitate trust and intimacy between North Korean refugees and South Koreans (Eight 90-minute sessions)	Adult North Korean refugees and South Koreans			In treatment groups, positive feelings, trust, and intimacy were significantly increased and negative and distant feelings were significantly decreased.
		n = 26 (11 North Koreans and 15 South Koreas)	N/A	n = 29 (14 North Koreans and 15 South Koreas)	
Song & Kang (2017)	Trauma Focused-Cognitive Behavioral Therapy (Eight 1-hour sessions)	9th graders who experienced relational loss			Treatment group reported significantly lower grief, internalizing symptoms, externalizing symptoms, and posttraumatic stress, and significantly higher posttraumatic growth.
		n = 11	n = 10 (supportive therapy group)	n = 10	
Kang & Jang (2017)	Mindful self-compassion group program (Six 2-hour sessions)	College students whose self-criticism scores fell in the top 30 %			In a treatment group, mindfulness, self-compassion and psychological well-being significantly increased and self-criticism, and negative affect significantly decreased.
		n = 16	N/A	n =19	

Lee, Park, & Kim (2017)	Unspecified: Stress management intervention for daycare teachers (Eight sessions)	Daycare teachers n = 8	n = 8 (communicatio n improvement program)	n = 9 (non-treatment)	In a treatment group, stress level decreased, and stress management, anger management, and teacher efficiency increased.
Lee (2017)	Cognitive Behavioral Therapy (CBT) vs. Acceptance and Commitment Therapy (ACT) (Eight 90-minute sessions)	College students whose are at risk of depression n = 9 (CBT)	n = 7 (ACT)	N/A	Both CBT and ACT groups indicated significant improvement in depression, anxiety, rumination, worry, acceptance, dysfunctional attitude, and automatic thoughts. No significant differences were found between CBT and ACT groups in terms of the variables above.
Cho & Jang (2016)	Psychodrama (10 2-hour sessions)	Middle school adolescents who scored higher than mild depression n = 36	N/A	n = 30	Depression, self-esteem, perceived stress, and relationship difficulties significantly improved in a treatment group.
Park, Sung, & Mi (2016)	Loving-kindness meditation (two and half days)	Adults (non-clinical sample) n = 16	N/A	n = 20	In a treatment group, self-compassion, self-esteem, forgiveness, social connections, and spirituality significantly improved at a post-test and a follow-up. Positive and negative emotions improved only at a follow-up. Mindfulness did not change.
Lee & Kim	Emotion-focused	Adolescents (non-clinical sample)			In a treatment group,

(2016)	therapy (six 1-hour sessions)	n = 33	N/A	n = 33	alexithymia, depression, somatization significantly improved at a post-test and interpersonal relationship improved at both a post-test and a follow-up.
Park & Lee (2015)	Self-compassion enhancement (six 2.5-hour sessions)	Adult under the age 32			In a mindfulness group, self-compassion, self-esteem, borderline tendencies, and life satisfaction significantly improved in a pre- and post-test and a pre- and follow-up test, and depression improved only in a pre- and follow-up test. In a self-esteem group, self-compassion, self-esteem and life satisfaction significantly improved in both a pre- and post-test and a pre- and follow-up test, and borderline tendencies improved only in pre- and follow-up test. There was no change in depression.
		n = 14	self-esteem improvement program (n = 13)	non-treatment (n = 13)	
Hong, Yu, & Nam (2015)	Unspecified: Smartphone addiction intervention (12 50-minute sessions)	Fifth and sixth graders in an elementary school whose smart phone addiction scores are in the highest quartile			A treatment group showed significant improvement in control failure, disturbance of everyday functioning, absorption and tolerance, avoidance of negative emotion, virtual life orientation, and withdrawal.
		n = 14	N/A	n = 14	

