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A 15-Year Progress Report on the Presence of Humanistic/Existential Psychology Principles in Mental Health Outcome Measurement: Thematic Discourse and Summative Content Analyses

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Abstract

Fifteen years ago, Pfaffenberger (2006) applied five implicit paradigmatic assumptions identified by Slife of the dominant positivistic medical model paradigm—hedonism, universalism, atomism, materialism, and objectivism—to psychotherapy outcome research and its practice implications. Her applied theoretical essay revealed critical issues involving hidden power and privilege dynamics therein. Furthermore, Levitt et al.'s (2005) research examined nine then-common outcome instruments to determine the extent to which their item content reflected humanistic psychology principles in nine domains derived from the authors' systematic review and thematic analysis of the humanistic literature. Their content analysis revealed that the majority of those domains were inadequately represented. In this article, using thematic discourse analysis (aka latent thematic analysis), I

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first identify how the philosophical and political assumptions summarized by Pfaffenberger are apparent in three outcome instruments that are commonly used in U.S. community mental health settings today: the *Adult Needs and Strengths Assessment*, the *Ohio Mental Health Consumer Outcomes System*, and the DSM-5 assessment measures. As part of my analysis, I contrast paradigmatic assumptions of the medical model with those of humanistic/existential psychology as a basis for contextualizing and understanding the implications of measurement-based care as articulated through the two discourses. Then, second, based on a summative content analysis of the three instruments, I report on the progress that both has been and remains to be made in their item content since Levitt et al. noted the general dearth of humanistic principles in mental health outcome measurement. Suggestions for future research and instrument development are discussed.

Keywords
measurement-based care, mental health outcome measurement, community mental health, humanistic/existential therapy, thematic and content analyses

In recent years, community mental health centers (CMHCs) throughout the United States have moved increasingly toward measurement-based care, in which clients routinely complete outcome assessments specific to their presenting diagnosis to show the effectiveness of the therapeutic services they receive. The "most important role" of measurement-based care is purportedly to give clinicians quantified details about whether clients show a demonstrable decrease in symptoms—and if so and/or if not, in what areas (AIMS [Advancing Integrated Mental Health Solutions] Center, 2018, para. 3). Muir et al. (2019) argued that doing so maximizes client benefit and reduces harm by helping clinicians "better know thy [client]" in ways that improve upon clinical judgment alone (p. 466).

These benefits have their appeal, and on the surface, Muir's conviction may even suggest a person-centered stance. On the other hand, similar to the failed No Child Left Behind initiative in education (Muller, 2018), behind these seeming good intentions are more troublesome motivating forces: cost containment and increased accountability in the face of economic uncertainty (Rousmaniere et al., 2020; Vermeersch & Lambert, 2003; Wright et al., 2020). Clinicians' ability to be reimbursed for providing services—especially to clients who receive public benefits—has become contingent upon demonstrable symptom reduction (Novotney, 2019; Rousmaniere et al., 2020; Wright et al., 2020). While this situation certainly propagates an existential

threat for clinicians in general, it particularly endangers those operating from a humanistic/existential orientation. Moreover, at the therapeutic level, if clients have not shown "at least a 50% improvement in symptoms using a validated measure," clinicians are required to change the treatment plan (AIMS Center, 2018, para. 8). This is to occur irrespective of clinicians' and clients' perceptions of progress and/or despite clients' preferences for therapeutic modality—which has been empirically substantiated to have a strong bearing upon the quality of the therapeutic relationship and, thus, to prevent premature termination (Norcross & Cooper, 2021).

Consequently, CMHCs have made a "shift to episodic care where services are provided for a particular problem goal using brief therapy models," as described in a training brochure from a CMHC in Cincinnati, Ohio (Talbert House, 2013). Such brief models include "instant" anger management (Karmin, 2021) and "high-speed" treatments for depression and anxiety (Burns, 2019) as well as trauma—the latter of which has been described by one of its proponents as "like CBT on steroids" to usher "rapid, profound" recovery (Burns, 2018). The proliferation of such approaches—especially for trauma, which arguably is implicated in *all* presenting conditions (Schneider, 2008), particularly in CMHC settings—flies in the face of abundant research evidence that therapies which emphasize rapid recovery can be overwhelming for clients (Levine, 1997) and can beget negative treatment outcomes (Serlin et al., 2019). For that reason, consistent with more bona fide humanistic and existential theorizing (see Bland & DeRobertis, 2018, 2020b), a process- and relational-oriented approach has been found to be both more effective and more ethical (Cameron, 2019; Kinsler, 2018).

Humanistic Critiques of Conventional Outcome Measurement

About a half-century ago, Hacker et al.'s (1972) humanistic critique of mental health outcome measurement cautioned against "[distorting] the portrayal of the person measured" by de-emphasizing the context behind and complexity of clients' "essentially human or spiritual qualities" due to "pressure to quantify certain aspects of human behavior for scientific investigation" (pp. 94–95; see also Matson, 1964). More recently, Pfaffenberger (2006) extended that observation by applying five assumptions identified by Slife (2004) of the dominant positivistic medical model paradigm—hedonism, universalism, atomism, materialism, and objectivism—to psychotherapy outcome research and its practice implications. Her applied theoretical essay revealed "critical issues" involving hidden power and privilege dynamics therein (Pfaffenberger,

2006, p. 336). In contrasting the medical model and humanistic/existential psychology discourses, Pfaffenberger examined how the polarization ("the elevation of one point of view to the utter exclusion of competing points of view," Schneider, 2013, p. 1) of the medical model perspective endangers clinicians operating from a humanistic/existential orientation (see also Schneider, 2019). Around the same time, Levitt et al. (2005) performed a content analysis of nine instruments then-commonly used in outcome research to report the extent to which their item content reflected nine domains (and dimensions thereof) derived from the authors' systematic review and thematic analysis of the humanistic literature. These domains incorporate attributes of physical functioning, cognitive functioning, wants/needs, emotional experience, interpersonal experience, personal growth, client agency in self-definition, therapy experience, and global functioning. The authors observed that, while emotional, physical, and cognitive experiences/functioning were most often covered by the instruments they evaluated, the other domains' "central humanistic concepts" (Levitt et al., 2005, p. 113) were inadequately represented.

Purpose of This Article

The investigations presented in this article offer a 15-year follow-up to Pfaffenberger's applied theoretical essay and to Levitt et al.'s research. First, using thematic discourse analysis, I identify how the philosophical and political assumptions noted by Slife and summarized and applied to clinical outcome measurement by Pfaffenberger remain abundantly apparent in three outcome instruments that are commonly used in CMHCs in the United States today. These instruments are: (a) the *Adult Needs and Strengths Assessment* (Praed Foundation, 2015), which is employed in California, Indiana, Maine, and Texas; (b) the *Ohio Mental Health Consumer Outcomes System* (Ohio Department of Mental Health, 2013), which is used not only in Ohio but also in Illinois, Oklahoma, Oregon, and Pennsylvania; and (c) the DSM-5 assessment measures (American Psychiatric Association, 2013b). The thematic discourse analysis is supplemented by a summative content analysis that tallies the number of occasions a theme/subtheme appears in the instruments' item content. These analyses are presented below in Findings, Part 1. Then, in Findings, Part 2, I further employ summative content analysis to report on the progress that both has been and remains to be made in the item content of these instruments since Levitt et al.'s pointing out the general dearth of humanistic principles in mental health outcome measurement. A contribution of my study is that the instruments I analyzed are commonly used in current day-to-day clinical *practice* in CMHCs, whereas Levitt et al. focused on

scales employed in outcome *research*—some of which have since fallen out of regular use and, in some cases, have become replaced with the instruments I appraised.

