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THE BELIEFS, EVENTS, AND VALUES INVENTORY (BEVI): IMPLICATIONS AND APPLICATIONS FOR THERAPEUTIC ASSESSMENT AND INTERVENTION

Every person is like all other persons, like some other persons, and like no other person.

—Clyde Kluckhohn and Henry Murray[1]

Within the larger mental health field, practicing clinicians are faced with an overwhelming number of therapeutic models and intervention techniques (Norcross, 2005). These approaches often employ different psychological constructs to guide clinical treatment and define therapeutic change (Henriques, 2011; Levitt, Stanley, & Frankel, 2005; Magnavita, 2010; Wachtel, 1997). One schema used to organize the multitude of psychotherapeutic models is the division of theoretical and clinical approaches into three broad frameworks: psychodynamic, cognitive behavioral, and humanistic (Gelso & Hayes, 2007). At the outset, an overview of this "big three" organizational schema may provide context for the integrative potential and therapeutic assessment implications of the Beliefs, Events, and Values Inventory (BEVI), which is the primary focus of this chapter.

FRAMEWORKS OF INTERVENTION

The psychodynamic framework begins with Freud, who developed drive theory, the tripartite model of personality, and the technique of psychoanalysis (Freud, 1909/1961; Freud, 1927/2011). Freud's theory and psychoanalytic method later were modified and expanded upon in what some theorists and historians refer to as the "relational turn" (Elisha, 2011). Major innovations in this movement include Klein's object relations, Winnicott's conceptualization of self, Bowlby and Ainsworth's attachment theory, Sullivan's interpersonal theory, and Kohut's self psychology (Greenberg & Mitchell, 1983; Priel, 2009; Wolitzky & Eagle, 1997). More recently, there has been increased interest in short-term dynamic therapies (e.g., Coren, 2009;

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[1] This quotation is derived from Kluckhohn and Murray (1953) and was adapted by McAdams and Pals (2006).

Davanloo, 1980; Luborsky, 1984; Luborsky & Crits-Cristoph, 1998; Mander, 2000; Strupp & Binder, 1984), while also demonstrating the overall effectiveness of psychodynamic interventions (e.g., Leichsenring & Rabung, 2008; Roseborough, 2006).

The cognitive behavioral framework consists of three waves, each of which extends the theoretical and clinical focus of the previous generation (Hayes, 2004). The first wave, classic behavioral therapy, was established by Watson (1913) in his Behavioral Manifesto, further developed by Skinner's (1947) theory of operant conditioning, and implemented clinically by Wolfe's (Wolfe, Brady, Serber, Agras, & Liberman, 1973) treatment model of Systematic Desensitization. The second wave incorporated a cognitive emphasis articulated by Ellis and Harper (1961) Rational Emotive Behavior Therapy and Beck's (1963) Cognitive Therapy. Cognitive behavioral approaches over the past 20 years comprise the third wave, which has expanded beyond a behavioral and cognitive focus to include experiential and mindfulness approaches toward theory and practice. Examples of these new approaches include Linehan's (1993) Dialectical Behavioral Therapy, Hayes's (2004) Acceptance and Commitment Therapy, and Wells's (2009) Metacognitive Therapy.

The humanistic framework has its origins in the work of Adler (1916) and Rank (1952), although Rogers (1951) is thought to be a major pioneer in this orientation, too, with his Person-Centered Therapy. Other approaches broadly considered to fall within the humanistic framework include Gestalt Therapy (Perls, 1951/2010), Experiential Therapy and Emotion-Focused Therapy (Greenberg, 2001), Existential Psychotherapy (May, 1958), and the postmodern, constructivist perspective (Kelly, 1963; Mahoney, 2003; Rennie, 2004).

Four Problems With the Big Three

The usage of the "big three" organizational frameworks begets at least four conceptual and applied problems. *First, despite the heuristic appeal of this tripartite framework, such an approach minimizes the theoretical and clinical heterogeneity within each of these frameworks.* This confound is due to many interacting factors, including the historical processes by which theories have been developed, interpreted, and implemented (e.g., Greenberg & Mitchell, 1983). To take just one example, within the psychodynamic framework, some clinicians assume a neo-Freudian epistemological stance toward constructs such as "the self" whereas others who also would consider themselves "psychodynamic" may adopt a more postmodern and constructivist approach (Elisha, 2011).

A second problem with the "big three" approach is the real world minimization of theoretical and clinical heterogeneity between each of these frameworks. That is because in practice, clinicians may rely upon theoretical structures, processes, or constructs within one tradition (psychodynamic, cognitive behavioral, humanistic) to inform their work while also employing intervention approaches and techniques from another tradition. Such integrative approaches to practice—whether they are deliberate or even acknowledged—are due to a range of real world influences such as theoretical cross-fertilization, theoretical assimilation, pragmatic exigencies of doing the work, and the integration movement (Magnavita & Achin, 2013; Norcross, 2005). For example, consider the theoretical overlap between Linehan's use of "dialectics" in her Dialectical Behavioral Therapy (a cognitive behavioral approach) and Gestalt's Field Theory (a humanistic approach). Both approaches emphasize relational, systemic, and contextual approaches toward conceptualization and intervention (Cain, 2002; Linehan, 1993).

A third problem with the "big three" approach is that such a framework underestimates the powerful role other subdisciplines and perspectives play in informing theoretical and

applied aspects of practice in the real world. Among many other candidates, systems theory, attachment theory, evolutionary psychology, and cognitive neuroscience all influence the way therapists think about their clients and their work (Badcock, 2012; Greenberg, 2001; Nichols, 2011). Consider that clinicians routinely conduct intake interviews at the outset of therapy, in which historical information about life/family history is gathered. Such information helps clinicians formulate their understanding of *why* clients present as they do regardless of the theoretical framework to which they ascribe. Also, this approach clearly is consistent with data and theory—if not best practice—from the field of developmental psychopathology, yet another field of considerable relevance to all three frameworks of therapeutic work (Cummings, Davies, & Campbell, 2000).

A fourth and final problem with the "big three" framework is that if a practitioner adheres solely to a specific tradition, such fixedness may produce barriers to conceptualization and intervention, by encouraging myopic fidelity to particular ways of thinking and working. For example, a cognitive behavioral therapist may focus upon maladaptive beliefs, whereas a psychodynamic therapist may emphasize historical processes, while a therapist from the humanistic framework might point to a lack of coherence and meaning in his or her client's narrative (Adler, 2012; McAdams, 2006; Norcross, 2005). Why does such singularity of focus matter? Because in practice, the pure psychodynamic clinician may eschew clinical emphasis on client beliefs that demonstrably are maladaptive, but could be addressed directly *and* empathically to good therapeutic effect; likewise, the pure cognitive behavioral therapy clinician may erroneously believe that the "relationship" between client and therapist—which theoretically is emphasized more within the humanistic or psychodynamic frameworks—is far less important than it actually is in terms of the necessary and sufficient conditions for therapeutic change (Henriques, 2011; Magnavita & Achin, 2013; Norcross, 2005). In short, encouraging strict adherence to a single therapeutic framework ultimately may limit a clinician's effectiveness by inculcating professional prejudices that are neither helpful to clients nor valid in terms of what actually happens within and between the practice areas (Shealy, Cobb, Crowley, Nelson, & Peterson, 2004).

INTEGRATIVE THERAPEUTIC ASSESSMENT: EI THEORY, EI SELF, AND BEVI

Recognition of these problems is not new, and attempts at redress are increasingly mainstream and widespread, most notably through the integration and unification movements vis-à-vis conceptual models and methods of intervention (Henriques, 2004; Magnavita & Achin, 2013; Norcross, 2005; Wachtel, 1997; Wampold, 2010). In light of these important developments, a concomitant question arises: Would it be possible to measure such therapeutic work, and use such measurement to understand and facilitate change through an integrative lens? In other words, it is all well and good to focus on integrative approaches toward therapy. However, might it also be possible to conduct our assessments in a manner that not only facilitates therapeutic intervention across the "big three," but also helps facilitate integrative conceptualization, planning, and intervention (Beutler, Groth-Marnat, & Rosner, 2003; Steele, Steele, & Murphy, 2009)? As has been the case with therapy common factors—"those aspects of treatment that are associated with positive or negative outcomes across all therapies or therapists" such as empathy, acceptance, and understanding (Shealy, 1995, p. 567)—might it be possible to identity "assessment common factors" (Shealy, 2016, p. 105) through an integrative "psychological assessment

as a therapeutic intervention" (PATI) lens (Finn, 2007; Finn & Tonsager, 1997; Poston & Hanson, 2010)? In doing so, could we illustrate how the interplay between content (e.g., scores on specific scales) and process (e.g., the experience or expression of affect, or engagement in self-reflection, as a result of discussing such scores) may deepen the therapeutic relationship, clarify relevant issues, and facilitate the pursuit of intervention goals?

Toward such means and ends, we describe Equilintegration (EI) Theory and the EI Self along with the BEVI. After an overview of this model and method, we illustrate how the BEVI facilitates an understanding of five proposed assessment common factors—formative variables, dichotomous thinking, dialectical thinking, emotional awareness, and self-awareness—that we believe are relevant especially to clinicians across the "big three." Finally, we highlight two therapeutic assessment principles in regard to utilizing an EI perspective and the BEVI therapeutically, and present findings from an exploratory study examining the integrative potential of the BEVI in both therapeutic and assessment contexts.

As a model and method, the EI framework and BEVI are highly compatible with PATI sensibilities (Fischer, 2000; Hanson & Poston, 2011; Poston & Hanson, 2010), by seeking to understand the meaning of client and trainee explanations about what is real or true for themselves, others, and the world at large, and engaging them in an attendant process of in-depth clinical assessment and exploration. As a model and method of assessment, EI Theory explains "the processes by which beliefs, values, and 'worldviews' are acquired and maintained, why their alteration is typically resisted, and how and under what circumstances their modification occurs" (Shealy, 2004, p. 1075). Along these lines, we contend that beliefs, values, and worldviews are centrally important constructs within the mental health field, which should warrant in-depth and routine assessment across settings and populations (see Chapter 2 for a full explication of EI hypotheses and principles).

Derivative of EI Theory, the EI Self explains integrative and synergistic processes by which beliefs and values are acquired, maintained, and transformed as well as how and why these are linked to the formative variables, core needs, and adaptive potential of the self. Informed by scholarship in a range of key areas (e.g., "needs-based" research and theory; developmental psychopathology; social cognition; affect regulation; therapeutic processes and outcomes; theories and models of "self"), the EI Self seeks to illustrate how the interaction between our core needs (e.g., for attachment, affiliation) and formative variables (e.g., caregiver, culture) results in beliefs and values about self, others, and the world at large that we all internalize over the course of development and across the life span (see Chapter 3 for more information about the EI Self).

Concomitant with EI Theory and the EI Self, the BEVI is a comprehensive and integrative assessment measure in development since the early 1990s (e.g., Anmuth et al., 2103; Atwood, Chkhaidze, Shealy, Staton, & Sternberger, 2014; Brearly, Shealy, Staton, & Sternberger, 2012; Hill et al., 2013; Shealy, 2004, 2005, 2015, 2016; Shealy, Bhuyan, & Sternberger, 2012; Tabit et al., 2011; for more information about the BEVI, see Chapter 4 as well as www.ibavi.org/content/featured-projects). This instrument examines how and why we come to see ourselves, others, and the larger world as we do (e.g., how life experiences, culture, and context affect our beliefs, values, and worldview) as well as the influence of such processes on multiple aspects of human functioning (e.g., learning processes, relationships, personal growth, the pursuit of life goals). Both the long and short versions of the BEVI consist of four components: (a) a comprehensive set of background information items;

(b) an intake interview that has been converted into a Likert-type format, and integrated into the BEVI via specific scales (e.g., Negative Life Events [NLE]); (c) 18 scales composed of 336 items on the long version and 17 scales composed of 185 items on the short version; and (d) three qualitative items. By design, the BEVI is meant to be a mixed methods measure, whereby both response sets are able to be mixed or integrated when used for assessment and therapeutic purposes (i.e., in a clinical context, both quantitative scores and qualitative responses may be used together in order to understand a client presentation, communicate results to a client, and facilitate interventions) (Creswell & Plano Clark, 2011; Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005). From the standpoint of scales, the BEVI assesses processes such as: basic openness; the tendency to (or not to) stereotype in particular ways; self- and emotional awareness; preferred strategies for making sense of why "other" people and cultures "do what they do"; global engagement (e.g., receptivity to different cultures, religions, and social practices); and worldview shift (e.g., to what degree do beliefs and values change as a result of specific experiences). BEVI results are translated into reports at the individual, group, and organizational levels and used in a wide range of contexts for a variety of applied and research purposes (e.g., to track and examine changes in worldviews over time) (for more information, see Chapter 4).

