

## ABSTRACT

Title of Document: CLIENT PREFERENCES FOR INSIGHT-ORIENTED AND ACTION-ORIENTED PSYCHOTHERAPY

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Client preferences for psychotherapy style have been understudied, despite their value in adding to our understanding of psychotherapy process and outcome. Furthermore, current research trends point towards investigating the match between client and therapist in determining outcome (ATI research). One match that has not been studied as much is the match between client preference for type of therapy and therapist therapy style. Two styles that seem particularly important are insight- and action-oriented therapy, which are often distinct therapy approaches. Clients often come to counseling anticipating either receiving insight or making a plan for action. This research has implications for enhancing client outcome due to its promise to determine better client-therapist matches.

The present study employed an experimental laboratory method with two independent variables. The independent variables were client preferences for insight oriented therapy versus action oriented therapy, and counseling style provided (insight oriented therapy vs. action oriented therapy). Dependent variables were changes in target problem, relationship strength (RS), session depth, session evaluation (SES), therapist

credibility, and change in preference for insight versus action. Control participants watched a videotape of Carl Rogers performing psychotherapy.

Hypothesis 1 was that clients who receive their preferred therapy style will have a more positive outcome than clients who do not receive their preferred therapy style. Result indicated that hypothesis 1 was not supported. Hypothesis 2 was that credibility will be associated with better outcome. Results indicated that hypothesis 2 was partially supported. Hypothesis three was that match between client preferences and treatment received will be a greater predictor of outcome than credibility. Hypothesis 3 was not supported. Hypothesis 4 was that clients who perceive their therapists as credible will shift more towards the style received than clients who do not perceive their therapists as credible. Hypothesis 4 was not supported. Limitations and suggestions for future research are discussed.

CLIENT PREFERENCES FOR INSIGHT-ORIENTED AND ACTION-ORIENTED  
PSYCHOTHERAPY

By

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## Chapter 1: Introduction

Suppose a client really wants to be told exactly what to do in order to solve a particular problem, and s/he goes to a therapist who values passive exploration and insight above action. Unless either the client shifts his or her preferences or the therapist shifts his or her approach, one can imagine the outcome would be negative. Now consider a client who wants to work on existential concerns and figure out the meaning of the problem s/he is experiencing and is paired with a therapist who really enjoys working on existential issues. One can imagine that this pairing would be more beneficial given that the client's preference was fulfilled. These examples suggest that preferences are important to examine in treatment.

Although research on preference for psychotherapy style is scarce, more research has been done on expectations. Most researchers seem to agree about the importance of studying clients' expectations of treatment and the effect of these expectations on treatment process and outcome. These researchers have hypothesized that differences in clients' and therapists' expectations of therapy may influence the amount of conflict/rapport/satisfaction, as well as outcome (Duckro et al., 1979; Gladstein, 1969, June & Smith, 1983; Locker & Dunt, 1978; Tessler & Mechanic, 1975). This research needs to be extended to client preferences.

Up until the last 30 years or so, researchers failed to differentiate between expectations and preferences, leading to a blurring of the literature. Several authors (e.g. Duckro et al., 1979; Grantham & Gordon, 1986) have stressed the need to differentiate between expectation as the *anticipation* of an event and expectation as the *preference* for



an event, noting that the two usages frequently have been confounded in previous research. As the literature has begun to differentiate between expectation (or anticipation) and preference, scholars have begun to see the value of studying preferences as an important client variable (Arnkoff, Glass, and Shapiro, 2002), claiming that “client. . . preferences have been thought by many authors to influence the client’s willingness to engage in and be influenced by the therapist and the process of therapy” (p. 335). Elkin and colleagues (1999) have suggested that therapists should be aware of their clients’ preferences and should assess these preferences and be responsive to them.

Not only are client preferences potentially important, but the match between preferences and treatment is probably important. This has been referred to as aptitude by treatment interaction (ATI) research (Shoham-Salomon & Hannah, 1991). Although there is little research supporting the notion that the individual client should be matched to a particular treatment tailored to that client’s difficulties and other characteristics (Kopta, Lueger, Saunders, & Howard, 1999), most psychotherapy studies lack sufficient power to examine potential matches between client and treatment variables (Shoham-Salomon & Hannah, 1991).