Instruments

My initial exposure to the three instruments analyzed in this article occurred when I routinely worked with them for between 2 and 5 years as a requirement of my employment as a clinician in various settings in three states during the last decade (including 5 years in two CMHCs with predominantly underprivileged and under-resourced populations). Adult forms of the instruments were selected for analysis based on these also having been the basis of Levitt et al.'s (2005) research. According to an internet search supplemented by consultation with colleagues, the three instruments appear to remain in regular use. In the case of the Ohio Scales, a slightly-revised updated form was evaluated to keep the study current.

Adult Needs and Strengths Assessment (ANSA)

The ANSA consists of 51 clinician-rated items to be completed every 6 months. A rubric is provided as a guide for evaluating a client's current level of functioning and access to resources on 4-point scale in five domains: life functioning (17 items pertaining to physical health, family/social relationships, employment, self-care, intellectual/developmental issues, sexuality, adaptive functioning, reliability of housing and transportation, legal issues, sleep, decision-making, and treatment compliance), strengths (12 items on access to and utilization of social, educational, vocational, spiritual, and other community resources as well as sense of optimism), acculturation (4 items on cultural stress and linguistic competency), behavioral health needs (10 items pertaining to symptoms associated with internalizing and externalizing conditions in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013a), and risk behaviors (8 items on risk of harm to self/others, gambling, and criminality). In addition, for each of the five domains, text boxes are provided for clinicians to elaborate. Over three quarters of the ANSA items ($n = 39$) pertain to needs, with higher scores indicating a need for action/intervention. The remaining 12 items focus on the degree to which strengths/resources are present versus absent in a client's life. At a CMHC where I previously worked, the ANSA served as the official intake form in clients' records as well as the tool for routine outcome measurement.

Ohio Mental Health Consumer Outcomes System ("Ohio Scales")

The Ohio Scales consist of 44 self-report items on 4- and 5-point scales (including some Likert-type ratings and some unidirectional metrics) to be completed every 6 months. The items are organized into four domains (Ohio Department of Mental Health, 2009): (a) quality of life (12 items pertaining to satisfaction with social connection/relations, meaningful and/or goal-directed activity, financial status, and living arrangements), (b) safety and health (4 items on physical condition, concern about medication, stigma), (c) symptoms (12 items related to internalizing *DSM* conditions as well as recognition and prevention of distress), and (d) empowerment (16 items on self-esteem/self-efficacy, power/powerlessness, community activism/autonomy, and optimism/control over the future). A fifth section consists of 4 forced-choice demographic items (education level, living arrangement, employment status, and meaningful activities in which the client is involved). Notably, only the first three domains are counted in the outcome algorithm. In my experience using the Ohio Scales in a CMHC, the first few empowerment items were crossed out on the form, and the remaining ones plus the demographic items were not made visible to the client because they appeared on additional pages that were omitted from the photocopied packet. This served to keep the focus principally on symptoms and symptom reduction. Similar to the aforementioned failed No Child Left Behind movement, public funding for the CMHC was contingent in part upon measurable changes in the Ohio Scales items based on aggregate data. For that reason, despite the meaningful context provided by the demographic items, because they were omitted in everyday practice, I also omitted them from the current analyses.

DSM-5 *Measures*

The 23-item DSM-5 Level 1 Cross-Cutting Symptom Measure is a self-report instrument. Using a 5-point unidirectional scale, clients rate the frequency and/or intensity of their symptomatic distress during the past 2 weeks in 13 domains (depression, anger, mania, anxiety, somatic symptoms, suicidal ideation, hallucinations/delusions, sleep disturbance, impaired memory, obsessive thoughts/compulsive behaviors, dissociation, identity/interpersonal issues, and substance use). Based on a client's ratings on the Level 1 measure, clinicians also select and administer Level 2 measure(s) that consist of between 5 and 10 items pertaining to more domain-specific symptoms/concerns—first to obtain a baseline and then to periodically track progress.

Method

Thematic Discourse Analysis

The purpose of this research was not to prove or disprove hypotheses or to establish causality. Rather, as presented below in Findings, Part 1, thematic discourse analysis (also known as latent thematic analysis, Braun & Clarke, 2006) was conducted to identify and generate qualitative data about "broader assumptions, structures, and meanings" that "[underlie] what is actually articulated in" the item content of the three outcome instruments. This served as a basis for "[theorizing] the sociocultural contexts and structural conditions" in which the instruments are embedded (Braun & Clarke, 2006, p. 85; see also Clarke, 2005; Taylor & Ussher, 2001). I found thematic discourse analysis, which is a constructivist qualitative method, to be effective for examining the "range of discourses operating within society" (Braun & Clarke, 2006, p. 81) to understand how they are used to strengthen versus inhibit social connectedness (Palmer Molina et al., 2020). By exploring contrasting discourses that reflect "two competing knowledges", my intention was not to produce a dichotomy between the medical model and humanistic/existential alternatives but rather to provide a basis for contextualizing, understanding the implications of, and making an argument for or against contemporary measurement-based care as articulated through the two discourses (Botelle & Willott, 2020, p. 6).

Whereas previous studies (Botelle & Willott, 2020; Clarke, 2005; Palmer Molina et al., 2020; Taylor & Ussher, 2001) used inductive thematic discourse analysis to extract themes from interview data, in this analysis, I used a deductive analytic stance whereby I situated my analysis in relation to extant literature (Aronson, 1995; Braun et al., 2014) to identify, describe, and illustrate discursive themes that, taken together, formulate a logical story (Tuckett, 2005). I began with the paradigmatic assumptions identified by Slife as the five principal themes reflecting the dominant medical model position. Then, for each paradigmatic assumption, I identified at least one subtheme based on Pfaffenberger's aforementioned summarization and application of Slife that represents humanistic/existential psychology as an alternative discourse. From there, I identified instances in which the five paradigmatic assumptions of the medical model, as well as humanistic/existential alternatives, were present in the instruments' item content. Then, I triangulated my findings with comparable arguments in the literature and/or research evidence. Accordingly, in Findings, Part 1, given the impossibility in qualitative research to "separate a given finding from its interpreted

meaning within the broader frame of the analysis," findings and discussion were "intertwined" (Levitt et al., 2018, p. 29).