Assessment Common Factors: Applications of EI Theory, EI Self, and BEVI

Before explicating five proposed assessment common factors of relevance to integrative therapeutic change—formative variables, dichotomous thinking, dialectical thinking, emotional awareness, and self-awareness—an important caveat is in order: from an EI and BEVI perspective, labeling and organizing phenomena into discrete categories for conceptualization may be useful as long as such processes are not done in a reductive or superficial manner, thus overlooking the complex nature of the interactions among these categories. It seems plausible that there always will be a dialectical tension between creating a coherent, logical narrative and capturing the dynamic and complex nature of human experience. At the same time, so long as our models and methods are ecologically valid, there is real merit in attempting to illustrate highly complex processes in a way that is maximally accessible.

Factor 1. Formative Variables: Background Characteristics and Life Events on the BEVI

From an EI perspective, formative variables (e.g., life history and background characteristics) are theoretically and empirically associated with how and why beliefs and values about self, others, and the larger world become structured as they are (Shealy, 2016). On the BEVI, in addition to a comprehensive set of background and demographic variables (e.g., education level, religious/political orientation), the Negative Life Events (NLE) and Positive Life Events (PLE) scales provide an indication of how an individual views his or her life history and formative experiences. More specifically, NLE and PLE include information regarding childhood experiences, the conduct of one's caregivers, as well as perceptions of their relative emotional health and stability, how much conflict individuals experienced in the home, and other life history processes common across the life span (e.g., performance in school, legal

problems, relations with peers). By design, these scales essentially comprise a comprehensive intake interview that has been converted into a Likert-type format and integrated into the BEVI.

Although psychodynamic perspectives have long emphasized the relevance of experiences in childhood or adolescence in terms of psychological functioning, in truth, many therapeutic schools of thought and allied programs of research recognize that life experiences affect psychological functioning for better or worse (Cummings, Davies, & Campbell, 2000; Wachtel, 1997). For example, psychodynamic, integrative, and systemic therapeutic models explicitly emphasize the relevance of childhood experiences in understanding adult conflicts (Gold, 2011; Nichols, 2011; Young, Klosko, & Weishaar 2003). Early events and formative experiences also are emphasized in attachment theory and the field of developmental psychopathology, which have influenced clinical practice across the spectrum of models and approaches (Bowlby, 1982; Cummings, Davies, & Campbell, 2000; Shealy et al., 2012). According to attachment theory, children develop internal working models of relationships, which essentially are cognitive/affective schemas that are derivative of relational experiences with early caregivers. These models then serve as templates for relating to others, which may be responsible for chronic struggles later in life (e.g., interpersonally, emotionally). Indeed, attachment style, with its origins in childhood, is associated with a wide array of psychosocial outcomes in adulthood (see Mikulincer & Shaver, 2007 for a review). Thus, a central emphasis for many psychodynamic and integrative therapies is for the client to develop insight into the nature of his or her early experiences as well as how such experiences relate to current functioning (e.g., relational and emotional processes) (Gold, 2011; Young et al., 2003). Similarly, many therapeutic approaches to assessment view increased insight and self-understanding as important outcomes (Finn & Tonsager, 1997; Fischer, 2000). Although cognitive behavioral and humanistic interventions may not focus on formative variables to the same degree as psychodynamic approaches, the former models often recognize that early life experiences are integral to the development of the self, emotional regulation strategies, and interpersonal coping skills (e.g., Linehan, 1993).

Finally, as noted previously, the fact that mental health clinicians typically conduct some form of an intake interview, which includes questions about life history and family functioning, illustrates that we implicitly, if not explicitly, recognize that the experiences we have early in life (e.g., in our families of origin) affect our functioning in ways that may have direct relevance to therapeutic interventions, regardless of theoretical fidelity or predilection, even if our focus tends toward the present and not the past. At the very least, then, it stands to reason that building an "intake interview" into the BEVI is logical because, by doing so, we are acknowledging the relevance of such experiences to "here and now" functioning, as well as their potential linkage to other affective and cognitive processes that are relevant both to practitioners and scholars (e.g., Shealy, 2004). Moreover, such inclusion helps socialize and, in essence, prepare clients for subsequent assessments and interventions (Claiborn & Hanson, 1999).

Factor 2. Dichotomous Thinking: Basic Determinism on the BEVI

Our second proposed assessment common factor is captured by the construct of "dichotomous" (i.e., "black and white") thinking, a manifestation that therapists across the "big three" encounter in their clients. A number of BEVI scales measure various aspects of an individual's cognitive style and attributional system—constructs

central to behavioral change in cognitive therapy models. BEVI scales that are particularly relevant to assessing such constructs include Basic Openness, Self Awareness, Basic Determinism, and Socioemotional Convergence. For example, the Basic Determinism Scale measures the degree to which an individual "prefers basic/simple explanations for why people are as they are or do what they do" (Shealy, 2016). A sample item that statistically loads on this scale, *People don't really change*, appears to illustrate a form of dichotomous thinking, in which an individual tends to view self, others, and the world through a simple, binary, and mutually exclusive polarity (Napolitano & McKay, 2007; Oshio, 2009).

Dichotomous thinking may be beneficial in certain contexts, such as when time is limited and a quick decision is needed (Oshio, 2009). However this "all-or-nothing" style of thinking may be also associated with negative interpersonal and psychological outcomes. For example, in Beck's (1995) *The Basics of Cognitive Therapy and Beyond*, "all-or-nothing thinking" is considered a form of cognitive error (p. 119). Dichotomous thinking has been also linked to psychopathology, including personality and eating disorders, as well as personality traits such as perfectionism (Byrne, Cooper, & Fairburn, 2004; Linehan, 1993; Napolitano & McKay, 2007; Oshio, 2009). Moreover, such either/or thinking is related to the psychodynamic construct of "splitting," which refers to the tendency to evaluate oneself, others, and interpersonal relationships through extreme positions such as "all good" or "all bad" (Oshio, 2009, p. 731). This polarized style of thinking and feeling may be associated with maladaptive patterns of emotional and behavioral functioning, which further impair interpersonal relationships and self-regard (Linehan, 1993).

Factor 3. Dialectic Thinking: Socioemotional Convergence on the BEVI

As a mirror opposite to dichotomous thinking, therapists also encounter clients who (mercifully) seem to have the capacity to think complexly in that they are able to apprehend self, others, and the larger world in "shades of gray" rather than black and white. On the BEVI, Socioemotional Convergence assesses these fundamental characteristics of an individual's experience of self, other, and the larger world, including whether and to what degree an individual apprehends "complex and seemingly contradictory" beliefs about matters that really do not resolve themselves to "one way or another" thinking (Shealy, 2016). Among other possible examples, items that load highly on Socioemotional Convergence include beliefs that too many individuals do not take sufficient responsibility for their own lives while simultaneously agreeing that we should help those who cannot help themselves. A low Socioemotional Convergence responder may agree with one statement but not the other; those who score higher appear to understand that both statements could be true, which is both an acknowledgment of the complex nature of reality and consistent with the capacity to tolerate disequilibrium, a fundamental proposition of the EI framework (Shealy, 2004). Dialectical thinking parallels this construct, in that seeming contradictions actually represent "opportunities to. . . .create new, more complex systems" (Wu & Chiou, 2008, p. 240).

Consistent with an EI framework, the dialectical position has both cognitive and affective aspects. The cognitive component involves an emphasis on the dynamic nature of knowledge whereas the affective component involves "the emotional tensions of the creative process, which include holding opposing views simultaneously, sustaining uncertainty, breaking away from established ways of

seeing things, and tolerating ambiguity" (Wu & Chiou, 2008, p. 240). Dialectical thinking has been also associated with models of creativity, cognitive development, and adaptive coping (e.g., Basseches, 1980; Chen, 2009; Riegel, 1976; Vukman, 2005). From the standpoint of intervention, attempts to facilitate a dialectical stance is exemplified by Linehan's (1993) Dialectical Behavioral Therapy, in which the dialectic of acceptance and change is emphasized while instruction in dialectical thinking is applied to the skills of mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance.

Factor 4. Affective Capacity: Emotional Attunement on the BEVI

As with the other assessment common factors, therapists regardless of theoretical predilection inevitably will contend—directly or not—with the relative capacity of their clients to experience and express emotion. On the BEVI, the Emotional Attunement scale is related to such capacity, assessing the degree to which individuals are "highly emotional, highly sensitive, highly social, needy, [and] affiliative" (Shealy, 2016). An example of an item from this scale is *I have real needs for warmth and affection*. Across all major therapeutic approaches, emotional awareness is considered central to well-being (Burum & Goldried, 2007; Warwar, Links, Greenberg, & Bergmans, 2008), regardless of how such capacity is encountered in practice. It is also central to therapeutic assessment processes and outcomes (Finn, 2007).

From an EI perspective, emotion serves multiple functions, including providing information regarding what is most important in one's interpersonal and social field and self-access to one's own internal sense of well-being, while providing motivational impetus for taking action in order to meet the "core needs" as described in the EI Self (see Chapter 3). As fundamental mediators of motivation, emotion guides interpersonal communication and interactions, and is pivotal to ongoing existential processes of meaning making in life (Warwar et al., 2008). Because emotion plays a central role in our adjustment and adaptation, the inability to tolerate, process, experience, or express affect is thought to be core to many psychological disorders. As Greenberg (2007) maintains in the Emotion-Focused Therapy model, three aspects of emotion are integral to well-being: emotional awareness, emotional acceptance, and emotional attention. Highly consistent with such emphases, the Emotional Attunement scale of the BEVI focuses explicitly on how a client's emotional awareness may be evaluated and communicated in the context of therapeutic assessment and intervention.

Factor 5. Access to Self, Others, and the Larger World: Self Awareness on the BEVI

As a final exemplar, therapists inevitably must grapple—to one degree or another—with their client's relative interest in and capacity for encountering and understanding who and why they, others, and the larger world are as they are. The BEVI measures different aspects of such processes via several scales. For example, Self Awareness measures the degree to which an individual is "open to difficult thoughts and feelings, introspective, [able to] tolerate confusion, [and] aware [of] how the self works" (Shealy, 2016). A sample item from this scale is *I like to think about who I am*.

As with all of these constructs, part of the difficulty is understanding—and operationalizing—what exactly we mean by "self," a question that is considered through definitional and pictographic aspects of the EI Self (see Chapter 3). From an

integrative therapeutic standpoint, the construct of self presents several challenges. First, there have been changes over time in the construct of self within various psychotherapeutic paradigms. For example, from a Freudian perspective, the self is largely unconscious, in conflict, and ruled by mechanistic, deterministic, and bioenergetic properties (e.g., drives/instincts) (Freud, 1927/2011; see also Elisha, 2011; Greenberg & Mitchell, 1983; Wolitzky & Eagle, 1997). With contributions from the British object relations theorists such as Klein, Winnicott, Guntrip, and Fairbairn, as well as Bowlby and Ainsworth's attachment theory and Kohut's theory of self psychology, the emphasis in psychoanalytic schools shifted toward the relational aspects of the self in terms of its development and properties (Elisha, 2011; Wolitzky & Eagle, 1997). Within the more relational and intersubjective models of psychoanalytic theory, the clear dichotomy between self and other breaks down such that self-awareness cannot be separated completely from the individual's relationships with significant others, both in the development of the individual's sense of self, and in the therapeutic treatment and healing of the self (Elisha, 2011).