Alternatively, it could be that it is the credibility of the therapist, rather than match between the therapist and client that matters. Strong’s (1968) social influence theory posits a two-stage process of interpersonal influence. In the first stage, the counselor gains influence by enhancing his or her perceived credibility. In the second stage, the counselor makes maximum use of the influence he or she has built in the first stage to bring about the desired changes in client behavior and cognitive framework.

Of particular interest are client preferences for insight- versus action-oriented therapy. Both these styles are well-established within the psychotherapy literature and many of clients' preferences fall within one of these two categories. Therefore, I will investigate client preferences for insight- versus action-oriented therapy and the influence of these preferences on treatment process and outcome.

## Chapter 2: Review of the Literature

This literature review will be divided into eight sections, each pertaining to a different aspect of this study. In the first section, I differentiate between preferences and expectations. In the second section, I examine the question “what are clients’ preferences?” using previous research as a guide. The third section examines the conflicting relationship between preferences and outcome. In the fourth section, I review Strong’s (1968) social influence therapy and how it can help inform this study. In the fifth section, I review literature pertaining to the change and/or maintenance of clients’ preferences before and after therapy. In the sixth section, I review literature that combines the relationship between preference and outcome and the malleability of client preferences. Seventh, I review the common limitations of this area of research and suggest ideas for future research. Finally, I review the theoretical base of insight and action oriented therapies, their relative efficacy, and future directions for investigating their efficacy.

### *Differences Between Expectations and Preferences*

Grantham and Gordon (1986) stated the following: “Expectation as anticipation and expectation as preference are different aspects of human cognition that warrant distinct treatment. Tinsley and Benton (1978) and Tinsley, Workman, and Kass (1980) emphasized expectancy in their work and used the terms expectancy, expectations, and preferences interchangeably. In doing so, they destroyed the distinction that theorists have been trying to draw for the last 30 years.” (p. 397). Much of the previous literature has generally failed to differentiate between preferences and expectations. Definitions of

the two terms vary from study to study, and rarely is a clear differentiation made. In this section, I review theory that has attempted to differentiate between these two concepts. Next, I review studies that have empirically differentiated between preferences and expectations.

Theory. The contradictory findings about the relationship between expectation and satisfaction may partly result from previous researchers evaluating expectations too globally. The tendency not to define expectation precisely may have accounted for the ambiguity in the literature (Duckro et al., 1979; Klepac & Page, 1974). Several authors (e.g. Duckro et al., 1979; Grantham & Gordon, 1986) stressed the need to differentiate between expectation as the *anticipation* of an event and expectation as the *preference* for an event, noting that the two usages frequently have been confounded in previous research.

Duckro, Beal, and George (1979) noted that a significant problem area in the research on role expectations (the client's expectation of the role that the counselor will play in his or her sessions) has been the ambiguous definition of *expectation*. Originally, the word clearly meant *anticipation* (Kelly, 1955), and the implication was that anticipation held some degree of certainty. Hence, many researchers (i.e. Pope, Siegman, Blass, & Cheek, 1972) were very careful to define expectation for their subjects as anticipation. Duckro and colleagues next differentiate between expectation as anticipation (the anticipation that an event will occur) and expectation as preference (the preference that some event should occur) as two different aspects of human cognition. However, most researchers in the area of role expectations have not differentiated between the two aspects, leaving their subjects to interpret expectation however they want.

Grantham and Gordon (1986) contended that the “problem has arisen because the psychotherapy and counseling literatures have used the word preference to refer to the process of arriving at a decisions, the elements considered, and the actual choice” (p. 396). They believed that preference is accurately defined as the choice one makes, not the process of arriving at the decision or the elements included in that choice. They differentiated between *deciding*, which refers to the processes that lead to choices, and *preference*, which refers to the choices that result from these processes. Deciding involves how certain characteristics of an object or situation are chosen over others. Preference contains two elements: affect and idealism. When a person makes a choice, he or she has both positive and negative feelings about alternatives that must be weighed. He or she subsequently chooses the alternative that makes him or her feel most positive. The preferred alternative reflects what the person estimates to be ideal.