When conducting the analysis, I reviewed the item content with fresh eyes in "researcher mode." Having taken time away from regularly working with the instruments as a CMHC clinician gave me an opportunity to bracket that experience and approach the item content afresh and with attention given to Pfaffenberger/Slife as a guiding framework for critically making sense of the contrasting discourses in their item content. Then, as the analysis unfolded, I recalled instances in which Pfaffenberger's (2006) postulates matched my lived experience as a clinician and included such illustrations when presenting the findings. (This constituted the first phase of Braun & Clarke's (2006) steps to thematic analysis: familiarizing yourself with the data.) Next, I provided initial codes and collated the coded data into subthemes based on Pfaffenberger's (2006) applied theoretical essay. (This constituted the second and third phases: generating initial codes and searching for themes.)

Next, to maintain fidelity to Pfaffenberger's discussion about the contrasting discourses as they appeared in the item content of the outcome instruments, some material was occasionally recoded. Subthemes were either consolidated or split into separate subthemes. Throughout this process, in lieu of using a predetermined coding system, I employed a recursive and "organic" (Braun et al., 2014, p. 190) process of coding and deriving themes from the data until I believed that the subthemes both stood well on their own and cogently addressed the research question (Clarke & Braun, 2014). (This constituted the fourth phase: reviewing themes.) Once the subthemes were thoroughly reviewed and finalized, they were mapped in relation to each other to form a coherent sequential narrative, provided labels, and triangulated with extant theoretical and empirical literature (Clarke & Braun, 2014). (This constituted the fifth phase: defining and naming themes.) Finally, parallels between the item content and Pfaffenberger's discussion points in conjunction with related extant humanistic/existential literature were formally explained and discussed. (This constituted the sixth phase: producing the report.)

Summative Content Analysis

To complement the thematic discourse analysis, summative content analysis (Hsieh & Shannon, 2005) also was employed to tally how often the item content of the ANSA, Ohio Scales, and DSM-5 measures reflected Pfaffenberger's discussion about contrasting discourses. (This is reported below in Findings, Part 1.) In addition, summative content analysis was the primary method used to identify the presence of the nine humanistic themes

from Levitt et al.'s study in the three instruments (reported below in Findings, Part 2). In both analyses, my aim was to determine and quantitatively report what progress has been made since Pfaffenberger's and Levitt et al.'s articles were published a decade and a half ago. For both content analyses, interrater reliability with an independent rater yielded a Cohen's Kappa coefficient of .97.

Findings, Part 1: Contrasting Paradigmatic Assumptions

Hedonism

Measurement-based care is founded on medical model assumptions of hedonism and linear progress (Pfaffenberger, 2006). This stands in contrast with humanistic/existential psychology's focus on eudaimonic and chaironic well-being (Arons, 2020; Gold, 2013; Robbins, 2021), as well as on process.

Hedonic Versus Eudaimonic and Chaironic Well-Being. From a hedonic stance, therapy is considered effective when it "reduces pain and increases well-being in a time-efficient and cost-efficient manner" (Pfaffenberger, 2006, pp. 337–338; see also Wahl, 2003). Contextually, this approach has roots in the United States being "a frontier nation" whose citizens tend, "above all, [to] want to 'fix things'" and, thus, to prefer "practical, simple solutions, even to complex problems" as well as reassurance (Elkins, 2009, p. 82; see also May, 1967; O'Hara, 2018; Singal, 2021). Thus, Pfaffenberger (2006) noted, in the measurement-based care climate, therapeutic modalities—including humanistic/existential ones—tend to be undervalued when they (a) encourage embracing (vs. alleviating) suffering, (b) emphasize long-term growth processes/dynamics over immediate symptom reduction, and (c) assist clients with developing a fuller sense of presence, authenticity, connectedness, responsibility, and meaning as aspects of fulfillment and genuine resilience (i.e., struggling well despite adversity; Walsh, 2016). Meanwhile, "more complex issues concerning the change process and the struggles that bring contemporary Americans into therapy" remain obscured (Pfaffenberger, 2006, p. 339)—including those that are both attributable to and reinforced by technocracy (O'Hara, 2018) and "capitalist life syndrome" (Vos, 2020, p. 4l; see also Fromm, 1955).

The assumption of hedonism is well illustrated in the DSM-5 Level 1 and 2 measures, where 100% of the items involve clients rating how much or how often they have been "bothered" by specific symptoms during the past 7 to 14 days. Similarly, more than half (n = 20; 51%) of the 39 ANSA

items pertaining to needs involve clinicians ranking the severity of a client's specific internalizing and externalizing symptoms, sleep disturbance, ability to concentrate and make decisions, threat of harm to self/others, and addictive behaviors based on their frequency, duration, and/or intensity. Similarly, half ($n = 14$) of the 28 Ohio Scales items counted in the outcome algorithm pertain directly to self-reported anxiety, depressive, trauma-related, and somatic symptoms ($n = 12$) and to concerns about stigma ($n = 1$) and about medication ($n = 1$).

Linear Progress Versus Process. Pfaffenberger (2006) noted the "questionable" emphasis on short-term symptom reduction that "may hide more complex issues concerning the change process" (p. 339). Indeed, on all three instruments, therapeutic progress is assumed to be linear—that is, an observable steady decrease in symptoms. From a humanistic/existential angle, this assumption has several serious limitations and implications. First, whereas the *DSM-5* is allegedly based on a dimensional system (which would better honor the complexity of clients' presenting concerns), it really is an ordinal system (Jones, 2012) consisting of unevenly distributed mild, moderate, and severe rankings. That is, the amount of change and working through required to gravitate from moderate to mild is considerably less than what it takes to move from severe to moderate. Arguably, this can spur clients' unrealistic expectations about the change process and discouragement when symptoms are not altogether eliminated. Second, humanistic/existential theorizing suggests that the process of growth—and therapeutic progress—rarely follows a straight line but rather involves a two-steps-forward-one-step-back trajectory (Arons, 2020; Bland, 2018; Bland & DeRobertis, 2020a). Third, though clients may report fewer symptoms, they may still benefit from—and want—continued therapy to promote further growth as described in the humanistic therapy outcomes that are discussed below in Findings, Part 2.

Fourth, when there is a decrease/increase in symptoms, it is insufficient to look only at the numbers on an outcome instrument without accounting for how the client makes sense of that change in relation to their immediate and recent experiencing and to situational factors in their lives. It also is important to consider the clinician's perception of the client's change process (progress sometimes can be harder for clients to see while they are in the thick of it). To illustrate, I once worked with a client who reported increases on several items on the DSM-5 Level 2 measure for social anxiety. Although this may seem like a regression on the surface, both the client and I agreed it was an indication of growth. That is, the client attributed the tension they had experienced at the time to actually engaging more with people. I further validated their courage to stretch their comfort zone and actualize their potential

whereas, previously, the client had avoided most people other than immediate family. I also invited the client to contrast their then-current experience with that from when they had initially entered therapy in the interest of promoting existential learning (in which "something about a person's life circumstances [is] changed such that [one] cannot go on as before," DeRobertis, 2017, p. 43). For another example, consider the relationship between depression and anxiety. Clients with mixed anxiety and depression have constituted at least two thirds to three quarters of my caseload, especially in CMHC settings. This comes despite the *DSM* not offering such a diagnostic category—and, thus, it being insufficiently represented in conventional therapy outcome research. On several occasions, I have observed clients' reporting on the Ohio Scales that their depressive symptoms have decreased while their anxiety symptoms have *increased*. During follow-up discussion, both the clients and I have regarded that as a hopeful sign insofar as they had begun dealing with the emotions and other experiences they had made themselves comfortably numb to at the outset of therapy.