Shin, Ryu, Kim, Lee, & Chung (2015)	Motivational interviewing: internet addiction intervention (six 2-hour sessions)	Male adolescents having internet addiction			In a treatment group, internet addiction symptoms and motivation to change significantly improved.
		n = 10	N/A	n = 10	
Kim, Kang, & Noh (2015)	Acceptance and commitment therapy (10 2-hour sessions)	Middle-aged, married women			In a treatment group, cognitive defusion significantly increased between a pre- and follow-up test while acceptance did not change.
		n = 8		n = 8	
Lee & Kim (2015)	Cognitive behavioral therapy (CBT) and mindfulness based cognitive therapy (MBCT) (10 50-minute sessions)	Fifth and sixth graders in elementary school with generalized anxiety and/or social anxiety			In both approaches, anxiety, social anxiety, automatic thoughts, negative future prediction significantly improved at a pre- and post-test. At a pre- and follow-up test: CBT: State anxiety, anxiety, social anxiety, automatic thoughts, negative future prediction, and social skills significantly improved. MBCT: State anxiety, anxiety, and mindfulness significantly improved.
		n = 9 (CBT)	n = 9 (MBCT)	n = 9	
Kang, Kim, & Jeong (2015)	Cognitive behavior therapy (10 2-hour sessions)	Infertile female adults with depression and anxiety			In a treatment group, depression, anxiety, marital satisfaction, quality of life with infertility, negative automatic thought, and irrational parenthood belief significantly improved in a pre-
		n = 12	N/A	n = 12	

					and post-test.
Kim & Cheon (2014)	Unspecified: Parent education program (six 3-hour sessions)	Parents in stepfamilies			In a treatment group, role strain, parent-child relationship satisfaction, caregiver stress, and psychological well-being significantly improved in a pre- and follow-up test.
		n = 6	N/A	n = 6	
Ham & Cheon (2014)	Unspecified: Suicide behavior intervention program for adolescents (10 45-minute sessions)	Adolescents scored higher in Suicide Ideation Questionnaire- Junior			Only in a treatment group, depression, suicide ideation, and psychological well-being significantly improved.
		n =10	n = 10 (Respecting life program)	n =10	
Shin & Park (2014)	Mindfulness-based expressive art therapy (10 sessions)	Industrial accident victims			In a treatment group, posttraumatic stress disorder symptoms (re-experience, avoidance, and hypervigilance), self-esteem, pain catastrophizing, and negative affect significantly improved.
		n = 9	N/A	n = 9	
Yang & An (2014)	Autogenic training (eight 90-minute sessions)	Adolescents seeking help from mental health agency			In a treatment group, anxiety significantly improved in pre- and follow-up test, while depression and adjustment to school did not significantly improved.
		n =10	N/A	n =8	
Kang & Park (2014)	An Enright forgiveness theory:	Female domestic violence survivors			In a treatment group, forgiveness, self-esteem,

	Forgiveness intervention (10 2-hour sessions)	n = 6	N/A	n = 6	hopefulness, subjective well-being, anger, anxiety, and depression significantly improved in pre- and follow-up test.
Cheon & Wang (2014)	Acceptance commitment therapy: Stress management intervention (six 2-hour sessions)	White-collar employees			In a treatment group, cognitive defusion and work engagement significantly improved.
		n = 16	N/A	n = 23	
Im & Oh (2014)	Unspecified: School violence prevention program focusing on empathy building (eight 1-hour sessions)	Fourth to sixth graders in elementary schools			In a treatment group, empathy and indifferent attitude to school violence significantly improved.
		n = 12	N/A	n = 15	
Kim & Kim (2014)	Trait based group art therapy (eight 90-minute sessions)	Third culture adolescents			In a treatment group, self-identity and intercultural sensitivity significantly improved.
		n = 29	N/A	n= 29	
Jeong, Yu, & Nam (2014)	Unspecified: Smartphone addiction prevention program (12 sessions)	Male students in middle schools at a potential risk of smartphone addiction			In a treatment group, disturbances in adaptive function, withdrawal, and tolerance significantly improved.
		n = 13	N/A	n = 13	

Appendix B

Outcome Rating Scale (ORS)

Name _________________________Age (Yrs):____ Sex: M / F
Session # ____ Date: _________________________
Who is filling out this form? Please check one: Self_______ Other_______
If other, what is your relationship to this person? _____________________________

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I---I

Interpersonally
(Family, close relationships)

I---I

Socially
(Work, school, friendships)

I---I

Overall
(General sense of well-being)

I---I

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Session Rating Scale (SRS V.3.0)

Name ________________________Age (Yrs):____
ID# _________________________ Sex: M / F
Session # ____ Date: ________________________

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected.	I---I	I felt heard, understood, and respected.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about.	I---I	We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is not a good fit for me.	I---I	The therapist's approach is a good fit for me.