Grantham and Gordon (1986) argued that preferences have three dimensions. The first dimension is that preferences are multidimensional and dynamic. One can have a preference about any number of characteristics simultaneously. Because of the potential affect linked to preferences, Grantham and Gordon (1986) contended that preferences can be ranked by priority. That is, not all the individual preferences will make a difference. The second dimension is that preferences operate at different cognitive levels (unconscious, preconscious, or subconscious). Whether conscious or not, people’s preferences will impact their behavior. Sometimes it is not until preferences are contradicted that people learn of their existence. Finally, both preferences and deciding are linked to a time dimension. They argued that the act of deciding is repeated over and over and new experiences are constantly being weighed, thus altering people’s

preferences. Hence, because decisions change, people's preferences change over time and are malleable.

Duckro et al. (1979) proposed that anticipation and preference are related hierarchically and that preference may be a more basic variable than anticipation. Helson (1964) suggested that preference was a more basic variable than expectation and that it must necessarily be known if one is to predict the nature of a given person's response to disconfirmation of an expectation. Hence, both Duckro et al. (1979) and Helson (1964) recommended that information be collected about clients' preferences in order to help predict the nature of a person's response to confirmation or disconfirmation of an expectation in terms of satisfaction.

Rosen (1967) recommended that client preferences for counselor characteristics be studied because of his belief that clients have implicit or explicit ideas concerning characteristics they would like manifested in their counselor. Such preferences might determine to a significant degree various aspects of the client-counselor interaction, and clients' subsequent evaluation of the counseling experience.

In summary, the history of differentiating between expectations and preferences has been complex, and the lack of early differentiation has been blamed for a lack of progression in the field. Duckro and colleagues (1979) differentiated between expectation as anticipation and expectation as preference as two distinct areas of human cognition. Grantham and Gordon (1986) defined preference as a choice, and as what the person perceives as ideal. They also claimed that preferences had three dimensions: they are multidimensional and dynamic, they occur at different cognitive levels, and they can be linked to a time dimension (are malleable). The definition of preference that was used

in this study is linked to Grantham and Gordon's definition: preferences are a client's choice of aspects of counseling that they believe would be helpful for them and would like to receive in their therapy.

Empirical Research. Empirical researchers (Tracey & Dundon, 1988; VandeCreek & Angstadt, 1985) began confirming the value of a preference-anticipation distinction in the late 1980s. In their 1988 study, Tracey and Dundon examined, among other things (reviewed later) the difference between role expectations and preferences. Thirty-three clients met with 11 counselors representing different experience levels (practicum students, interns, doctoral level counselors) in a large university counseling center. The clients were nonpsychotic and had an average Brief Symptom Inventory Global Severity Index *T* score of 49. The treatments lasted an average of 13 sessions, with the range between 1-34 sessions. The assignment of clients to counselors was made by a treatment team that tried to make the most appropriate match.

Before beginning treatment, and after each session, clients completed the Brief Symptom Inventory, as well as the Psychotherapy Expectancy Inventory-Revised twice (once with respect to how they anticipated counseling to be and once with respect to how they preferred counseling to be). Following each session, the counselors filled out measures of satisfaction and measures rating the client's functioning. Several measures were used as indicators of final outcome, including client self-report, therapist report, premature termination, and change in index scores.

In response to the first research question concerning the relation among initial client role anticipations and preferences, results revealed that there were significant differences between anticipations and preferences. For example, clients preferred less

approval than they anticipated receiving, whereas they preferred more advice and relationship than they anticipated receiving.

Although this study has a lot of positive attributes, particularly taking into account both anticipations and preferences, there are a number of limitations. One limitation is that the clients had already participated in an intake counseling session before being assigned to a counselor, which may have significantly impacted their preferences for a counselor. Particularly if counselors in this particular counseling center had similar theoretical orientation or a similar culture, the measurement of client preferences may have been more similar to their expectations based on the intake session. So although the results showed that anticipations and preferences differed, the results might have been more extreme if the preferences had not been influenced by an intake session.