Universalism

Consistent with the mainstream U.S. penchant for standardization, this medical model's paradigmatic assumption "explains the contemporary emphasis on theoretical principles, uniform procedure, replicability, standardized diagnosis, and manualized technique" (Pfaffenberger, 2006, p. 340; see also Dewell & Foose, 2017; Vermeersch & Lambert, 2003) based on a nomothetic approach and predetermined (Mølbak, 2012) treatment methods to address static, generalizable phenomena. As such, universalism also is at the core of the controversial No Surprises Act of 2021. This viewpoint stands in contrast with humanistic/existential psychology's idiographic stance that values and emphasizes clients' narratives and the intersecting contexts in which their presenting symptoms are situated (Pfaffenberger, 2006; see also Charon, 2017b; Dewell & Foose, 2017; Gallegos, 2005; Levitt et al., 2005). Notably, universalism also flies in the face of research evidence that, whereas clinicians tend to devote the vast majority of intake time collecting information to formulate a diagnostic impression, clients are more inclined to rate their perceptions of the working alliance more favorably when clinicians (a) focused on letting clients tell their story and (b) demonstrated effective listening and responsiveness to clients' personal history and sociocultural background (Nakash et al., 2015). With the latter in mind, the tendency for measurement-based care to overlook cultural and contextual factors is the primary subtheme discussed by Pfaffenberger for universalism.

Generalizability Versus Sensitivity to Cultural/Contextual Factors. Psychologists' understanding remains limited when it comes to the generalizability of therapeutic outcomes across cultural boundaries, intervention settings, and other contexts (Pfaffenberger, 2006). More importantly, standardization reflects and serves to promote middle-class values as situated in a particular period in history (Elkins, 2009; see also Vos, 2019), as well as White privilege (Moats, 2020; Weilbacher, 2012). This is clearly demonstrated in Kelly et al.'s (2019) research, which revealed a disconnect between providers' priorities in CMHC settings (building clients' self-reliance, self-efficacy, and coping) and those of clients (staff listening and offering support), as well as clients' perception of the helpfulness of community integration services, which the authors stressed are key to promoting client progress.

Indeed, none of the three instruments directly assess clients' concerns related to helpfulness of services for culturally diverse, often underprivileged and under-resourced populations. Likewise, item content directly pertaining to clients' cultural contexts is omitted altogether from the DSM-5 measures and the Ohio Scales. Meanwhile, while the ANSA does include 4 items on acculturation (pertaining to English fluency, cultural identity development, ability to practice rituals consistent with one's cultural identity, and culture-related distress), it is important to remember that they are clinician-rated. As such, some clients' level of comfort addressing cultural issues with their therapist may be limited (La Roche & Maxie, 2003), which could result in issues being minimized if not overlooked altogether. Moreover, although the ANSA item pertaining to English fluency is well-intentioned and reasonable to include in the United States, it also arguably reflects a problematic assumption that English is the primary language spoken in a client's community. Furthermore, the ANSA item pertaining to cultural identity development focuses only on the presence of conflict regarding cultural identity without accounting for a client's *level* of cultural identity development and the therapist's role in facilitating movement along that trajectory (Sue & Sue, 2013).

Atomism

Consistent with the allopathic definition of mental illness in the opening pages of the *DSM-5* (APA, 2013a), atomism refers to the attribution of "social-psychological problems to an ever-increasing number of individual defects" (Ratner, 2014, p. 299). This comes despite "an increasing body of research [that] supports the contextualized, concrete situatedness of behavior" (Pfaffenberger, 2006, p. 341). Pfaffenberger further explained that, in contrast, humanistic/existential psychology encourages recognition of oppression, family dynamics, and hyper-individualistic values that contribute to and reinforce clients' suffering.

Dysfunction in the Individual Versus Oppression as the Pathogen. Therapeutic models centered around problem-solving to reduce symptoms tend to be valued at the expense of those that employ relational approaches to address systemic issues including but not limited to racism, poverty, and patriarchy (Pfaffenberger, 2006). Otherwise, outcome measurement "would be utterly meaningless if we were to let go of the belief" that individuals are the "source and container of problems" (p. 341). Notably, neither the DSM-5 measures nor the ANSA include items that directly address oppression as a pathogen for diagnosable conditions—especially for underprivileged individuals (see Smith et al., 2009). In contrast, the Ohio Scales feature five items assessing clients' beliefs that they are powerless ($n = 1$), that they can overcome barriers ($n = 1$), and that people working together can influence their community ($n = 3$). However, returning to my point above in the Instruments section, it is important to note that these items appear in the section not factored into the outcome algorithm. Furthermore, the first section of the Ohio Scales also contains items pertaining to clients' satisfaction with their living arrangement, their neighborhood, and their personal safety ($n = 1$ item each) as well as their financial situation ($n = 3$), amount of freedom ($n = 1$), and physical health ($n = 1$). While these items arguably allude to systemic issues (see Maslow, 1971), they do not touch on more fundamental issues involving, say, a client's sense of trust in their community (see Sue & Sue, 2013).

Dysfunction in the Individual Versus Situated in Family Dynamics. Another humanistic/existential counterforce to atomism involves problematic family dynamics (Pfaffenberger, 2006) and other developmental processes (Bland, 2013) as a contextual dimension of clients' presenting concerns. Again, the DSM-5 measures contain no items in this area. However, the Ohio Scales include 1 item about clients' degree of satisfaction with their family relations, and the ANSA has 1 item each on family needs and on family resources. Nonetheless, these items still provide little in the way of meaningful contextual data that could be yielded by a genogram or an individualized developmental profile.

Dysfunction in the Individual Versus Outcomes of Hyper-Individualistic Values and Isolation. Furthermore, Pfaffenberger (2006) noted that atomism reflects cultural values of "achievement, competitiveness, and autonomy" (p. 342) as well as social role proscription (e.g., the glass ceiling and other barriers to women in the United States) that stem from capitalistic (see also Olds & Schwartz, 2009; Vos, 2020) and patriarchal (see also Newsom, 2015) macrosystemic metanarratives which became amplified during the Trump era. Indeed, this is seen in the three instruments' absence of items pertaining to

social roles (gender-based or otherwise) that could be at the core of some clients' presenting concerns.

Moreover, isolation and alienation—Maslow's (1987, 1999) *deficiency-belonging*—are likely to emerge in a society where *I–it* relationships are modeled at the expense of authentic *I–Thou* encounters (Bland, 2020a), yet historically these issues have tended to remain obscured in conventional diagnosis and treatment (Pfaffenberger, 2006). Notably, the DSM-5 Level 1 measure does contain one item about clients not feeling close to or enjoying their relationships with others, and the Ohio Scales feature items about satisfaction with social connection (n = 1) and about feeling alone (n = 3), including loneliness in the presence of others. Furthermore, the ANSA has items pertaining to social needs (n = 1) and resourcefulness (n = 2), as well as community connection (n = 1), involvement in volunteering (n = 1), and religion/spirituality (n = 1). Taken together, these items seem to reflect a shift in conventional discourse toward recognition of effective therapy's ability to being to promote clients' development of social interest as a facet of self-actualization (see Bland & DeRobertis, 2020a). However, while calls have been made nationally for improved community integration services for populations served by CMHCs (Kelly et al., 2019), none of the instruments directly touch on the availability of meaningful social resources in a client's community, especially for clients for whom security and belonging needs (Maslow, 1987) are more salient than self-challenging.