Overall

There was something missing in the session today.	I---I	Overall, today's session was right for me.

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상담 결과 평가 척도

이름: ______________________ 나이:____ 성별: ____
회기: ____ 날짜: ______________________
본 척도를 작성하는 사람이 누구인지 표시해 주세요. 본인______ 타인______
다른 사람에 대하여 작성하는 경우, 그 사람과의 관계는 무엇입니까? __________

오늘을 포함하여 지난 한 주간을 돌아보고, 아래 제시된 측면과 관련하여 어떻게 보냈는지 응답하여 주시기 바랍니다. 잘 보냈을 수록 오른쪽 끝으로, 잘 보내지 못했을 수록 왼쪽 끝으로 응답해주시면 됩니다. 만일 다른 사람에 대하여 이 설문지를 작성하는 경우, 작성자가 보기에 그 사람이 어떻게 지내는지를 생각하며 작성하시면 됩니다.

개인적 측면

(개인적인 건강 및 안녕감)

I--I

관계적 측면

(가족 및 가까운 관계)

I--I

사회적 측면

(직장, 학교, 우정)

I--I

전반적 측면

(전반적인 건강 및 안녕감)

I--I

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상담 회기 평가 척도

이름: ________________________ 나이:____
번호: _________________________ 성별:
회기: ____ 날짜: ________________________

오늘 상담 경험을 가장 적절하게 설명하는 정도를 아래 선에 표시해 주세요.

상담자와의 관계

상담자가 내 말을 잘 듣거나 이해한 것 같지 않았으며, 상담자에게 존중받았다는 느낌이 들지 않았다.

I---I

상담자는 내 말을 잘 듣고 이해해주었으며, 상담자에게 존중받았다는 느낌이 들었다.

상담 목표 및 주제

내가 원했던 내용으로 상담을 하지 못했다.

I---I

내가 원했던 내용으로 상담을 하였다.

상담 접근법

상담자의 방식이 나에게 적합하지 않았다.

I---I

상담자의 방식이 나에게 잘 맞았다.

상담 전반

오늘 상담에서 어딘가 부족한 점이 있었다.

I---I

오늘 상담이 전반적으로 나에게 잘 맞았다.

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Appendix C

Demographic Questionnaire

Please indicate your sex:

Please indicate your age:

Your highest level of education: (major:)

Are you currently under training (master's or post-master's training)? Yes / No

How long have you practiced therapy? (years months)

What is your therapeutic orientation(s)?

What kind of a work setting are you in?

1) Counseling center at a university 2) Private practice 3) Counseling center at a company 4) Non-profit organization/Religious center 5) Other (Please specify.)

Do you have relevant license? Please indicate the type and level of your license and the year when you were conferred.

For how many clients and sessions have you used PCOMS?

The number of clients:

The number of therapy sessions for each client: (from a minimum number to a maximum number)

Demographic Questionnaire (a Korean Version)

다음은 선생님의 개인 정보 및 상담자 전문적 특성에 관한 질문입니다.

선생님의 성별은 무엇입니까?

나이(만)는 어떻게 됩니까?

학력과 전공을 표시해 주세요.

1)대학 졸업 2) 석사 학위 취득 3)박사 학위 취득

4) 기타 ( ) (전공:)

현재 상담 실습 (교육생, 인턴, 레지던트 등)을 하고 있습니까?

1) 예 2) 아니오

상담을 시작 하신지 얼마나 되었습니까? (년 개월)

주요 상담 접근법은 무엇입니까? (복수 응답 가능)

현재 근무 장소는 어디입니까?