Galassi, Crace, Martin, James, and Wallace (1992) investigated client preferences and anticipations in career counseling. Participants were students who sought career counseling at a university counseling center, and were representative of a counseling center population (22 men, 70 women). Their primary career concerns were career indecision, selecting a major, both, and other concerns.

The authors designed an open-ended questionnaire to assess clients' pre-counseling preferences and anticipations regarding career counseling. They asked about preferences and expectations related to number of sessions, what the client and counselor would do during sessions, what would occur between sessions, outcome or goal, and role of testing. The responses were unitized and coded into discrete categories. They developed the unitization guidelines with the data of one quarter of the participants for each question and then cross-checked for adequacy on the data of another quarter. Two independent



raters unitized the responses with an overall agreement rate of 94.3%. They then developed a coding system for each question. They first divided the data into halves. One quarter of the data was used to develop a response category system and another quarter of the data was used to cross check the adequacy of that scoring system. Their total agreement rate for coding category was 86.2%.

Results indicated that clients have clear preferences about career counseling, but their anticipations are somewhat less certain and less optimistic. There were also a number of mismatches between client preferences and anticipations. For example, significantly more clients wanted to have chosen or confirmed a career or major by the end of counseling than anticipated accomplishing these objectives. Clients also wanted to talk about specific careers and/or decision making significantly more than they anticipated doing so. They anticipated having to explore self and engage in good client behaviors more than they would have preferred. They preferred counselors to give advice and facilitate decision making more than they anticipated it happening. Galassi and colleagues also compared clients who had previous counseling to those who had not, and found almost no differences with respect to both precounseling preferences and precounseling anticipations. However, when preference-anticipation matches were considered, a few different mismatches were evident for participants with previous counseling as compared to those without.

Although there were only a small number of men in the sample, the authors drew tentative conclusions about gender. They found that gender differences did not play a role with respect to preferences or anticipations. However, there were more mismatches between expectations and anticipations for women. They concluded that gender

differences were likely to be found not in preferences and anticipations, but rather in the degree to which preferences and anticipations are in harmony.

In conclusion, Galassi and colleagues found that clients had fairly clear ideas about what they wanted, but were less certain about what career counseling would actually be like (and less optimistic). The clients anticipated accomplishing less of what they most preferred to accomplish. They also anticipated achieving more of the goals and activities that are less preferred.

Although Galassi et al. contributes to our understanding of the relationship between preferences and anticipations, there are a few limitations. Their conclusion that clients have fairly clear ideas about what they want warrant closer inspection because of the inconsistencies between their conclusions and their methods. Clients did not necessarily have clear ideas about what they wanted, rather they were required to fill out a measure asking them their preferences. Clients had to fill out the measure completely in order to participate in the study. A second issue is that this study does not incorporate any measure of the strength or clarity of people's preferences, rather it just measures what their preferences are. In addition, they conclude that clients were not clear about what they anticipate occurring in counseling. Again, this is impossible to measure using their methodology because clients simply indicated their anticipations on a measure that they were required to complete. The unitizing and coding system eliminated all multiple responses for an individual item, and thus there was no way that the system could measure strength of an anticipation or a preference.

Another limitation may be the order of inquiry, given that the investigators first asked about preferences and then asked about anticipations. One might wonder if the results

would have been different if the order were reversed. Perhaps one way to remedy this would be to ask half the sample about preferences and then anticipations, and ask the other half of the sample the same questions but in the reverse order.

In summary, both Tracey and Dundon (1988) and Galassi et al. (1992) found significant differences between anticipations (expectations) and preferences. Thus, it appears that expectations and preferences are two different concepts, and each should be investigated independently of one another. Thus, in this study we examine only client preferences.