Materialism

Commonly referred to as *physics envy* in psychology and other social sciences (Holzman, 2013; see also Gantt, 2018), the positivistic medical model's paradigmatic assumption of materialism refers to the almost-exclusive valuing of and focus on what is "tangible, visible, and substantial" (Pfaffenberger, 2006, p. 343). It both underlies and reinforces the "increasing . . . biologization of psychology" and, applied to therapy and measurement-based care, the emphases on "cost-effectiveness over quality, prevention, and long-term benefit" and on "that which is easily operationalized to the almost complete exclusion of less tangible factors that may be just as important" (Pfaffenberger, 2006, pp. 344–345). By "superimposing a medical schema on . . . what is essentially an interpersonal process," the field has managed to "move from literal description to analogical description" (Elkins, 2009, p. 45) that is "akin to weighing oranges with thermometers" (Levitt et al., 2005, p. 113). More importantly, many clients still tend to describe "their problems more in terms of existential anxieties than symptoms" (Gallegos, 2005, p. 376). As an alternative to the medical model, which promotes tension/

symptom reduction (first-order change), humanistic/existential psychology places a premium on second-order change processes.

First- Versus Second-Order Change. Psychotherapy that focuses on tangible first-order change at the expense of transformative second-order change (Bland, 2013, 2019, 2020a, 2021; Duncan et al., 2018)—also known as existential liberation (Schneider & Krug, 2017)—"[deals] with pseudo-problems [without getting] to the client's real problems" (Elkins, 2009, pp. 23–24). As noted by Levitt et al. (2005), whereas outcome instruments often assess emotional *pathology*, they tend to overlook clients' development of emotional *intelligence* ("comfort with emotion, the resolution of negative emotion, or emotional expression," p. 125). They also minimize personal growth processes: feeling empowered; appreciating vulnerability; cultivating tolerance of ambiguity, spontaneity, flexibility, creativity, meaning-making, wisdom, self-awareness, self-compassion, resilience, ability to access dormant aspects of and potentials within oneself, and connection to one's identity/values/narrative. These processes involve building acceptance of and commitment to the fuller range and depth of human experiencing of self in relation to others—including its tragic dimensions—and the ability to live well with tension, dialectics, and paradox (Schneider & Krug, 2017; Wahl, 2003). Notably, these outcomes have been reported by clients as the most vitalizing aspects of therapies that promote second-order change, including those in the humanistic/existential tradition (Elliott, as cited in Levitt, 2016; Murray, 2002; Timulak & Creaner, 2010).

Not surprisingly, second-order change outcomes are absent from the DSM-5 measures. In contrast, the ANSA does contain 1 item each on optimism/hopefulness (orientation toward the future), creative talents/interests, resilience (ability to use one's strengths to address challenges), and resourcefulness. Similarly, the Ohio Scales include items about clients' satisfaction with the amount of freedom they have ($n = 1$); their abilities to overcome barriers ($n = 1$) and to accomplish what they set out to do ($n = 2$); their feeling empowered versus powerless ($n = 1$); their degree of social conformity versus self-determination ($n = 1$); and their beliefs about self-efficacy ($n = 2$), self-worth ($n = 1$), decision-making ($n = 2$), taking action to solve problems ($n = 1$), and optimism about the future ($n = 1$). However, all but one of these items (regarding freedom) are included in the section not included in the outcome algorithm. Also, they pertain to only some of the aforementioned personal growth processes—and some only indirectly—while others remain unaddressed.

Objectivism

Conventional measurement-based care is predicated on the a priori assumption that "an objective, knowable world exists [separately] from the value-laden world of subjective meanings and interpretations" (Pfaffenberger, 2006, p. 345). Alternatively, humanistic/existential psychologists and clinicians contend that this false bifurcation (Bland & DeRobertis, 2020b) leads to attention being paid to observable change to the neglect of internal changes that may unfold (Vermeersch et al., as cited in Levitt et al., 2005) by way of authentic relational encounters (Schneider & Krug, 2017). Importantly, therapeutic modalities that emphasize depth, process, and the therapeutic relationship as the vehicle for sustainable change over manualized techniques have been "neglected and marginalized" (Pfaffenberger, 2006, p. 337; see also Dewell & Foose, 2017) *not* because research data suggest they are ineffective. Indeed, more than 85 years of research has consistently demonstrated it is the most salient ingredient of sustainable therapy (Bland, under review; Elkins, 2009, 2016). Instead, it is because

> the data that might support them could not be collected within the dominant paradigm. . . . [Meanwhile,] many psychologists believe that research has demonstrated that cognitive-behavioral treatments work better than other forms of therapy. But this has not really been shown; we have just collected more evidence for their efficacy because this data is easier to collect. In this way, we can see the current trend toward evidence as a systematic bias. This point is frequently lost especially because the naturalistic, objective method has not been explicated as a paradigm based on specific philosophical assumptions. (Pfaffenberger, 2006, p. 346)

This not only poses the risk of atrophying humanistic/existential therapies for future generations (see also Gnaulati, 2018; Vermeersch & Lambert, 2003), but it also results in mental health treatment policy being based on faulty science (Dewell & Foose, 2017) and scientism (see also DeRobertis & Bland, 2021; Stolorow, 2012).

Technical Interventions Versus Therapeutic Relationship as Vehicle for Change. From the standpoint of humanistic/existential psychology, most outcome instruments have "neglected to ask about the therapy experience at all" (Levitt et al., 2005, p. 125). This runs the risk of clinicians "[compromising their] connection with clients . . . when [clinicians] are focused on [developing] interventions and clients are concerned with the relationship itself" (Levitt, 2016, p. 99). Worse, with "little incentive to improve quality" in the absence of feedback, clinicians may be left believing they are doing a good

job by naively following a treatment protocol and achieving the desired predetermined result without consideration of the client's perspective on how they experience the process (Kilbourne et al., 2018, p. 33).

Indeed, the DSM-5 measures and ANSA offer no items about the therapeutic relationship. Meanwhile, the Ohio Scales do contain 1 item ("I have been treated with dignity and respect at this agency"). However, that wording is arguably problematic insofar as many clients in CMHC settings tend to receive multiple services from the same organization—sometimes of varying quality and consistency due to high burnout and turnover rates, among other factors—and may conflate the various services and interactions with multiple staff when responding to that item.

Findings, Part 2: Follow-Up to Levitt et al.'s (2005) Analysis

Levitt et al. (2005) began their analysis of the presence of humanistic themes in nine then-common instruments for outcome research with observations of how the instruments are structured. The patterns they noted remain the same in the ANSA, Ohio Scales, and DSM-5 measures: forced-choice (vs. open-ended) questions that focus on reduction in specific symptoms (with no mention of holistic change) as well as minimal opportunity for clients to define their therapy needs in their own terms. Regarding item content, Table 1 outlines the frequency by which humanistic domains and attributes were/were not present in the nine instruments Levitt et al. examined compared with the item content of the three I investigated.