A second difficulty in examining the concept of self and self-awareness is that these constructs not only evolved over time, but also were influenced, in part, by theoretical cross-fertilization between the different frameworks (Magnavita, 2010). That is, theoretical plurality has begun to characterize each of the schools. Therefore, when examining the construct of self vis-à-vis self-awareness, distinctions blur among psychodynamic, humanistic, and cognitive behavioral frameworks. For example, there are many postmodern and humanistic strains within some of the current psychodynamic and psychoanalytic models (Elisha, 2011). Some contemporary psychoanalytic theorists interpret Freud's concept of self from a constructivist and postmodern point of view in which self constructs are most effectively viewed as a dynamic narrative that is interpersonally, socially, and culturally constructed. In this light, "false" and "true" selves are viewed "less as structured layers than as evolving processes, as two diverse forms of being in time. . .True-self processes imply an open, flexible, temporality, whereas false-self processes are characterized by a static and. . .rigid. . .past oriented. . .(mode of being)" (Priel, 2009, p. 494). Along these lines, it should be noted that this descriptor of self-awareness is highly congruent with the dialectic cognitive/affective processes noted earlier and measured by the Self Awareness, Basic Determinism, and Socioemotional Convergence scales on the BEVI.

Closely related to self-awareness, the constructs of self-understanding and self-discovery also have been integral to therapeutic change in several studies that examined the perspectives of both psychotherapists and clients (e.g., Binder, Holgersen, & Nielsen, 2010; Gibbons et al., 2009; Levitt, Butler, & Hill, 2006; Levitt & Williams, 2010). Additionally, enhancing self-understanding and self-discovery also are an integral part of assessment interventions (Finn, 2007; Fischer, 2000). Even so, most of these approaches focus more on the overarching goal of enhancing self-understanding through interventions, rather than doing so in the context of measuring this construct in a valid and reliable manner, or illustrating its relevance to other aspects of the human condition. Correlation matrix and other predictive analytic data from the BEVI clearly illustrate that self-awareness not only is relevant to other constructs, it also is mediated by life experiences and other formative variables (Shealy, 2010). In particular, it appears that the greater degree of Negative Life Events (NLE) reported by an individual, the lower the relative degree of Self-Awareness, a finding that has important implications for how individuals in therapy are understood and where the focus of our interventions might be directed.

The BEVI in Practice

Assessment as a Therapeutic Intervention

Although "assessment as intervention" increasingly evokes professional attention and discourse (Hanson & Poston, 2011; Lilienfeld, Garb, & Wood, 2011), the fundamental issue at stake is captured by Riddle, Byers, and Grimesey (2002), who identify two methods by which assessment measures are used in therapy. The traditional perspective tends to emphasize objective classification, which largely regards the client as a passive agent. Here, test results are not readily shared with the client, but rather used to diagnose, select a treatment approach, and predict outcomes. The role of therapist is that of expert and the role of client is that of service recipient. The "human science" perspective, on the other hand, regards the assessment process as potentially transformative and empowering (p. 33). Here, the therapist shares test results with the client and seeks interpretation within the interpersonal frame of the therapeutic relationship. Various terms have been used to describe this framework, including "Therapeutic Assessment. . .collaborative/individualized assessment. . .collaborative consultation to psychotherapy. . .and brief personalized assessment feedback" (Poston & Hanson, 2010, pp. 203–204).

Along these lines, Finn and Tonsager (1997) regard assessment as consisting of both information gathering and the facilitation of integrative interventions. From this perspective, assessments should function primarily as a therapeutic intervention, and be characterized as nonpathologizing, noncategorical, individualized, and collaborative. To date, substantial empirical support has accumulated, theoretical explanations of benefit have been offered, and key variables have been identified, such as how much feedback should be delivered and how to deal with discrepancies between assessment findings and self-representation (Claiborn & Hanson, 1999; Finn, 1996, 2007; Finn & Tonsager, 1997; Hanson & Claiborn, 2006; Hanson & Poston, 2011; Ward, 2008). In real world usage, the BEVI is deliberately aligned with such an ethos and way of working. There are two fundamental principles, in particular, that are relevant to the BEVI's use in therapeutic assessment. Described next, these principles consist of moving beyond a diagnostic framework and of working within a collaborative context.

Principle 1: Broadening the Framework of Who Clients Are— Moving Beyond Diagnoses

A central ethical tenet of psychotherapy practice is to do no harm, as stated in Principle A of the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2012). For this reason, many humanistic therapists decry the use of psychological assessments because they perceive it as "dehumanizing. . .and judgmental" (Finn & Tonsager, 1997, p. 377). Fischer (2000) has observed that "assessment processes and the resulting reports were often destructive to patients' self-respect" (p. 7). The prevailing diagnostic role of psychological assessments may bear partial responsibility for this experience (Quinn & Chaudoir, 2009). Negative feelings of embarrassment, shame, fear, and guilt may arise when one is given a psychological diagnosis. From the client perspective, receiving a diagnosis may feel as though one's core sense of self is being sentenced and judged (Corrigan & Wassel, 2008).

In reality, of course, the real world situation vis-à-vis diagnosis is complex, as a number of first person accounts attest. For example, *Firewalkers: Madness, Beauty, & Mystery* documents the experiences of individuals who received some of the most serious diagnoses the mental health field may confer (see www.vocalvirginia.org). On the downside, one of the book's authors, who was diagnosed with chronic undifferentiated schizophrenia, observed: Rather than a diagnosis, "what I needed was for someone to trust that my mind was intact" (Spiro, 2010, p. 20). On the other hand, as *Firewalkers* also illustrates, there are times when receiving a diagnosis may serve a beneficial function for an individual in distress. For example, relief may be experienced when a coherent explanation is attached to suffering, which was previously inexplicable (Frank & Frank, 1991; Perry, 2011). In addition, a diagnosis may guide a clinician toward an effective empirically based treatment or provide an avenue for a client to obtain funding for much-needed services.

Despite the potential benefits of diagnostic labels, the experience of receiving a label from an external authority often feels alien, disempowering, and demoralizing (e.g., Spiro, 2010). As such, Fischer (2000) has long advocated that clinicians move beyond "classification assessment" (p. 3) through a process of open and collaborative formulation between client and therapist. Recognizing the epistemologies that inadvertently shape what we know to be "true" as assessors and therapists (Kimble, 1984), Fischer warns against the imposition of "artificial, categorical clarity" (p. 7) because putative "knowledge" always is influenced by subjective perspective and contextual influence. Therefore, clinicians should respect the complexity and ambiguity inherent to the therapeutic process, viewing assessment as a hermeneutic process of "circling repeatedly from an observation back to context or to larger prior comprehensions, (and) then back again to observation" (p. 13). As an added feature, this approach enhances multicultural awareness, knowledge, and skill (Ridley, Li, & Hill, 1998). Finally, from a clinical perspective, traditional classification also may imply that therapeutic struggles are fixed and immutable, which may create a self-fulfilling prophecy for clients, who come to identify with a label, therefore reductionistically truncating the complexity and potential of their lives (Perry, 2011; Pouchly, 2011; Quinn & Chaudoir, 2009). In short, therapeutic assessment emphasizes dynamic processes over rigid classification, goals that are core to the intent and structure of the BEVI and its EI framework.

More specifically, the BEVI seeks credibly to privilege unique elements of a client's presentation while embedding such specificity within an empirically based, normative frame. Such an approach is not without precedent. For example, Finn and Tonsager (1992) developed a structured, empirically based, and individually tailored assessment procedure—a Therapeutic Assessment—which is influenced by the humanistic framework, self psychology, and relational psychotherapy (Finn, 1996, 2007; Finn & Tonsager, 1992). Core to such an approach, and consistent with the BEVI, is what might be called an ideographically centered, but nomothetically grounded assessment designed to help ". . .clients generate questions they would like answered/ addressed by the assessment and testing, collecting background information related to their questions, exploring past assessments—and/or testing-based hurts,. . .answering as much as possible clients' initial questions" (p. 204).

In the final analysis, the BEVI recognizes both the potential hazards and benefits of a "traditional" method of assessment and diagnosis. As such, this measure is not "anti-diagnosis," but rather directed toward a deeper understanding of the underlying formative, cognitive, affective, and contextual variables that ultimately

relate etiologically to the manifestation of "symptoms" that become the basis for such a diagnosis. By explicitly linking the BEVI to processes of therapeutic intervention—and by deliberately attempting to use assessment approaches to help understand "where clients are" while facilitating understanding and the therapeutic alliance—the BEVI offers an illuminating and constructive function vis-à-vis the process of intervention. In this sense, it deliberately sides with the hope and potential that is—or should be—a central focus for therapists, because such aspects of the therapeutic relationship have been shown empirically to be ameliorative (Horvarth & Bedi, 2002). Moreover, by including complementary aspects of self (e.g., culture, religion) that may be as, if not more, important to clients than the foci that traditionally are considered paramount by clinicians (Dana, 2005; Pouchly, 2011; Ridley et al., 1998), the BEVI seeks to include the client's experience of his or her own world more deliberately in the therapeutic process.

Principle 2: Facilitating Collaboration and Connection

The processes by which BEVI feedback is gathered and shared with clients is oriented deliberately toward a collaborative approach, which is meant to bring the client into the process of understanding self, others, and the larger world, and thereby promoting connection between the therapist-assessor and client, as well as the broader context in which they both are embedded. Commitment to such collaborative work has been prized by practitioners and scholars, because this approach has been linked to reduced feelings of isolation, increased feelings of hope, decreased symptoms, greater insight, increased self-esteem, increased positive rapport with the therapist, and a higher level of agency and motivation as described and/or reported by therapists and clients alike (e.g., Allen, Montgomery, Tubman, Frazier, & Escovar, 2003; Finn & Tonsager, 1997; Fischer, 2000; Hilsenroth, Peters, & Ackerman, 2004; Norcross, 2002). Because the strength of the therapeutic alliance is among the most predictive variables of therapeutic outcomes (Norcross, 2002), it should not be surprising that "collaboration is one of the key features of the alliance concept" (Horvath & Bedi, 2002, p. 59). Such collaborative and relational processes extend to, and are perhaps exemplified by, the usage of assessment data within therapy, because such processes require a therapist to share his or her professional expertise with clients in a way that is open, honest, and coherent (e.g., Lambert, 2010). Indeed, a positive and collaborative relationship with an assessor is associated with clients experiencing greater gains in new self-understanding from an assessment intervention (Poston, 2012). Consistent with such collaborative and egalitarian practices, APA ethical guidelines maintain that,

> results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance. (APA, 2012)

Along these lines, it should be noted that providing feedback is not merely a recommendation, but an explicit ethical mandate, even with the most widely used psychological measures in the field. Thus, it is important that test feedback is given in a manner that maximizes its therapeutic potential for clients. For example, in his Minnesota Multiphasic Personality Inventory-2 (MMPI-2) manual, Finn (1996) maintains that:

Clients become most engaged in taking the MMPI-2 when they are treated as collaborators, whose ideas and cooperation are essential to the assessment. Clients become most invested in an MMPI-2 assessment when the results will be used to address their personal goals. When an MMPI-2 assessment addresses clients' goals and clients are treated as collaborators, they are more likely to give accurate and useful information when completing the test. When MMPI-2 feedback is given to clients in an emotionally supportive manner, they often feel affirmed, less anxious, and more hopeful, even if the test feedback seems likely to produce painful emotional reactions. (pp. 5–6)

Finn also observes that although such guidelines were prepared for the administration and interpretation of the MMPI-2, they may be applied to other assessment measures. Further explicating this approach, Finn and Tonsager (1997) specify three overarching areas of foci when introducing assessment data into the therapeutic realm: (a) the client's subjective experience of the assessment, (b) the assessor's own subjective experience, and (c) the dynamic interplay between the client and the assessor (p. 379). In regard to feedback, they suggest that information aligning most closely with the client's worldview be shared first, with more opaque results saved for later in the process. Wholly consistent with these mandates, guidelines, and practices, the BEVI seeks to prioritize and illuminate the client's experience—their questions, feelings, reactions, interpretations, contradictions, complexities, and hopes. As such, as we hope to illustrate next, the BEVI provides a method for collaboratively channeling rich and relevant content into therapy, which opens the process to deeper exploration, interpretation, and meaning making.