### *What are Clients' Preferences?*

Although there is much research describing clients' expectations for counseling, research about clients' preferences for counseling is limited. Galassi, Crace, Martin, James, and Wallace (1992; reviewed above) found that career clients had fairly clear ideas about what they wanted (preferences) from career counseling. Particularly, clients wanted to have chosen or confirmed a career or major by the end of counseling, and wanted to talk about specific careers and/or decision making. Clients also expressed a preference for counselor advice and facilitating client decision making. Clients preferred assignments to read/research careers, internships/hands-on experience, and to interview people in careers. Finally clients desired career/person or major/person matches from testing.

Although this study provides valuable information about what clients prefer in career counseling, the results must be interpreted cautiously. The methodology of this study asked clients to describe their preferences for therapy, and thus in order to participate in the study they were required to record fairly clear ideas about what they preferred in

counseling. Thus, it may not be appropriate to assume that clients have clear preferences for counseling unless they are primed to think about what they would prefer before having counseling. In addition, these clients were asked what they prefer to happen in career counseling, and of course the results cannot be generalized to personal counseling.

In sum, although there is much research on client preferences for therapists' sex (Boulware & Holmes, 1970; Simmons & Helms, 1976), race (Acosta & Sheehan, 1976; Jackson & Kirschner, 1973), and response style (Fancher & Gatkin, 1971; Holen & Kinsey, 1975), there is little research answering the question of what counseling style clients prefer in counseling. Galassi et al. (1992) found that career clients wanted concrete results from the counseling, wanted to talk about specific careers and decision making, wanted counselor advice and directiveness, and hands-on experience in exploring careers.

#### *Relationship Between Preference-Treatment Congruence and Outcome*

Kelly (1955) said that almost all clients hold a highly personalized conceptualization of the nature of the psychotherapy relationship and of the psychotherapist's role. He argued that in the beginning stages of therapy, the psychotherapist must accept the client's preconception of the therapist's role, because failure to confirm the client's expectations results in confusion or disappointment. Many research studies were published that confirmed this hypothesis that disconfirmed expectations would result in negative outcome (Frank, Gliedman, Imber, Nash, & Stone, 1957; Heine & Trossman, 1960; Lennard & Bernstein, 1960). However, most of the research conducted after the 1960s either failed to support the negative effects of disconfirmed client expectancies or was equivocal (Volsky, Magoon, Norman, & Hoyt,

1965). Duckro et al. (1979) summarized the studies conducted between 1962 and 1979 and reported that 21 studies (49%) supported the hypothesized relationship that failure to confirm client expectations would result in negative consequences, while 22 studies (51%) did not support this hypothesis.

Tracey and Dundon (1988) summarized the discrepancies in the literature as a result of different ways of operationalizing the relationship between disconfirmed role expectations and negative initial outcomes. They described the *linear discrepancy model*, which assumes a linear relation of the discrepancy of role expectations and actual in-session behaviors with negative outcome. Researchers have traditionally failed to find a relationship between expectation and outcome using this model (Duckro & George, 1979; Heine & Trossman, 1960; Klepac & Page, 1974), although this model may hold true for client preferences for type of therapy (i.e. there may be a linear relationship between the mismatch of client preferences with received type of treatment and negative outcome, such that the more different the session is from what the client prefers, the more negative the outcome would be). If the model were to be disconfirmed, as it was with expectations, we would expect that there would be no relationship between client preferences match with received treatment and outcome.

As noted above, many studies have examined the congruency hypothesis as it relates to client expectations for therapist behavior. However, only seven studies were found that examined the relationship between client preference for a type of therapy and outcome. I review these here.

Devine and Fernald (1973) examined the outcome of receiving a preferred, randomly assigned, or non-preferred therapy. They suggested that “it is reasonable to

expect that as awareness of psychological treatments grows prospective patients will not select a therapy without comparing it with others” (p. 104). Thus, the purpose of their study was to investigate the effect a patient’s preference for treatment has on outcome. Specifically, they hypothesized that “subjects placed in a preferred therapy will show greater progress than participants who receive a non-preferred therapy or who are assigned a therapy without concern for their preferences” (p. 104).