Questions pertaining to physical and cognitive functioning and to emotional experience were most common in Levitt et al.'s analysis (noted in 6, 5, and 7 of the nine instruments they evaluated, respectively), and those domains continue to constitute a substantial portion of the item content in the instruments I appraised (60% on the DSM-5 measure, 24% on the ANSA, and 32% on the Ohio Scales). Perhaps the area of greatest improvement since Levitt et al.'s study is in the interpersonal domain, which was found in only one third of the instruments then and is now represented in all three instruments (and constitutes a fifth of the item content on the ANSA and over a quarter on the Ohio Scales)—most notably in content areas involving increased connection. Another noteworthy advance is the inclusion of items in the domains of personal growth (pertaining to creativity and spirituality on the ANSA and to freedom and self-efficacy on the Ohio Scales) and agency in self-definition (resourcefulness and resilience on the ANSA, self-awareness about presenting concerns and self-empowerment/self-determination on the Ohio Scales), which had been absent altogether from the scales in Levitt et al.'s investigation.

Table 1. Comparison of Humanistic-Oriented Item Content Domains and Attributes Accounted for in the Item Content of Nine Measures Evaluated by Levitt et al. (2005) and in That of Three Common Outcome Measures Used in CMHC Settings Today.

	Levitt et al. (2005)	DSM-5 (23 items)	ANSA (51 items)	Ohio Scales (44 items)
Physical functioning	6 (67%)	3 (13%)	5 (10%)	4 (9%)
Sleep	5	2	2	—
Appetite	3	—	—	—
Awareness of physical sensations	2	1	—	2
Sexual functioning	2	—	1	—
Medical issues and impact thereof	—	—	1	2
Eating disorder	—	—	1	—
Cognitive functioning	5 (56%)	4 (17%)	4 (8%)	4 (9%)
Thinking patterns	5	1	—	—
Decision-making	4	—	1	1
Suicidal thoughts	3	1	1	—
Thinking about expectations	2	—	—	1
Looking forward to the future	2	—	—	—
Psychotic thoughts	2	2	1	—
Engaging in self-evaluation	2	—	—	2
Engaging in self-monitoring	2	—	1	—
Awareness of own assumptions	1	—	—	—
Logical thinking	1	—	—	—
Wants–Needs	3 (33%)	1 (4%)	2 (4%)	5 (11%)
Sexual desire	4	—	—	—
Desire to be active	3	—	1	1
Desire to live	1	—	1	—
Desire to play	—	—	—	1

(continued)

Table 1. (continued)

	Levitt et al. (2005)	DSM-5 (23 items)	ANSA (51 items)	Ohio Scales (44 items)
Mobilization of hopes/dreams	—	1	—	3
Emotional experience	7 (78%)	7 (30%)	3 (6%)	6 (14%)
Anger	2	1	—	—
Panic	1	2	1	1
Phobia	1	1	—	2
Anhedonia	4	1	—	1
Depression	6	1	1	2
Resolution of past emotional experiences	—	—	—	—
Resolution of anger specifically	—	—	1	—
Symbolization of past emotion	—	—	—	—
Symbolization of new emotions	—	—	—	—
Greater access to feelings	—	1	—	—
Greater comfort with emotional experience	—	—	—	—
Increased ability to express emotions	—	—	—	—
Change in the experience of grief/loss	—	—	—	—
Change in inhibition of internal experience from awareness	—	—	—	—
Development of new meaning connected to internal experience	—	—	—	—
Emotions experienced in session	—	—	—	—
Interpersonal	3 (33%)	1 (4%)	10 (20%)	12 (27%)
Change in intimacy levels	2	—	2	3
Lessening of criticism of others	2	—	—	—
Increased connection to others	2	1	4	3
Change in aggression	1	—	—	—

(continued)

Table 1. (continued)

	Levitt et al. (2005)	DSM-5 (23 items)	ANSA (51 items)	Ohio Scales (44 items)
Change in assertiveness	1	—	—	—
Increased connection to the environment	1	—	—	4
Relationship growth	1	—	—	—
Increased sensitivity to others	1	—	1	—
Reduction of marital distress	1	—	—	—
Increased trust and openness	1	—	—	—
Adjustment to separation	—	—	—	—
Reconsideration of childhood history	—	—	—	—
Resolution of conflict	—	—	—	—
Changes in emotional dependency	—	—	—	—
Changes in financial dependency	—	—	2	2
Increase in decisional independence	—	—	1	—
Changes in empathy	—	—	—	—
Shifts in gender stereotyping	—	—	—	—
Improvement in communication	—	—	—	—
Changes in negative feelings toward others	—	—	—	—
Resolution of unfinished business	—	—	—	—
Personal growth	0 (0%)	0 (0%)	2 (4%)	4 (9%)
Increased tolerance of ambiguity	—	—	—	—
Increased creativity	—	—	—	—
Feeling creative	—	—	1	—
Resolution of conflict within the self	—	—	—	—
Resolution of self-criticism	—	—	—	1
Accessing dormant parts of self	—	—	—	—

(continued)

Table 1. (continued)

	Levitt et al. (2005)	DSM-5 (23 items)	ANSA (51 items)	Ohio Scales (44 items)
Meaning-making of past experience	—	—	—	—
Meaning-making process in general	—	—	—	—
Sense of freedom	—	—	—	1
Strength of identity, insight, being in touch with oneself	—	—	—	—
Increased wisdom	—	—	—	—
Developing new story about oneself	—	—	—	—
Personal beliefs/values	—	—	1	1
Feeling connected to stories/events	—	—	—	—
Experience of telling one's own story	—	—	—	—
Self-actualization	—	—	—	—
Self-awareness	—	—	—	—
Ability to direct self-growth	—	—	—	—
Feelings of separate existence	—	—	—	—
Spontaneity/flexibility	—	—	—	—
Understanding of own feelings, presenting concerns, oneself	—	—	—	1
Sense of unique identity	—	—	—	—
Awareness of one's values	—	—	—	—
Agency in self-definition	0 (0%)	0 (0%)	3 (6%)	6 (14%)
Clients' perspectives on sources of their presenting concern	—	—	—	1
Perception of own goal-setting	—	—	1	1
Experience of increased/new choices	—	—	1	—
Change in client's experience of control	—	—	1	4

(continued)

Table 1. (continued)

	Levitt et al. (2005)	DSM-5 (23 items)	ANSA (51 items)	Ohio Scales (44 items)
Therapy experience	2 (22%)	0 (0%)	0 (0%)	1 (2%)
Whether therapy helped with the client's presenting concern	1	—	—	—
Client's perception of therapeutic bond	1	—	—	—
Acceptance of therapist	1	—	—	—
Trust/security in therapist	1	—	—	—
Satisfaction with therapy experience	1	—	—	1
Mutuality of understanding and of goals in therapy	1	—	—	—
Helpfulness of therapy to date	—	—	—	—
How therapy helped	—	—	—	—
Helpfulness of therapy exercises	—	—	—	—
How in-session exercises helped	—	—	—	—
Helpfulness of homework	—	—	—	—
Increase of client insight in session	—	—	—	—
Change in client resistance	—	—	—	—
Global functioning	4 (44%)	0 (0%)	1 (2%)	1 (2%)
Overall assessment of self/global functioning	3	—	—	—
Feeling good/positive	2	—	1	1
Quality of dreaming	1	—	—	—
General symptom change	1	—	—	—
Client's ability to self-reward	—	—	—	—

Note. The column for Levitt et al.'s study refers to the number of *measures* (out of nine) containing items in each domain. The columns for the DSM-5 measures, the ANSA, and the Ohio Scales refer to the number of *items* in each domain.