Methods and Design

This study of the BEVI is grounded in a social constructionist theoretical framework, which postulates that the derivation of "meaning" is constructed within, and mediated by, sociocultural processes and contexts (Merriam, 2009). This theoretical framework aligns well with the fundamental propositions of the EI model and BEVI method, which are designed to examine how and why human beings make sense of self, others, and the world at large as they do (Shealy, 2016). Using a basic qualitative design as described by Merriam, the following study is multimethod, using data from three sources: clinician focus groups, client written responses, and a transcribed therapy session in order to examine and understand the experiences of both clinicians and clients vis-à-vis the BEVI. More specifically, the study focused on the following research questions:

1. Is the BEVI ecologically valid (e.g., are profile results consistent with clinician observations and the phenomenological experience of clients)?
2. Can the BEVI be useful to clinicians for purposes of facilitating case conceptualizations?
3. When used clinically, does the BEVI correspond to best practices for therapeutic assessment (e.g., Finn, 1996; Fischer, 2000).
4. How specifically might the BEVI add value to various assessment and therapeutic activities?

5. Do the hypothesized "assessment common factors" (formative variables, dichotomous thinking, dialectical thinking, emotional awareness, and self-awareness) emerge thematically when clients and clinicians discuss their usage and experience of the BEVI?

Participant Population

Client Participants. Fourteen clients participated in this qualitative study. One of them participated in the videotaped and transcribed therapy session; the other 13 completed the BEVI, and their written qualitative responses were analyzed. These clients were selected by convenience, and included undergraduates seen for individual counseling at a senior military college; individuals, couples, and families seen in an outpatient private practice; individuals and families seen at a community mental health clinic; and individuals seen for counseling at a community mental health clinic.

Clinician Participants. Ten clinicians participated in this qualitative focus group. Because we were interested in issues of both training and practice, we took a nontraditional sampling approach. Specifically, focus groups included doctoral students across the spectrum of training, as well as licensed master's- and doctoral-level clinicians working in different settings. All participants had to participate in an orientation process for the BEVI, to be actively engaged in its usage, and to have at least a master's degree in a mental health field (all were licensed at the master's level prior to matriculating in the doctoral program). Thus, participants included three second-year doctoral students, two third-year doctoral students, and one doctoral-level intern; all of these individuals were licensed at the master's level prior to doctoral-level matriculation. In addition, two doctoral-level, licensed psychologists participated (one for each of two focus groups) along with another licensed master's-level clinician. Of the ten clinicians, one was male and nine were female; nine self-identified as White/European American; and one self-identified as African American. Although clinicians ascribed to various theoretical leanings, all classified their theoretical orientation as integrative. They deliberately were not told to interpret the BEVI through a particular framework (e.g., including, but not limited to, "therapeutic assessment"). Two of these clinicians also served as researchers in this study. The first author (a second-year doctoral student) and the developer of the BEVI (a professor, who participated in the development of focus group questions, but did not participate in focus group processes, discussions, or coding) are the primary researchers in this study. Another second-year doctoral student cofacilitated the focus groups, and also served as a researcher in this study. Three other doctoral-level students and one doctoral-level intern assisted with the coding and analysis for the focus groups.

Focus Groups

To appraise matters of inter-rater reliability, the two focus groups were conducted according to the basic guidelines advocated by Barbour (2005). Both focus groups consisted of clinicians and lasted approximately 45 minutes. The same written protocol was followed for both focus groups, which included a brief introduction and a list

of questions read from a script (see Exhibit A) that addressed both the clinicians' experiences, as well as the clients' reactions to the BEVI. Summary descriptions of the BEVI scales were distributed to the participants in order to help them remember and identify relevant scales. The protocol material was e-mailed ahead of time to the participants for their review.

Focus group 1 consisted of five clinicians, two of whom participated through phone conferencing and three of whom participated face to face. Focus group 2 consisted of three clinicians, two of whom participated through phone conferencing and one of whom participated face to face. To ensure balance and perspective, each of the focus groups deliberately included doctoral trainees and licensed psychologist participants. The same researchers co-facilitated both focus groups, and were responsible for recording process and reflection notes.

Both focus groups were audiotaped and transcribed; participant names were eliminated from the transcripts to maintain anonymity. The transcriptions were then consensus coded in three stages. The first stage consisted of reviewing the transcripts and identifying emergent themes relevant to the research questions. The second stage consisted of narrowing these themes down to the most salient and developing a code book with the code names, criteria, and exemplars (see Exhibit B). The third stage consisted of using this code book to code the responses in the two focus groups. All stages were exercised through consensus (e.g., Schielke, Fishman, Osatuke, & Stiles, 2009).

Clients' Qualitative Questions

The BEVI contains three open-ended questions regarding the clients' experience of taking this measure. Thirteen sets of these responses were collected, analyzed, and coded by the principle researcher through a process of analytic coding (Richards, 2009).
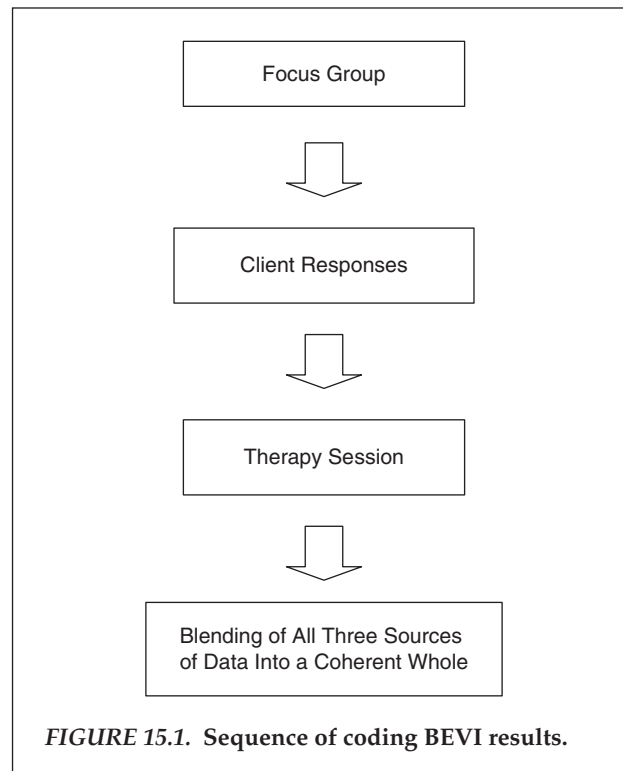
Videotaped Therapy Session

As a final check on focus group findings, and to evaluate further the ecological validity of study methods, a therapy session was recorded and transcribed in which BEVI results were cointerpreted with a client. Sections of the transcript were then analyzed and interpreted in relation to the themes that emerged from the other two data sources.

Sequence of Analysis and Interpretation

Although the analysis and interpretation of the qualitative data involved an iterative process among these different data sources, in order to best answer the research questions, the following sequence of coding was followed:

1. Analyses of the focus groups for main themes.
2. Analyses of client responses embedded in the BEVI measure.
3. In-depth analyses of a therapy session to compare and contrast with the other data sources.
4. Blending of all three data sources to create a complex, coherent, and rich framework in which the research questions could be addressed.

This sequence of analysis and interpretation is represented graphically in Figure 15.1.

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│          │     Focus Group     │            │
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│          ┌─────────────────────┐            │
│          │   Client Responses  │            │
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│          ┌─────────────────────┐            │
│          │   Therapy Session   │            │
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│    ┌───────────────────────────────┐        │
│    │ Blending of All Three Sources │        │
│    │ of Data Into a Coherent Whole │        │
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│   FIGURE 15.1.  Sequence of coding BEVI results.
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FIGURE 15.1. **Sequence of coding BEVI results.**

More About Emic Positioning

With the support and knowledge of other members of the core faculty in the first author's APA accredited doctoral program, this project was undertaken in order for extant doctoral students to have the opportunity to participate in real world clinical research on a measure—with therapeutic assessment potential—that had been in development since the early 1990s. Nonetheless, six of the clinicians (including the first author) are currently in a doctoral program, of which the developer of the BEVI is a core faculty member and adviser; two of the clinicians were former advisees of the developer prior to graduating from the program. Thus, 10 of the clinicians are in emic positioning in terms of having multiple relationships with the developer of the BEVI and having had prior exposure to the BEVI measure. The two primary researchers are in emic positioning in regard to the data in that both researchers are currently using the BEVI as a conceptual aid and intervention tool with clients. As noted, one of the researchers is the developer of this instrument. Such emic positioning potentially could threaten credibility by inhibiting critical feedback from the participant clinicians and/or bias the researchers toward the BEVI. As such, a number of steps were taken to attenuate possible risks.

First, we recruited a separate faculty-level researcher and faculty member with etic positioning, who is an expert in qualitative analysis, to oversee this project and the interpretation of data. Specifically, the methodology for this study, its implementation, and data analysis all were developed, reviewed, approved, and conducted deliberately under the auspices of this same separate

researcher and faculty member's mixed methods course. Second, by design, the test developer had no role in conducting either of the focus groups, transcribing either session, developing the coding system, or coding data from the focus groups, client feedback, or therapy session. Third, no names or identifying information of focus group participants were associated with any transcribed observations from either group. Fourth, as noted, data were integrated directly from clients (qualitative responses and observing therapy sessions) so as to triangulate the evidence and offer multiple viewpoints (Creswell & Plano Clark, 2011; Richards, 2009). Fifth, the first author engaged in a technique of bracketing while also explicitly tracking processes of collecting, coding, analyzing, and interpreting data (Merriam, 2009). Sixth and finally, the first author reevaluated and revised the overarching emphasis of this research from "Does the BEVI work?" to "Can the BEVI work?," a paradigmatic shift that should reduce the threat to credibility because the purpose is more descriptive and exploratory than evaluative.

Results

Focus Groups

After reviewing the transcripts of the two focus groups, 65 themes were identified initially. Through a process of consensus, these themes were merged and reorganized into 11 final themes. Table 15.1 (see Exhibit C) shows the final result. The codes are displayed in a hierarchy with parent codes listed on the left column, child codes listed in the middle column (when applicable), and the number of references or responses that were categorized within the code listed on the right column. The sequence of codes listed is determined by the number of references within the text. In the following section the criteria, relevance, and relationships between the themes are described, and examples of responses that align with each of the 11 codes are provided. The focus groups from which the responses were taken are identified by the labels "FG1" and "FG2" for the first and second focus groups administered, respectively.

Theme 1: Understanding Causal Connections
The most common theme to emerge from the focus groups was "Understanding Causal Connections." This theme refers to how the BEVI may be used to help the therapist and client gain a deeper understanding of the underlying causal connections between forces and elements that may have been viewed previously as disconnected and disparate. Because this theme is somewhat broad, it was divided further into four subthemes (called "child themes" in the vernacular of qualitative methodology). The four child themes include three types of causal connections; the fourth referred to the increased understanding or insight that is the outcome of deriving these causal connections. The first subtheme, "Cognitions, Emotions, and Behavior," refers to how the BEVI helped highlight causal relationships between a client's beliefs, emotions, and behaviors, as is reflected in the following focus group response:

> I think it was particularly helpful. . .in terms of explaining. . .what was going on with her, some of the reasons that she might be internalizing a lot of her emotions. . .For example, [her] beliefs about how a woman should be, not expressing anger, holding everything in, that type of thing. (FG2)

The second subtheme, "Self and Others," refers to the causal relationships between the client's own behavior and the behavior of others. The response following indicates this type of connection:

> One client started thinking about it and reflecting on his relationship with his mother and how she has different beliefs than him and how his beliefs match with that and how he can use that understanding in being able to connect with her more. (FG1)

The third subtheme, "Past and Present," refers to the causal relationship between the client's past and his or her current life:

> The BEVI certainly opens up discussion for how maybe you were this way, and became this way. (FG2)

The apparent outcome of "making causal connections" is to increase insight and understanding. In several therapeutic approaches, as well as in change process research, insight is a central step toward change (Gibbons et al., 2009). Even in therapeutic approaches that de-emphasize the necessity of client insight, such as some behavioral and family systems techniques, the clinician still must understand how causal connections are established by a client in order to plan appropriate interventions (Nichols, 2011). That said, many theorists within the humanistic tradition contend that gaining greater insight about oneself and the world is not only a means toward change, but a central human need in itself (Pervin, 2002). According to this tradition, which is aligned with the EI framework underlying the BEVI, we are meaning-making creatures; psychological well-being is thereby predicated on the relative ability to develop a rich and consistent narrative regarding one's self and the world (Adler, 2012).