1)대학 상담소 2)개인 상담소 3)기업 상담소 4) 시민단체/종교단체 5)기타

(구체적으로 작성해주세요:)

상담 관련 자격증을 가지고 있는 경우 그 종류와 급수 및 수여 년도를 작성해 주세요.

얼마나 많은 내담자와 회기에서 상담 성과 관리의 동반자를 사용하셨습니까?

내담자 수:

회기 수: (가작 적은 회기 수 ~ 가장 많은 회기 수로 표기)

Appendix D

Interview Protocol

Have you used PCOMS?

If a participant says yes:

With how many clients and sessions have you used PCOMS?

How did you use the ORS and SRS?

Please tell me about your experience when using PCOMS with clients.

Please tell me about significant moments when using PCOMS.

Have you had any benefits when using PCOMS? Please describe. What kinds of clients (presenting concerns, the severity of symptoms, personal characteristics, and so forth) were you working with at that time?

Have you had any difficulties when using PCOMS? Please describe. What kinds of clients (presenting concerns, the severity of symptoms, personal characteristics, and so forth) were you working with at that time?

Are there any clients with whom you did not want to use or did not use PCOMS? If yes, please describe.

Do you think Korean culture influenced the PCOMS process? If yes, please describe.

Do you want to continue to use PCOMS? Why is that?

Is there anything that should be improved about the Korean ORS and SRS?

If a participant says no:

What made you not use PCOMS?

What challenges do you anticipate when you use PCOMS?

What therapist's characteristics would impede using PCOMS?

What client's characteristics would impede using PCOMS?

What Korean cultures would impede to using PCOMS?

Is there anything that should be improved about the Korean ORS and SRS?

Interview Protocol (a Korean Version)

상담 성과 관리의 동반자를 내담자와 실제로 사용해 보셨습니까?

(사용한 경우)

몇 명의 내담자와 상담 성과 관리의 동반자를 사용하셨습니까?

상담 결과 평가 척도와 상담 회기 평가 척도를 어떻게 사용하셨습니까?

상담 성과 관리의 동반자를 사용한 경험에 대하여 말씀해주시기 바랍니다.

상담 성과 관리의 동반자를 사용할 때 있었던 주요 상황에 대하여 말씀해주시기 바랍니다.

상담 성과 관리의 동반자가 도움이 되었습니까? 구체적으로 설명해주시기 바랍니다.

어떤 내담자 (주 호소 문제, 증상의 심각도, 개인적 특성 등)에게 도움이 되었습니까?

상담 성과 관리의 동반자를 활용하는 데 어려움을 느꼈습니까? 구체적으로 설명해주시기 바랍니다. 어떤 내담자 (주 호소 문제, 증상의 심각도, 개인적 특성 등)와 사용할 때 어려움을 느꼈습니까?

상담 성과 관리의 동반자를 활용하지 않았던 내담자가 있습니까? 그렇다면 구체적으로 설명해주시기 바랍니다.

선생님의 생각에 상담 성과 관리의 동반자를 활용하는 데 한국 문화가 영향을 미친다고 생각하십니까? 그렇다면 구체적으로 설명해주시기 바랍니다.

상담 성과 관리의 동반자를 앞으로도 사용하고 싶습니까? 그 이유는 무엇입니까?

두 척도에서개선해야 할 것이 있습니까?

(사용하지 않은 경우)

사용하지 않은 이유는 무엇입니까?

상담 성과 관리의 동반자를 사용하는 경우 어떤 어려움이 예상됩니까?

상담 성과 관리의 동반자를 사용하기에 부적절하거나 맞지 않는 상담자 특성이 있다면 무엇이라고 생각합니까?

상담 성과 관리의 동반자를 사용하기에 부적절하거나 맞지 않는 내담자 특성이 있다면 무엇이라고 생각합니까?

상담 성과 관리의 동반자 활용과 맞지 않는 우리 사회 문화적 특성이 있다면 무엇이라고 생각합니까?

상담 성과 관리의 동반자가 상담에 효과적으로 쓰일수 있는 방법(실시 방법 및 척도 수정 등)이 있다면 무엇이라고 생각합니까?

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