Furthermore, while Table 1 suggests the need for continued item development in several areas across all the domains, therapy experience and global functioning remain particularly underdeveloped.

Finally, it is worth noting that the ANSA, Ohio Scales, and DSM-5 measures also include item content which expands upon that featured in Levitt et al.'s analysis and which can better inform humanistic assessment, especially salient needs of clients typically served in CMHC settings. Examples include clients' perception that their concerns are not taken seriously by others, access to safe/stable housing and transportation, trauma responses, stigma, and coping via substance use. All these issues reflect under-fulfillment of Maslow's (1987) basic physiological, safety, and belonging needs. As such, per Maslow's dynamic systemic theorizing (see Bland & DeRobertis, 2020a), if left unaddressed, these unsatisfied needs pose barriers to personal growth (self-actualization). However, when they are addressed as part of therapy (not just case management services), clients may have a better opportunity to flourish via relational healing.

Discussion

Since the 2006 publication of Pfaffenberger's "Critical Issues in Therapy Outcome Research," measurement-based care has arguably intensified the salience of assumptions identified by Slife (2004) of the dominant positivistic medical model paradigm: hedonism, universalism, atomism, materialism, and objectivism. However, concurrently, some noteworthy enhancements also have been observed in the incorporation of humanistic/existential psychology principles into outcome instruments commonly used in CMHCs.

First, the assumption of hedonism remains strong, with 100% of the items on the DSM-5 measures and more than half of the ANSA items pertaining to needs and half of the Ohio Scales items counted in the outcome algorithm pertaining to symptom reduction. Moreover, all three instruments are predicated upon and serve to reinforce the assumption of linear progress at the expense of process.

Second, with regard to universalism, none of the instruments directly assess clients' concerns related to helpfulness of services for culturally diverse, often underprivileged and under-resourced populations. Likewise, item content directly pertaining to clients' cultural contexts is present in only one of the instruments—and with notable limitations that reveal its well-intentioned but nonetheless ethnocentric assumptions.

Third, only one of the instruments addresses oppression as a core pathogen for diagnosable conditions—and then it does so only indirectly and in a section of the instrument that is excluded from the outcome algorithm. This

omission arguably upholds the assumption of psychopathology as an individual defect (atomism). On the other hand, two of the instruments assess family relations and resources. Moreover, while none of the instruments assess (a) the effects of culturally prescribed social roles based on capitalistic and patriarchal macrosystemic metanarratives or (b) the availability of meaningful social resources in a client's community, all three instruments assess loneliness, and one instrument includes items pertaining to protective factors against isolation/alienation in a hyper-individualistic society. As discussed further below, this is a step in a good direction since Levitt et al.'s (2005) analysis, which drew attention to the dearth of item content regarding interpersonal relations in mental health outcome research.

Fourth, two of the instruments contain items pertaining to aspects of personal growth and outcomes associated with transformative second-order change (albeit sometimes only indirectly): optimism/hopefulness, creative talents/interests, resilience, resourcefulness, freedom, overcoming barriers, goal-orientedness, empowerment, self-determination, self-efficacy, self-worth, and optimism about the future (though some are not included in the aforementioned algorithm). Again, this is a notable improvement over the absence of such items identified in Levitt et al.'s research 15 years ago.

Fifth, one of the instruments includes an item about clients feeling they have been treated with dignity and respect at the CMHC. Despite the aforementioned limitations of this item, it is certainly a step in a good direction of assessing the quality of the therapeutic relationship.

Moreover, since Levitt et al.'s (2005) analysis of the presence of humanistic themes in nine instruments then-commonly used in mental health outcome research, there has been generally little change insofar as the principal focus remains on symptom reduction. Improvements have been noted especially in the interpersonal, agency in self-definition, and personal growth domains, while item content pertaining to clients' therapy experience and global functioning remains particularly underdeveloped. This seems to reflect a trend in which clinicians are placed in the expert role as an automatonic technician who listens for, diagnoses, and treats minute aspects of symptoms while greatly running the risk of missing the big picture and thus leaving underlying concerns relatively unaddressed and prone to eventual return (May, as cited in Schneider et al., 2009).

Opportunities for Humanistic/Existential Psychologists to Make Further Contributions

Demonstrable outcomes are increasingly a requirement in contemporary mental health services, especially in CMHC settings. On the other hand,

although intervention science based on protocol-based treatments for specific disorders "has created a robust and progressive field" in recent decades, it "has now reached a dead end" (Hayes et al., 2020, p. 1; see also Elkins, 2015). As such, this is an opportunity for humanistic/existential psychologists to make both a conceptual and practical contribution to measurement-based care to supplement their proposals for diagnostic alternatives to the *DSM* and the medical model (see Bland, 2020b). If mental health treatment has lost its way in favor of economics, humanistic/existential theorizing can set the stage for a more sustainable modus operandi to emerge out of the chaos of the current era.

At its best, providing alternatives and/or augmentations to existing outcome instruments can help mitigate concerns raised in the literature about the serious limitations of measurement-based care in its current form. These include, first, clinicians becoming adversely affected by misuse of data by health care administrators and/or policymakers (Rousmaniere et al., 2020). A second concern is the process of data collection about symptoms being exhausting for clients (Hayes et al., 2020) and clients not completing outcome assessments honestly out of fear of losing benefits or services (Resnick & Hoff, 2020). Third, other forms of measurement error (Muir et al., 2019) as well as technological issues (Resnick & Hoff, 2020) may stem in part from quality instruments and data collection/management systems being too costly for CMHCs and the resulting need to settle for inferior tools that uphold the cultural status quo and, thus, reinforce the wealth gap (see also Bland, 2015; Taibbi, 2014) and consequent health disparities (Charon, 2017b). That is, while corporate test publishers, computer companies, insurance providers, and health care administrators profit from the uncritical employment of outcome measurement, the roots of client suffering remain overlooked via *systems blindness* (Goleman, 2013) that ultimately works against the very populations that CMHCs serve. In that regard, humanistic/existential psychology heeds Rousmaniere et al.'s (2020) calling for alternatives to a one-size-fits-all approach in outcome measurement and for flexibility in implementation (see also Dewell & Foose, 2017).