The final subtheme under the parent theme of "Causal Connections" is labeled "Deeper Understanding." There were many references in the discussion group to this subtheme. A sample response reflecting the BEVI's potential to facilitate client understanding includes the following:

> Using the framework of the BEVI and going over some of that data with her she was better able to make sense of herself, and her life, and how she had gotten to where she was in her life. (FG2)

Theme 2: Big Picture

The second most common theme that emerged from the two focus groups was the BEVI's utility for developing a broad, holistic, and integrated framework through which clients may be understood and therapeutic processes facilitated. We labeled this theme "Big Picture." The theme of "Big Picture" does overlap with the theme "Causal Connections," and specifically, the subtheme of "Deeper Understanding." All of these share the core element of integration, of "fitting things together" into a cohesive narrative or picture, of "making sense of the world." However, the responses within the code of "Big Picture" specifically emphasize breadth, and the broadening or widening of both the therapist's and client's viewpoint and understanding of self, others, and the larger world, which is wholly consistent with a therapeutic assessment framework. Some of the responses that are included in this code are included in the following:

It just seemed . . . to expand on the frame. (FG1)

It provides a more holistic frame. (FG2)

It brought it together . . . in a picture that created some more pockets to understand her at a bigger picture level. (FG1)

It helps me to be more mindful of really seeing the client . . . holistically. There are times where I find myself getting really focused . . . on one piece of the picture. . .[and] it helped me to be more mindful of broadening the lens that I was looking through and being able to really meet the client's needs and meet them where they're at. (FG2)

Theme 3: Nonpathologizing

The third most frequent theme that emerged was labeled "Nonpathologizing." This theme refers to how the BEVI is useful in developing a nonpathologizing framework that allows the therapist and client to focus on strengths and resources as well as areas of difficulty. This attribute of the BEVI aligns well with the therapeutic assessment model outlined by Fischer (2000), Finn (1996), and others. Some of the responses in this category included the following:

It was able to capitalize on some areas of the strengths where things could go differently for clients. So they may be able to capitalize on these strengths even though they have a number of negative life events and show resiliency. So I like its ability to do both. (FG2)

And it's such a nice frame . . . to explore . . . in that non-threatening way [helping them in] thinking about their beliefs and values. (FG2)

We were talking about the MMPI the other day and how it tends to be pathologizing and I thought that the way he interpreted [the BEVI], while it was honest, it also was supportive and it didn't make them feel bad. (FG2)

It isn't pathologizing and it isn't necessarily threatening but it feels so informative as opposed to labeling. (FG2)

Although problem-focused tests like the MMPI-2 can be remarkably helpful, especially in therapeutic assessment contexts (Finn, 1996), other tests, like the BEVI can be equally helpful and complementary. Along these lines, it should be noted that because BEVI scales are reported along a percentage-based continuum (very high to very low), any given scale could be interpreted in terms of strengths or weaknesses (e.g., a very high degree of Emotional Attunement generally would be advantageous for purposes of therapy whereas a very low degree of Emotional Attunement could indicate that a client may experience considerable difficulties dealing with emotions not only in therapy, but in relationships more generally). In any case, presenting both types of information—relative strengths and areas for improvement—appears to be experienced as helpful by clients (Hanson & Claiborn, 2006).

Theme 4: Sharing the Conceptualization With the Client

Although each of the three broad therapeutic frameworks (psychodynamic, cognitive behavioral, and humanistic) leads to different and often conflicting frames for conceptualizing a client's presentations and problems, all three approaches stress the critical task and question of how to share the therapist's conceptualization and test results with the client in a therapeutic manner (Wampold, 2001). The BEVI's usefulness in this

crucial therapeutic task emerged as a common theme within the two focus groups. Following is an example of a response which fell into this category:

> Helping with the conceptualization of your client for yourself and then also how to share that with the client in a way that is going . . . to create movement and be therapeutic for them. (FG1)

Theme 5: Broader Range of Information
The theme we labeled "Broader Range of Information" refers to the BEVI's ability to capture information regarding different domains of the client's life and experience, which traditional measures may not access. These different domains include the client's perception of his or her early experiences (Negative and Positive Life Events Scales) as well as beliefs and values regarding religion (Socioreligious Traditionalism); nature and the living world (Ecological Resonance); different societies and cultures (Sociocultural Openness); what roles and responsibilities we have toward the larger world (Global Engagement); and what males and females should be, and how they should act (Gender Traditionalism). Although topics like these may emerge in therapy, or undergird key aspects of functioning, they often are implicit despite the fact that such matters are often at the very heart of daily life and the experience of self, others, and the larger world. Thus, once such issues are brought into the room via discussion of quantitative scores and qualitative responses on the BEVI, the therapist and client often are surprised at how these basic beliefs and values can be highly relevant to core aspects of how the client organizes his or her experience, and in fact may open up new ways of relating to the overarching therapeutic or assessment process. Thus, this theme includes the BEVI's capacity both to capture this additional information while also using it to catalyze discussion of these domains within the therapy session. The comments following fall into the first category:

> It really does sort of flush out other factors that may not show up in other measures. (FG2)

> It was a nice springboard to allow her to speak about certain areas that may not have come up in a typical informing not using the BEVI, like her views of what it means to be a woman, that kind of thing, sort of her religious views and where those came from. (FG2)

> [It was] providing an opening for talking about those things. Some things that maybe wouldn't come up otherwise, like issues of religiosity, of gender traditionalism, things like that that aren't accessed on a, at a very easy level otherwise, unless it's within the context of something like this. (FG1)

Theme 6: Assessing Openness, Defensiveness, and the Ability to Self-reflect
Another theme that emerged was the measure's value in helping the therapists to access and assess the clients' capacity for openness and self-reflection, another key area of relevance across therapeutic traditions, generally, and therapeutic assessment, specifically. Because clients may experience a range of reactions to test feedback, BEVI scores can be used to anticipate, and subsequently enhance, feedback processes and outcomes. Following is a comment that represents this category:

> At a foundational level . . . it . . . does inform the way that they really see the world, their defensiveness, ability to even trust, and that helps a lot especially with a therapy client that I'm seeing now. And the BEVI really caught that. (FG2)

At a related level, the client's capacity for self-reflection may be a good indicator of how successful he or she can be in therapy (e.g., Dimaggio, 2011), as indicated by the response following:

> We've had several cases of this very rigid way and approach of thinking and yet the openness is still there. . .so it was helpful to. . .see and to make sense of . . . (that) . . . in the therapeutic relationship. (FG1)

The measurement of a client's openness, defensiveness, and self-reflective capacity can be useful in deciding what treatment approach to use—essentially an issue of matching approach to client readiness and style—and where to begin, or transition, treatment, as indicated in the responses following, which reflect common processes for therapists in the context of understanding and furthering therapeutic interventions:

> [Is] this person ready and able and at capacity to handle some kind of deep therapy work or does more work need to be done at that building trust and alliance level before you can move on? So I think it [BEVI]. . . .provides [this in a] more tangible [way] and ties it to where we need to go from here. (FG2)

> I think that fundamentally the BEVI really assists in better understanding the clients so that you can get a sense of where really to begin or what they're able to hold. (FG2)

Theme 7: Client Motivation and Engagement
Another theme that emerged in the focus groups was the use of the BEVI to increase client motivation and engagement in therapy. The theme of client motivation can be divided conceptually into two sections. First, some clients were immediately positively motivated by the idea of the assessment. These cases can be seen in the following responses:

> She was looking forward to the opportunity and particularly because we're talking about terminating soon. She thought that this would be a perfect way to kind of encapsulate everything that we have been working on. (FG1)

> Actually she was pretty excited about the idea and she's like "Yeah this will be great. This will be wonderful." (FG1)

Second, the motivation of some of the clients increased as a by-product of the measure and receiving feedback. In effect, it mobilized the change process and empowered clients. Examples of these cases can be seen in the following responses:

> Something about them having entered the information themselves and having it reflected back to them kind of without my filter . . . was helpful. It almost seemed more unbiased that way. . . . They bought into it a little bit more. (FG1)

> One particular young man who initially came in . . . was not a very good therapy client . . . [However] by the end, shortly after the BEVI his insight had increased and he was also sharing information about other aspects. (FG1)

Theme 8: Flexibility
The BEVI's integrative, nonpathologizing, and broad framework appears to promote flexibility in a number of different domains including theoretical orientation, clinical

population, and therapeutic application. Moreover, focus group participants also identified a number of other domains (besides therapy and assessment) that would be relevant for the BEVI. Responses that refer to the BEVI's flexibility in this regard include:

> It can be used within several different frameworks, several different theoretical kinds of orientations. (FG1)

> It would be really great for the Peace Corps volunteers to take this kind of thing. Any kind of international corporation that might be sending the employees abroad to. . .optimize their experience and hopefully . . . have a happy and productive employee on the other end. . . . (FG2)

> I also wondered even about the. . .military in a similar . . . sense. I wonder if there would be any way to help particularly people who might be vulnerable to PTSD through some kind of measure like this. (FG2)

> For us in higher ed, I think . . . it's a helpful thing. . .I think for programming purposes and just trying to get a deeper understanding of the population that you're serving, and then how to target certain programs to address some of those needs. (FG1)

Theme 9: Accuracy
The effectiveness of a measure depends upon its validity and reliability in both a psychometric and real world sense. In other words: Can the measure accurately and appropriately capture usable information (e.g., is it ecologically valid)? The BEVI's accuracy in this regard was evaluated in the following manner. The developer of the assessment measure gave blind interpretations of various BEVI profiles. In other words, he read, analyzed, and interpreted profiles "blind" without any knowledge of whom the profile referred to. His interpretations were then given to clinicians who were participating in the focus groups. When asked later during the focus group processes about the accuracy of such interpretations, and how they converged with the therapist's clinical assessment as well as the client's own perspective, feedback was uniformly positive. Some examples of responses that fell into this category are included in the following:

> I think that looking at the scale is providing a very accurate analysis of this individual. (FG2)

> For the assessment client that I was working with, I mean, it was pretty spot on actually. (FG2)

> They were very insightful. They were right on target. (FG1)

> He was really able to sort of nail the two or three main pieces of her personality structure that are contributing to a lot of her distress. (FG2)

Theme 10: Validating for the therapist
In addition to enhancing client engagement, a final theme that emerged was how using the BEVI helped increase the therapist's motivation and engagement. Essentially, it appears that the process of giving, interpreting, and discussing the BEVI tends to reinforce insights, illuminate an underlying clinical sense or intuition, or clarify ideas the therapist had about the client but was unable to substantially articulate or justify. Moreover, the therapist's increased motivation also appeared to result from the measure's ability to identify areas of struggle or challenge (e.g., through the

pattern of high and low scale scores; qualitative responses; review of "strongly agree" and "strongly disagree" items), while also emphasizing areas of client strength, growth, and development potential. These results renewed hope in the therapist for a successful outcome while also validating the work that already had been achieved with the client. An example of the therapist's increased motivation and engagement as a result of using the BEVI, is reflected in the response following:

> I think sometimes you get exhausted . . . But . . . I think being able to see that there are some areas that are making growth possible, I think for me it was kind of a little like, because I think sometimes we can get real jaded when we're working with clients week after week so seeing particular scale of openness for me with that one particular client when I was started to feel like Lord she's never going to make much progress but . . . for me it was a rejuvenation afterward. (FG1)

Three Qualitative Questions Embedded in the BEVI[2]

As discussed in the methodology section, the BEVI deliberately is a mixed methods instrument, because in addition to its quantitative scales, it also includes three qualitative items. When the quantitative scale scores are combined, or integrated, with the open-ended qualitative responses, a traditional mixed methods approach emerges, seemingly as an explanatory or embedded approach (Creswell & Plano Clark, 2010; Hanson et al., 2005). By combining the data strands vis-à-vis dialogue with clients, the overall experience of therapy and assessment is enriched. Along these lines, the basic structure of client feedback (e.g., during the post-assessment discussion) as well as therapist review (e.g., prior to meeting with a client) also is "mixed methods," including both a written narrative, as well as scale scores and critical items that are presented from the BEVI reports. Regarding the qualitative items, at the conclusion of answering quantitative items, the client is asked three questions regarding his or her experience either in taking the BEVI (if he or she had not yet engaged in assessment or therapeutic work) or in the context of a therapeutic or assessment experience that was already under way. The questions are as follows:

1. First, please describe which aspect of this experience has had the greatest impact upon you and why?
2. Is there some aspect of your own "self" or "identity" (e.g., gender, ethnicity, sexual orientation, religious or political background, etc.) that has become especially clear or relevant to you or others as a result of this experience?
3. Third, what are you learning or how are you different as a result of this experience?

A sample of 13 BEVI profiles were collected and reviewed for this aspect of the project. This was a sample of convenience, which included therapy clients from four different venues: a counseling center from a university; a counseling center from a military college; an outpatient community clinic; and, a private outpatient practice. The 13 sets of answers were coded and analyzed by the first author for emergent

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[2] The de-identified presentation of clinical material in this chapter, and book, is informed by the March, 2012 Special Section of the journal *Psychotherapy,* entitled "Ethical Issues in Clinical Writing," Volume 49, Issue 1, pp. 1–25 as well as Health Insurance Portability and Accountability Act (HIPAA) regulations, American Psychological Association (APA) ethical guidelines, and other best practices for reporting clinical information.

themes regarding the clients' experience in taking the BEVI, and how this experience may have been therapeutically useful. Responses were related for the most part to the clients' reactions to taking the BEVI assessment measure because those experiences also appeared to have therapeutic meaning. It should be noted that our procedure for using the BEVI as a therapeutic intervention was informed by Finn's (1996) model as described in his manual on how to use the MMPI-2 as an intervention tool, and involved a sequence of four steps:

1. Orienting the client to the BEVI measurement and developing a referral question or questions for which the results can be applied.
2. Having the client take the BEVI inventory.
3. Analyzing the results.
4. Presenting the results to the client and collaborating with the client on a meaningful conceptualization and interpretation.

After coding and analysis by the principle researcher, 17 themes related to the research questions were identified, which then were organized hierarchically under four major headings: Aspects of Self; Values; Self and Others; and No Impact. The themes are listed in tabular form (see Table 15.2, Exhibit D), with the number of references within the text to these themes listed on the right. Based upon analysis of this initial organization of content, these 17 themes were then collapsed further into the following 5 overarching themes, which appeared to encompass and account for these qualitative data from clients.

Theme 1: Identity and Self Worth
In response to the BEVI qualitative questions, the themes related to Aspects of the Self were the most common. The most common of these themes were responses related to self-image and self-worth. These included responses that reflected a disparity or incongruence between the ideal and perceived self:

> I would like to be a better person than I am in reality.

It also included responses that related to a positive identity:

> I am a naturally happy person and I have a good relationship with my family.
> I've learned to be strong and I am better person after military school.

Finally, it included responses that related to one's social or public self:

> People think that I am gay here in America because I like and do different things from them.

Theme 2: Ability to Self Reflect
Examples of client responses that related to this theme—"the ability to self-reflect"—are included in the following:

> I liked how this made me think about questions I never would have thought about unless asked.

> I believe everything I need to understand is deep inside me, but it needs more excavation and integration.

Theme 3: Complexity

Another theme common to the experiences of therapists and clients is the notion of discovering complexities and contradictions within the self. Client responses that reflect this theme are included in the following:

> I am hoping it will help to take our counseling to another level. I enjoy learning about myself, [and I am] more complex then I originally thought.

> Realizing I hold some seemingly conflicting views, such as on social issues.

Theme 4: Values and Religion

Within the category of values, the theme of Religion was among the most frequently referenced, which perhaps is not surprising, given the focus on such matters by many therapy clients, whatever their inclination, from devout to atheist. Even so, mental health professionals often struggle to address such matters as part of practice, despite long-standing best practice recommendations to do so (e.g., Shafranske, 1996). Thus, the BEVI appears to offer an accessible and nonactivating way to address such issues, when salient for clients, within a therapeutic context. Some examples are given in the following:

> My faith plays a significant role in how I view others.

> The aspect that has affected me the most was religion. I had never tried in the past to answer any of the questions about my religion that this assessment has.

> The questions about religion showed me my strong views

Theme 5: Self in Relation to Others

The theme relating to learning about oneself in relation to others was also one of the most frequently referenced, a finding that is consistent with results from "contrast cases" and personalized normative feedback studies (Hanson & Poston, 2011). This theme included responses in which clients reflected on how their values related to others around them:

> It seems to me that I am more liberal than I think other people are around me.

It includes reflections regarding intimate relationships:

> Learning how . . . different spouse's perceptions of identical situations can be.

This theme also included reflections relating to the client's desire to become more involved with others:

> My world is currently small and without influence. I potentially could make a small influence somewhere even at this stage of life.

Individual Therapy Session

Finally, in order to determine whether the themes identified in the preceding results emerge in real time interactions between therapists and clients, we include portions of a therapy session that was conducted by one of the authors of this chapter. In doing

so, we use the BEVI as a therapeutic assessment in accordance with guidelines outlined in Finn's (1996) manual for using the MMPI-2 as a therapeutic intervention. Sections of the de-identified transcripts (see footnote 1) are reproduced with brief summaries of the related themes that emerged. In the following transcript, the therapist has just given the client her BEVI results and they begin discussing the client's results regarding various scales.

TH: The other thing it [BEVI results] said was that you were very attuned to your emotional world.

CT: Yes.

TH: And that felt like it was….

CT: It was very, very right, yes, very much so. I react a lot on emotion.

TH: And you're very aware of your emotion, what you're feeling. . .it's a big part of your life. . .and it's a big motivator.

CT: Yes. It's true. Maybe that's not a good thing.

TH: Well I'm sure there's difficulties about being sensitive.

CT: Yes, I'm pretty sensitive to what's going on around me.

TH: And inside of you.

CT: Mmmhmmm.

TH: And one thing that we've talked about before is difficulty tolerating a lot of painful emotions.

CT: I really don't have . . . I can't do that….

The accuracy of the BEVI appears valid in this case, in terms of how it resonates with the client and validates her own internal experience. This aspect of herself and experience is then linked to an area that had been a focus in previous sessions, that of feeling vulnerable, which led to further discussion and reflection:

TH: So the emotion part. The problem is the control? You feel things very deeply but the problem is that once something touches you, you worry about how you will be flooded with emotion and you will not be able to….

C: See even talking about it makes me emotional.

TH: And it makes you feel vulnerable.

C: Yeah.

TH: Vulnerability is one of the big things we've talked about even in terms of….

C: But if I'm vulnerable I'm going to get burned.

In this phase of the session, sharing the BEVI results led the client to disclose one of her core beliefs: "If I'm vulnerable I'm going to get burned." Thus, the process of reviewing the BEVI scores with this client appeared to have uncovered a core conflict for her. On the one hand, she feels that she is a sensitive and emotional person; on the other, if she allows herself to feel and express this emotion, she believes she will get "burned." In short, the BEVI results provide an opening for the therapist to directly address the client's pessimistic or cynical belief system, by focusing on other aspects of the client's BEVI profile:

TH: Well, the other thing that I noticed was the positive thinking, the skepticism and tell me how you feel . . . this thing about if you're vulnerable and you're hurt. That lesson or that belief seems to go into that. You don't go into that positive thinking business. You're skeptical.

CT: What's his name. Scientology. The power of positive thinking. That's bullshit. (Laughs)

TH: But even beyond the cult thing just talking about you know when we talk about . . . when you talk about the ability to change, writing yourself off "Well maybe [he] . . . can but me, no, it's too late. What's the point?" Is that right?

CT: That's what I said.

TH: What's the point? Because we can't change it. It's the way it is.

CT: Yeah.

TH: That part of your belief of who you are and how you think about things . . . I wonder if that applies to vulnerability . . . like what's the point of showing vulnerability? I'm not going to get what I need anyway?

CT: Well all of that which you just said. You probably hit the nail on the head to use such a cliché term. I think that probably is how I deal with things.

In this portion of the session, the BEVI is used to open up and discuss a central conflict for the client in a way that is nonpathologizing, validating, and experience-near. The client appears to be able to feel understood while she grapples with a belief system that may be maladaptive and ultimately painful for her. Addressing the client's belief system through a discussion of the measure allows for a nonconfrontational, matter of fact, and collaborative approach. This collaborative stance allows the client to approach core issues in a more open and reflective manner.

TH: . . .the thing [score on the Positive Thinking scale of the BEVI] that is smallest of all is positive thinking. This is really a huge bit of skepticism.

CT: It really is, isn't it?

TH: . . .very . . . like, almost sort of jaded about the world.

CT: It's funny that you should say that, because Sam tells me that all the time. He just said it to me the other day.

TH: Well then….

CT: He says, "Why don't you believe in me? Why are you so negative? Why can't you be positive? Why can't you think it's gonna be okay?"

TH: Because you learned very early that the way to avoid disappointment is to be very cynical and skeptical. That way you don't get disappointed, or even worse, you don't get hurt.

CT: Yes!

TH: And, it's hard for Sam, kind of, sometimes, when that part of you, that part of how you to deal with life....

CT: Well, I'm sure it's probably not more . . . Seeing that on paper is scary.

TH: Is it scary?

CT: Yeah. I didn't realize I was that negative.

From a process standpoint, at this point in the session, it was important to validate the client's emotional experience and explore her reaction to experiencing an aspect of how she sees self, others, and the larger world as it was represented through her BEVI scale scores. Later, it would be valuable to explore the source of this belief system and associated attitudes toward her own emotions and relationships.

In conclusion, the preceding excerpt illustrates many of the themes that have emerged from other sources (e.g., the focus groups, client reports) in this examination of the BEVI: Deeper Understanding; Nonpathologizing; Openness, Defensiveness,

and the Ability to Self Reflect; Increasing Client Engagement; Sharing Conceptualization; and Accuracy. In short, the exchange also illustrates how the BEVI can be used as a therapeutic intervention in a collaborative, experience-near, and client-centered manner.

DISCUSSION

This chapter considers the EI model and BEVI method from the standpoint of therapeutic assessment and intervention. It also presents results from an exploratory study, which addressed the following five research questions regarding the use of the BEVI measure in a therapeutic context:

1. Is the BEVI ecologically valid (e.g., are profile results consistent both with clinician observations and the phenomenological experience of clients)?
2. Can the BEVI be useful to clinicians for purposes of facilitating case conceptualizations?
3. When used clinically, does the BEVI correspond to best practice principles for therapeutic assessment (cf., Finn, 1996; Fischer, 2000)?
4. How specifically might the BEVI add value to various assessment and therapeutic activities?
5. Do the hypothesized "assessment common factors" (formative variables, dichotomous thinking, dialectical thinking, emotional awareness, and self-awareness) emerge thematically when clients and clinicians discuss their usage and experience of the BEVI?

In order to examine these questions, three qualitative data strands were collected, examined, and interpreted. These strands included two focus groups that consisted of participant therapists, qualitative responses from clients, and a transcript from a therapy session that addressed BEVI findings.

In relation to the first research question, the accuracy of the BEVI was a common theme that emerged from the focus groups. As noted, responses vis-à-vis BEVI results such as, "They were very insightful" or "They were right on target" referred to the perceived accuracy by clinicians of the blind interpretations they received regarding the measure. Support for the ecological validity of the measure was illustrated by a number of clinician responses regarding the "real world" nature of BEVI findings, as well as the client's reaction to the BEVI results as detailed in the preceding therapy session. In short, although additional research should be conducted and is under way, results from the present study suggest that the BEVI appears to map closely to the realities, complexities, possibilities, and objectives that are inherent to the clinical enterprise. Perhaps that is because this measure was developed in large part on the basis of actual client and trainee verbalizations (e.g., belief statements) over many years and in multiple contexts (Shealy, 2004, 2015, 2016).