Indeed, several new instruments have already been developed—the item content of which can be incorporated into existing assessment tools such as the ANSA and the Ohio Scales and which can be used in conjunction with the DSM-5 measures to arrive at a better portrayal of the whole client in relational and cultural contexts. For instance, Duncan et al.'s (2018) *Partners for Change Outcome Management System* offers measurement of (a) holistic second-order change (vs. symptom reduction), (b) global functioning (in its Outcome Rating Scale), and (c) therapy experience (in its Session Rating Scale)—all of which were generally absent in Levitt et al.'s (2005) analysis

as well as in my research. In addition, Levitt's *Client Experiences of Therapy Scale* (Levitt et al., 2019) also provides assessment of the quality of in-session therapy based within the experiences of clients and what they value. Moreover, positive psychologists have developed instruments to measure traditionally humanistic constructs (see Kaufman, 2020) that also should be reviewed.

Henceforth, additional potential directions called for in the literature include Vos (2019) suggesting the development and refinement of instruments that "measure existential moods, concerns, and crises and to examine how these relate to psychopathology in the medical paradigm and with the client's request for help" (p. 607). Furthermore, the development of more open-ended questions in outcome instruments is recommended to better capture nuances of growth processes in therapy. For example, "To what extent do you feel therapy is helping you to become a better person?" and "To what extent are you becoming a less self-critical person?" (Levitt et al., 2005, p. 120) could be used in place of scaling questions pertaining to clients' level of satisfaction or agreement with predetermined item content based on preconceptions by third parties—which poses a precarious scientific ethic (DeRobertis & Bland, 2021).

Furthermore, continued research can inform richer conceptualizations of therapeutic progress that may be employed to formulate more relevant and rigorous outcome instruments that meet the requirements of the managed care system. Humanistic/existential psychologists have long favored (as well as developed) qualitative methodologies that are particularly conducive to (a) understanding clients' internal experiences as well as therapists' intentionality from their respective frames of reference, (b) identifying contextual factors to inform helpers' decision-making and enhance their responsiveness, and (c) transforming clients' experiences via the assessment process (Levitt, 2016). Through "hypothesis-generating, not hypothesis-testing" (Charon & Marcus, 2017, p. 282), qualitative methodologies can be employed to generate item content and wording by "[engaging] the imagination of clients" to better understand "the experience of change [that] consists of a qualitative shift into a whole new way of seeing the world," and doing so will help "move these systems away from being viewed as mechanisms for external managerial or societal control" (Rousmaniere et al., 2020, p. 569).

In addition, to better understand clients' experiences from within a cultural perspective (*emic*), qualitative methodologies can be employed to gain insight via a narrative stance (Charon, 2017a) regarding how cultures make sense of emotional well-being and threats to it. Used appropriately, this approach may also serve to enhance instruments (like the ANSA) that feature items about acculturation that, while well-intentioned, are built on *etic*

assumptions that can uphold discriminatory policies and practices (Charon, 2017b). Such humble positioning is essential to joining with communities that are skeptical of traditional helping models due to histories of systematic oppression (Smith et al., 2009), which arguably exacerbates race-based mental health disparities via underutilization of services (Harb et al., 2019).

Finally, humanistic and existential theorizing on self and growth processes (see Bland & DeRobertis, 2018; Grimes et al., 2019) can provide insight into attributes of psychological health and its cultivation identified by Levitt et al. (2005). Humanistic psychologists can advocate for having that better accounted for in the item content of revised and/or new outcome instruments.

Limitations

Despite the aforementioned strengths and contributions of these analyses, my study also has limitations. First, I employed summative content analysis of the three instruments to examine *how many* of their items reflected particular themes/subthemes (in Findings, Part 1) or humanistic domains/attributes (in Findings, Part 2) in a more categorical fashion. This was due primarily due to space limitations—and, to a lesser extent, for the sake of continuity with Levitt et al.'s (2005) analysis, which had used the same method. On the contrary, with a couple of notable exceptions, my analyses did not examine *how* the items were worded and/or how that wording could be potentially improved.

Second, the analyses in this article were limited to three instruments, and other instruments that may be commonly used in CMHCs today were omitted. Although it seems that the paradigmatic assumptions discussed in Findings, Part 1 would be applicable to other conventional instruments, further analyses using additional instruments are therefore recommended, especially to follow up on Levitt et al.'s (2005) content analysis. Similarly, third, both Levitt et al.'s and this analysis involved only adult assessment tools. A similar approach could be used to determine the extent to which humanistic principles are present in child mental health outcome instruments. Fourth, the humanistic therapy attributes presented in Part 2 are based solely on Levitt et al.'s thematic analysis. Some attributes (e.g., "resolution of anger specifically" and "change in the experience of grief/loss") are situational/context-bound and/or population-specific. Others (e.g., "how in-session exercises helped," "helpfulness of homework," "quality of dreaming") may be more or less relevant depending on the individual client's preferences as well as clinician's therapeutic style. Furthermore, despite it being a noteworthy contribution, the list of humanistic therapy outcomes is not exhaustive. In addition to the item content identified above in Findings, Part 2 that can be used to enhance the list, further content could also be added to better address

additional outcomes associated with existential therapy (see Vos, 2019) that are not currently included in Table 1. Finally, Pfaffenberger (2006), Levitt et al. (2005), and now this article pertain to mental health outcome measurement in the United States. Additional attention should be given to the extent to which the observations, arguments, and research findings presented in these articles about contrasting discourses in measurement-based care are relevant in therapeutic settings elsewhere in the world.

Conclusion

As we venture further into a fast-paced era of information overload and uncertainty, attraction to arbitrary criteria over expertise has become increasingly common (Muller, 2018), seemingly to uphold capitalistic and patriarchal values discussed 15 years ago by Pfaffenberger (2006). Muller cautioned against *metric fixation*, "the aspiration to replace judgment based on experience with standardized measurement" that "seems solid but is actually deceptive" in the interest of improving institutional efficiency. "The problem is not measurement, but excessive . . . and inappropriate measurement" that "may provide us with distorted knowledge" while drawing "effort away from the things we really care about" (pp. 3–4, 6). Similarly, Dewell and Foose (2017) "advocate for an extensive approach that addresses the complexity of being human through a widened lens"—a "historical, pragmatic, and interdisciplinary approach . . . that acknowledges the rich tradition of humanism while embracing current thinking" (p. 121).

As outcome measurement becomes further ushered in the direction of being conducted in relation to idiographic context and with emphasis on the therapeutic relationship, it moves closer to bona fide *assessment*, and not merely testing (Suhr, 2015), called for a generation ago by humanistic psychologists such as Fischer (1992). As noted by DeRobertis and Bland (2021), humanistic/existential psychologists are not one-sidedly averse to quantification, as they have been problematically criticized. Rather, they value and encourage epistemological pluralism and competency in multiple methods while also remaining critical of scientism as monoculture (see Gantt & Williams, 2018) that fuels Muller's (2018) aforementioned metric fixation and increasing focus on quantification at the expense of other, equally important perspectives that can enhance the quality of services in CMHCs. Doing so can help further demonstrate the contemporary relevance of humanistic/existential psychology in the interest of countering common misunderstandings of it as a mere historical relic (DeRobertis, 2013, 2016).

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