Regarding the question of whether the BEVI assists in case conceptualization, several emergent themes appear to speak directly to this point. For example, from the focus group processes, Theme 1, "Understanding Causal Connections," Theme 2, "Big Picture," and Theme 3, "Nonpathologizing," all concern matters of how we help ourselves as clinicians, and our clients, understand the *what* and *why* of case conceptualization (e.g., what is happening conceptually and why a particular cognitive/affective/behavioral configuration came to be). Moreover, Theme 2, "Complexity,"

and Theme 3, "Values and Religion" from qualitative client results also provide conceptual information that enriches our understanding of how our clients experience self, others, and the larger world, which certainly are relevant to processes of developing and refining our client conceptualizations. On the question of best practice, leaders in the field of therapeutic assessment have advocated for a wide range of changes in our approaches toward clients, including a move toward less pathologizing approaches to assessment, a greater degree of openness regarding what we "experts know" and the bases for such status, and a deeper commitment to collaboration and inclusion, among other recommendations (e.g., Finn & Tonsager, 1997; Fischer, 2000; Poston & Hanson, 2010). Of particular relevance to the current approach, an adapted version of the following principles promulgated by Finn (1996) vis-à-vis therapeutic assessment and the MMPI (see pp. 5–6), also appear highly consistent with how the BEVI is used in therapy and assessment, and may serve as an initial basic best practice framework for this measure:

1. The BEVI's nature and purpose should be explained before giving the measure to the client.
2. Results should be shared in a collaborative spirit with the client, while avoiding an authoritarian stance.
3. Results should be related, if possible, to the client's presenting problems, initial questions, and current conflicts.
4. Results should be discussed in a jargon-free manner using the client's language when possible.
5. The client should be given an opportunity to explore his or her own reactions to the results.
6. The client's process of reacting to the results can further add to the clinician's conceptualization of the client's unresolved conflicts and coping style.
7. The interpersonal process between the client and therapist during the reviewing of BEVI results should be explored and worked through if salient and relevant—conflicts, ruptures, wounds, positive connections, and other issues and dynamics may be considered.
8. Intrapsychic process, interpsychic process, transference, and countertransference may all be explored within the context of co-evaluating the BEVI results.

From our perspective, all of these "best practices" were followed in relation to how the BEVI is used and experienced in the real world by clients and clinicians alike. For example, the process of sharing results with clients necessitates a "collaborative spirit" as well as an exploratory approach, as clinicians essentially appear to be using the BEVI to try and understand—*with clients*—how to make sense of their presentations, symptoms, processes, struggles, and hopes vis-à-vis BEVI results. Thus, although it may be used in this manner, the BEVI is not intended to be a vehicle for "giving feedback" to clients who are meant passively to receive it, but is rather a method for engaging clients in depth-based exploration about how emergent results may help clinicians and clients understand better what the realities and possibilities are for the clients, in terms of how and why they experience self, others, and the larger world as they do, and what the potential implications of such an organizational self-structure may be. For example, as the preceding transcript illustrates, by encouraging the client to generate her own examples or links to BEVI scores and content, she was able to assume a level of collaboration, and indeed ownership, of the therapeutic process (Hanson, Claiborn, & Kerr, 1997). Such an outcome seems highly

congruent with the preceding principles as well as the letter and spirit of therapeutic assessment (e.g., Finn & Tonsager, 1997; Fischer, 2000; Poston & Hanson, 2010).

On the fourth and broader question of whether and how the BEVI might facilitate additional goals and activities that are inherent to therapy and assessment, these points (e.g., regarding usage as a conceptual tool; relative degree of congruence with the best practices of therapeutic assessment) speak to the apparent "value-added" nature of the BEVI. However, based upon the themes that emerged earlier, some additional explication may be in order. For example, focus group findings suggest that the BEVI (a) helps therapists identify "core" or underlying issues that are most relevant; (b) expands the frame of conceptualization, to include domains that are not usually addressed but are central to the lives of our clients, including their beliefs about gender, religion, or other cultures, among other foci; (c) facilitates a more comprehensive, integrative, and holistic frame, which helps therapists understand conflicting aspects of the client's personality and character structure; (d) enables therapists to assess a client's relative capacity and inclination for openness and self-reflection; (e) assists therapists in understanding better how to engage their clients, moving therapeutic processes forward in a constructive manner; and (f) facilitates the cultivation of nonpathological and nonreductionistic perspectives of their clients.

Finally, there is the question regarding the putative "assessment common factors" (Shealy, 2016, p. 105) that were hypothesized to be measured by the BEVI and underlying the processes of therapeutic change. These five proposed common factors—formative variables, dichotomous thinking, dialectical thinking, emotional awareness, and awareness of self—were drawn from the literature regarding the three traditions of clinical psychology (Psychodynamic, Cognitive Behavioral, and Humanistic) as well as from common factors theory and related data and the broader integration/unification movements, and were associated with specific scales of the BEVI. Fully granting the preliminary nature of such a process, for present purposes, we reviewed the content that both clinicians and clients generated to see if the themes that emerged appeared consistent with such factors.

First, consider the proposed assessment common factor of "formative variables," which is operationalized on the BEVI via Negative Life Events (NLE), Positive Life Events (PLE), and Needs Closure. How salient were such processes? From our reading, the first "parent theme"—Causal Connections—is directly related to such factors. Recall the previous examples of thematic content under this theme from the focus groups:

> One client started thinking about it and reflecting on his relationship with his mother and how she has different beliefs than him and how his beliefs match with that and how he can use that understanding in being able to connect with her more. (FG1)

> The BEVI certainly opens up discussion for how maybe you were this way, and became this way. (FG2)

In short, clinicians appear to value that the BEVI "brings out" these connections between *what* individual clients say about who they are, and *why*, from an etiological standpoint, they are inclined to do so.

Regarding the proposed "assessment common factors" of "dichotomous thinking" and "dialectic thinking"—which correspond respectively with (among other scales) Basic Closedness and Socioemotional Convergence on the BEVI—focus group

processes also seem to offer confirmatory evidence. As noted, these perspectives essentially represent mirror opposites (a reality that is illustrated further by the following correlation matrix data: http://www.thebevi.com/docs/bevi_scale_pairwise_ correlations_and_significance_levels.pdf).

From the focus groups, the "Big Picture" theme that emerged speaks to the importance of "putting it all together" in a meaningful way. Consider, for example, the following representative observations that emerged along these lines:

> It brought it together . . . in a picture that created some more pockets to understand her at a bigger picture level. (FG1)

> It helps me to be more mindful of really seeing the client . . . holistically. There are times where I find myself getting really focused . . . on one piece of the picture. . . .[and] it helped me to be more mindful of broadening the lens that I was looking through and being able to really meet the client's needs and meet them where they're at. (FG2)

As another example, the parent theme of "Assessing Openness, Defensiveness, and the Ability to Self Reflect" also seems to tap directly into the factor of "dichotomous thinking." Consider the following focus group observations:

> We've had several cases of this very rigid way and approach of thinking and yet the openness is still there . . . so it was helpful to . . . see and to make sense of . . . (that) . . . in the therapeutic relationship. (FG1)

In short, regarding these two proposed assessment common factors, it would appear that the BEVI helps to explicate the relative degree of complexity that is there to be apprehended in clients, which would seem to be congruent with the "dialectical" framework, and by definition, mitigating against dichotomous thinking, which tends to be associated with reductionistic or linear ways of apprehending our clients in therapy and assessment (e.g., Cummings, Davies, & Campbell, 2000; Horowitz, 2002; Spiro, 2009).

Fourth, the proposed assessment common factor of "emotional awareness" also emerged consistently both for clinicians and therapists as a key factor in understanding client presentations and how to intervene. Recall, for example, the following excerpt from the clinician/client exchange given earlier, during review of the client's BEVI profile, with a particular focus on the Emotional Attunement scale.

TH: The other thing it (BEVI results) said was that you were very attuned to your emotional world.
CT: Yes.
TH: And that felt like it was….
CT: It was very, very right, yes, very much so. I react a lot on emotion.
TH: And you're very aware of your emotion, what you're feeling . . . it's a big part of your life . . . and it's a big motivator.
CT: Yes. It's true. Maybe that's not a good thing.
TH: Well I'm sure there's difficulties about being sensitive.
CT: Yes, I'm pretty sensitive to what's going on around me.
TH: And inside of you.

CT: Mmmhmmm.

TH: And one thing that we've talked about before is difficulty tolerating a lot of painful emotions.

CT: I really don't have . . . I can't do that….

Fifth and finally, the potential of the BEVI to explicate the proposed "self-awareness" assessment common factor also appeared salient in a number of thematic areas. From Causal Connections, for example, consider the following focus group observation:

> Using the framework of the BEVI and going over some of that data with her she was better able to make sense of herself, her life, and how she had gotten to where she was in her life. (FG2)

It should be emphasized that all five of these proposed assessment common factors are not conceptualized as orthogonal in nature, as each may share an affective and cognitive component with the other. For example, on the BEVI, Self Awareness theoretically is subsumed under a broader rubric of "Self Access," which includes Emotional Attunement, Positive Thinking, and Self Awareness. Arguably, then, to be "self-aware" a client or clinician must be able to tolerate the sort of disequilibrium that results from experiencing aspects of self that disconfirm our preferred ways of experiencing what we believe we are. Such an ability to accept contradictions and hold complexity is akin to the skill of dialectical thinking. As measured by Socioemotional Convergence on the BEVI, then, dialectical thinking may be a precursor or facilitating condition for increased self-awareness, an empirical question that could be investigated in the future. Likewise, the role of formative variables in producing a relative degree of "self-access" is further suggested by the following focus group observation:

> The BEVI certainly opens up a discussion for how maybe you were this way, and became that way. (FG2)

As a final consideration, the difference between content and process alluded to at the outset of this chapter should be explicated more fully. Specifically, it is one thing to capture "where" a client is vis-à-vis his or her specific BEVI profile. That content focus may be contrasted with a more process-oriented usage of the BEVI to promote various therapeutic and assessment means and ends, such as greater awareness of self, others, and the larger world. That said, it should be recognized that these two domains (process and content) are intricately connected. For example, in the case vignette outlined previously, the client becomes aware of her tendency to be skeptical and avoid positive thinking (i.e., content-based findings). Then, by engaging in process-based discussion of these findings, the client appears to become more aware of these self-tendencies, and how they affect her larger relationships, which leads to clarification of future therapeutic goals. Consistent with the PATI model, then, content and process on the BEVI are interwoven in the integration of measurement, collaborative interpretation, and therapeutic intervention, which all are designed to facilitate the clarification and pursuit of therapeutic processes and goals.

LIMITATIONS

Convenience Sampling

One limitation of the study is that participants were recruited through convenience sampling, as opposed to purposeful sampling (Creswell & Plano Clark, 2011). As a result, the sample is more heterogeneous than usual. Typically, qualitative studies involve highly homogeneous samples. Consequently, we may have lost meaningful, culturally rich data. In any case, in future research, it may be useful to study specific, closely aligned subsets of clinicians and clients, as well as diverse types of clinicians who are committed to different theoretical perspectives.

Sample Size

Another limitation is the small sample size. Although not unusual for qualitative research of this nature, the themes derived from client qualitative responses from the BEVI were extracted from a sample of 13 different clients. It would be important to note if an examination of a larger sample of responses, where saturation was clearly reached, led to similar themes.

Coding Reliability

A difficulty that emerged from the thematic analysis of the source material was the conceptual overlap between some of the codes. For example, the response that follows could be reasonably coded within either Causal Connections (Deeper Understanding) or Big Picture code.

> It brought it together . . . in a picture that created some more pockets to understand her at a bigger picture level. (FG1)

The conceptual breadth of the thematic codes, the subjective nature of thematic analysis, and the difficulty in establishing effective inclusion and exclusion criteria led to some difficulties with inter-rater reliability. Part of this difficulty stemmed from the tension between two goals in the coding process. First, there was a necessity to impose a conceptually clean and orderly structure upon the material. Second, there was a desire to stay close to the participant's wording and logic in order to capture the lived-in experience of the therapists and clients who used this measure. The dialectic between these sometimes competing objectives was difficult to navigate.

In order to counteract any variance between the researchers' coding choices, responses that appeared to satisfy criteria for more than one code were coded for all relevant categories.

In the end, although there was some variability in terms of determining the exact frequency of references to individual codes, there was overall consensus in regard to the coding categories. Thus, greater emphasis should be given to the themes—and data "trustworthiness" (Morrow, 2005)—than to the number of references each theme received.

SUMMARY AND CONCLUSION

In this chapter, we have attempted to describe the EI model—and BEVI method—against the backdrop of traditional and emerging approaches to intervention, with a particular focus on therapeutic assessment. More specifically, we began with a brief overview of the "big three" frameworks for intervention, psychodynamic, behavioral, and humanistic, before articulating four problems with the "big three": (a) minimizing heterogeneity *within* these frameworks; (b) minimizing heterogeneity *between* these frameworks; (c) underestimation of the powerful role of subdisciplines in informing practice; and (d) the problem of myopic fidelity to particular ways of working. We then provided an overview of the EI model and BEVI method, with a particular emphasis on their congruence with the PATI approach. Along these lines, we offered five putative "assessment common factors" that seemed to be indicated by the current approach, and consistent with an integrative approach toward therapeutic assessment: (a) formative variables, (b) dichotomous thinking, (c) dialectical thinking, (d) emotional awareness, and (e) self–other awareness. From our perspective, two overarching principles seemed to capture the essence of the present PATI approach—"broadening the framework of who clients are" and "facilitating collaboration and connection." Against this theoretical, empirical, and applied backdrop, we posited five specific questions to be examined in the current study: (a) Is the BEVI ecologically valid? (b) Can the BEVI facilitate case conceptualization? (c) Does the BEVI correspond to best practices of therapeutic assessment? (d) How specifically does the BEVI add to assessment and therapy activities? and (e) Do the hypothesized "assessment common factors" emerge thematically for clients and clinicians vis-à-vis BEVI usage?

To examine these questions, methods for this study drew from three sources of information: (a) two independent focus groups; (b) a review of qualitative questions by clients; and (c) analysis of a videotaped transcript. Results emerged in the form of two sets of themes for clinicians and clients. From the perspective of clinicians, the BEVI appeared to: (a) promote an understanding of causal connections; (b) allow for a "Big Picture" focus; (c) emphasize nonpathologizing findings and observations; (d) facilitate sharing of a conceptual framework with clients; (e) broaden the range of information that was gathered and presented; (f) allow for the assessment of openness, defensiveness, and the capacity for self-reflection; (g) promote client motivation and engagement; (h) be applied flexibly not only to therapy and assessment, but in other areas of inquiry and practice; (i) provide perspective that clinicians and clients experienced as accurate; and (j) validate and support the work of clinicians. From the perspective of clients, the BEVI appeared to (a) clarify matters of one's personal identity and self-worth; (b) appraise and promote one's capacity for self-reflection; (c) capture the real world complexity of one's presentation and life situation; (d) allow for inclusion of one's personal values and religious (or not) convictions; and (e) emphasize the relationship of self to others. Finally, to demonstrate how such processes actually manifest in the context of a therapeutic assessment approach, we provided a transcript of a videotaped session to show the iterative and dynamic way in which BEVI results are experienced by clinicians and clients alike in the furtherance of clinical processes and goals.

Overall, these results point to the many potential benefits of the BEVI in a clinical context generally, and toward the therapeutic assessment paradigm and approach, more specifically. Other potential uses of the BEVI within the therapeutic

context may be explored in future studies, including but not limited to usage of the BEVI as a screening tool for therapy readiness; for matching therapy clients with specific approaches, interventions, or therapist styles; as a therapy outcome measure; to facilitate different types of therapeutic interventions (e.g., couples, family, group); and to facilitate training processes for students, who may complete the BEVI to understand their own beliefs and values vis-à-vis self, others, and the larger world. As focus group findings suggest, there are many other uses of the BEVI (e.g., for psychological assessment; in military settings; for organizational and leadership development locally and internationally; in higher education), which also may help inform and enrich usage from the standpoint of therapeutic assessment and intervention. In the final analysis, a gap certainly exists between the need and supply of integrative, depth-based, process-oriented, and comprehensive assessment measures that can effectively be used across a range of clinical applications, contexts, and populations. This chapter points to the BEVI's potential to help meet these important needs, while opening up a wide range of issues, processes, and foci that are of considerable relevance to clients, therapists, and the broader mental health field.

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EXHIBIT A

BEVI FOCUS GROUP:
INTRODUCTION AND QUESTIONS

INTRODUCTION

Today we are hoping to gather some information about your experience thus far in using the BEVI in clinical practice, including both therapy and assessment cases. Over the next 30 to 60 minutes, we are going to ask you to tell us about what this process has been like for you, as well as what you think it may have been like for the client based on feedback they provided to you, their responses to the BEVI, and your experience with them in the room. There are no "right" or "wrong" answers. The responses you provide will be confidential in the sense that the researchers will only identify you by number and not by name. We ask that you be as open as possible in providing your responses and are respectful of the other group members.

QUESTIONS

Prior to Administration

1. Prior to administering the BEVI to your clients, how did you frame the instrument to them and what was their response to this possibility?
2. *If you administered the BEVI to a therapy client*. . .How did the BEVI relate to your own understanding of therapeutic work? In other words, what aspects of the BEVI relate most to the actual process of preparing to conduct therapy?
3. *If you administered the BEVI to an assessment client. . .*Based upon your understanding of the BEVI, what information were you hoping to gain from adding this measure to an assessment battery?

After Administration

Administer a handout with each of the BEVI scales and/or direct them to explanatory information at www.thebevi.com.

   Please take a minute to read this document, which reviews each of the BEVI scales. Because you are participating in this focus group, you have discussed the BEVI and its interpretation with the developer of the BEVI, have engaged in the administration of the BEVI, and have attempted to use the BEVI in assessment and/or therapy with your client.

1. For those of you who received a "blind" interpretation of the BEVI by its developer (in other words, the developer of the BEVI did not know anything about the client except the scale profile), what was your experience of the blind interpretation you received?
2. How helpful and relevant was this "blind" interpretation to understanding your client in assessment and/or therapy?
3. How did you use information from the BEVI in your work with clients?
4. What was the clients' reaction to the BEVI?
5. From your perspective, how is the BEVI similar, different, or complementary to other forms of assessment in the context of therapy and/or assessment?

6. What seem to be the main contributions of the BEVI to your therapeutic and/or assessment work?
7. From the standpoint of education and training, has the BEVI and its underlying theoretical and empirical framework helped you reflect upon or further your own process of growth and development as a mental health professional?
8. From an interprofessional standpoint, how might the BEVI facilitate collaboration (e.g., case formulation, treatment planning) across different providers or disciplines?
9. Are there other settings, populations, or applications that you think would be particularly well suited to the BEVI?
10. In summary, what do you think are the major themes or points that have emerged from our discussion? Is there anything else you would like to add regarding your experience of the BEVI and its usage in practice?

EXHIBIT B

CODE BOOK FOR CLINICIAN FOCUS GROUPS

Causal Connections

Child Theme 1—Cognitions, Emotions, Behavior

Criteria: The measure's usefulness in providing an understanding of the causal connections between cognitions, emotions, and behaviors.

Example: I think it was particularly helpful with the assessment client that I'm working with now in terms of explaining some of what was going on with her, some of the reasons that she might be internalizing a lot of her emotions. . .For example, beliefs about how a woman should be, not expressing anger, holding everything in, that type of thing. (FG2)

Child Theme 2—Self and Other

Criteria: The measure's usefulness in providing an understanding of the causal connections between the client's beliefs, values, and attitudes and his or her relationships.

Example: Another person has used it in interpersonal relationships in trying to reflect on why at times he can trigger certain responses in people. (FG1)

Child Theme 3—Past and Present

Criteria: The measure's usefulness in providing an understanding of how the client's past affects his or her present self and experience.

Example: The BEVI certainly opens up discussion for how maybe you were this way, and became this way. (FG2)

Child Theme 4—Deeper Understanding

Criteria: The BEVI's use in helping the therapist and client to "make sense" of the client's experience, to create a coherent picture.

Note 1: What differentiates responses that fall into this code from those that fall into "Big Picture" is that these responses focus solely on coherency and understanding whereas the responses that belong to "Big Picture" focus both on coherency and breadth.

Big Picture

Criteria: The measure's helpfulness in developing a broad, holistic, and integrated frame. The two main elements contained in these responses are breadth and integration.

1. Breadth: It is a big picture and covers a broader range of information (the idea of breadth emerges again in the theme "Broader Range of Information").
2. Integration: It fits together as a whole. It is a coherent picture that "makes sense" (the idea of coherency emerges again in the theme "Causal Connections").

Example: It was just really interesting to see how those things fit together in. . .a visual graphic. (FG1)

Note 2: The reason this code is a child code of "Making Causal Connections" and not a separate code altogether is that these notions are logically intertwined. It is difficult to imagine gaining

insight *without* making causal connections. This conclusion is borne out by the fact that most of the responses that included understanding either implicitly or explicitly refer to the causal connections between different factors.

Example: Using the framework of the BEVI and going over some of that data with her she was better able to make sense of herself, and her life, and how she had gotten to where she was in her life. (FG2)

Nonpathologizing

Criteria: The measure's usefulness in developing a nonpathologizing frame that allows the therapist to focus on the client's strengths and resources as well as areas of difficulty.

Example: It isn't pathologizing and it isn't necessarily threatening but it feels so informative as opposed to labeling. (FG2)

Openness, Defensiveness, and the Ability to Self Reflect

Criteria: How the measure helps to assess the client's openness, defensiveness, and the ability to self reflect.

Example: (The results) didn't fit my own conceptualizing, I would be like "oh!" I didn't know if I would find that person necessarily. . .open in the ways that. . .(the BEVI). . .reflected and showed. (FG1)

Client Engagement

Criteria: How the measure can be useful in increasing the client's motivation and engagement with the therapeutic process.

Example: I think it was helpful for them to kind of see, because it's something about them having entered the information themselves and having it reflected back to them kind of without my filter. (FG1)

Sharing the Conceptualization

Criteria: How the measure can be useful in framing the conceptualization for the client in a therapeutic manner.

Example: Helping with the conceptualization of your client for yourself and then also how to share that with the client in a way that is going. . .to create movement and be therapeutic for them. (FG1)

Broader Range of Information

Child Theme 1: Capturing the Information

Criteria: How the measure can capture a broad range of information. The theme of breadth was also covered in "Big Picture." The difference here is that the factor integration/coherency is not as emphasized (i.e., emphasis is not solely on the breadth aspect).

Example: It really does sort of flush out other factors that may not show up in other measures. (FG2)

Child Theme 2: Using the Information

Criteria: How the measure can be used to bring this information into the therapy process.
Example: (It was) providing an opening for talking about those things. (FG1)

Flexibility

Criteria: How the measure is flexible. This flexibility may occur on multiple levels (e.g., theoretical approaches, different populations, different functions).
Example: I've also seen the potential of using it with couples as well, who we don't get to work with a lot. But I do think that would be a tremendous tool to put two steps together, to kind of compare and contrast, I'm sort of moving on a little bit. . .(inaudible). . .within the different family systems, umm, different relationships as well. (FG1)

Accuracy of BEVI Blind Interpretation (Validity)

Criteria: The ability of the blind interpreter to review the profile resulting from a BEVI administration and accurately capture the client's presentation.
Example: Well for the assessment client that I was working with, I mean, it was pretty spot on actually. . .for the most part 95% she really resonated with. (FG2)

Validating for the Therapist

Criteria: How using the measure can be validating for the therapist and useful in increasing the therapist's motivation and engagement in the therapy process.
Example: I think sometimes you get exhausted. . .But. . .I think being able to see that there are some areas that are making growth possible, I think for me it was kind of a little like, because I think sometimes we can get real jaded when we're working with clients week after week so seeing particular scale of openness for me with that one particular client when I was started to feel like Lord she's never going to make much progress but umm for me it was a rejuvenation afterward. (FG1)

EXHIBIT C

TABLE 15.1
Emergent Themes of Focus Groups 1 and 2

PARENT THEME	CHILD THEME	NUMBER OF REFERENCES
Causal Connections		13
	Cognitions, Emotions, and Behavior	4
	Self and Others	3
	Past and Present	2
	Deeper Understanding	6
Big Picture		12
Nonpathologizing and Strength-Focused		11
Broader Range of Information		10
Openness, Defensiveness, and Ability to Self Reflect		6
Increased Client Engagement		5
Sharing Conceptualizations with Client		5
Flexibility		5
Accuracy		3
Increased Therapist Engagement		3

Note. Some references may have met criteria for coding in more than one "child theme" (i.e., the number of references to "child themes" may add up to more than the total references for a "parent theme").

EXHIBIT D

TABLE 15.2
Emergent Themes of Client Responses

CATEGORY	THEME	NUMBER OF REFERENCES
Aspects of Self		28
	Self-Image/Self-Worth	7
	Affirming/Validating	3
	Complexity	4
	Self-Reflection	4
	Discomfort	3
	Changing Aspects of Self	3
	Emotional Self	2
	Self-Knowledge	2
Values		14
	Religion	8
	Environment	3
	Where I stand	2
	Politics	1
Self and Others		11
	Self-in Relation to Others	9
	Effects of Family of Origin	1
	Community Involvement	1
No Impact		5
	No aspect of Self-became clearer	3
	Did not learn anything	2