Participants were selected from 725 undergraduate psychology students if they indicated on a brief questionnaire that they had an extreme fear of snakes. Out of 108 students with an extreme fear, 74 were randomly selected and invited to proceed to the second part of the selection process, which involved a behavioral rating scale consisting of asking each subject to approach a snake. Forty-eight students met the criteria on the behavioral rating scale and were able to participate in the actual study. Thirty-two participants were shown a 40-minute videotape of therapists conducting four approaches (systematic desensitization therapy, encounter approach, rational-emotive approach, and a combination of modeling and behavioral rehearsal). After viewing the tape, the participants were asked to rate their preferences for the four therapies and then were assigned to a therapy for which they either expressed an extreme liking or disliking. The additional 16 participants who did not see the tape and hence did not express a therapy preference were assigned across the four therapy groups. Therefore, there were 16 participants in each of the three conditions (preferred treatment, non preferred treatment, no stated preference). The therapists conducting the systematic desensitization, encounter, and rational-emotive conditions were Ph.D clinical psychologists with several years of experience, and one graduate student with little experience as a therapist

conducted the modeling-behavior rehearsal condition. Each condition met for two one-hour sessions. One week after the second therapy session, the behavioral rating scale (approaching the snake) was again administered to each subject.

Results indicated that most of the participants, regardless of the condition, showed significant improvement in fear reduction. However, there were differences between the conditions. Analyses revealed there were significant differences in fear reduction among those participants receiving the preferred therapy accompanied by the randomly assigned and nonpreferred therapy groups. Specifically, the participants receiving a preferred treatment showed less fear of the snake than those receiving either a randomly assigned or nonpreferred therapy.

In their discussion section, the authors suggested that when circumstances permit, clients should learn about various techniques and select the treatment that they prefer in order to attain better outcome. They explained their findings in three ways: first, perhaps the preferred therapy was effective because the participants expected it would be. Another explanation assumes that some therapies are more effective than others for a particular client, and that the client identifies in his or her preference ratings his or her awareness of this matching phenomenon. A third explanation is that once assigned a particular therapy, those receiving a preferred treatment may have tried harder to demonstrate a positive outcome than those assigned a nonpreferred treatment.

Although this was a very effective and well-controlled study, a few limitations are evident. First, the failure to differentiate the therapist and the intervention is important to consider. It is unclear whether the therapists in the videotape were the same therapists who later went on to conduct the sessions. In addition, it is unclear whether clients were

actually indicating preferences for the type of therapy or if they were indicating preferences for the particular therapist, perhaps based on attractiveness or likeability. Although preferences were still being measured in either case, the preference may have been for the therapist overall instead of for the particular treatment. Perhaps clients have stronger preferences for therapist gender, attractiveness, or likeability than they have for therapist techniques.

Another limitation was the assumption that the participants who did not view the videotape did not have clear preferences for a certain type of therapy. Preferences can be developed in many ways, and it is plausible that these participants had clear preferences for a type of therapy or for particular therapist characteristics that were not measured. Furthermore, we do not know if any of these clients had previously been in therapy, which may have furthered their development of a preference for treatment or therapist characteristics.

Yet another limitation was the failure to determine the strength of the preferences. This study simply determined whether or not the client had a preference for particular form of therapy, but failed to differentiate between people who had relatively stronger or weaker preferences. It is expected that clients entering therapy may have different strengths of preferences, and their reaction to therapy might not only depend on which preference they have but on the strengths of their preferences. Perhaps strength of preference should have been considered in analyses.

A final limitation was the sample size. Each of the three groups only had 16 participants, which is a very small number for testing for between group differences. Perhaps if the sample size was larger, and thus there was more power, significant



differences between the nonpreferred and the randomly assigned groups would have been detected.

In another study, Duckro and George (1979) hypothesized that failure to meet client preferences for high- or low-directive counselor style would adversely affect interpersonal process. They argued that this hypothesis can not be tested simply by demonstrating that clients do hold strong preferences, but that one must experimentally observe the results of situations in which preferences are met as compared with situations in which preferences are not met.

Forty-eight undergraduate psychology students were selected from a larger pool of volunteers on the basis of their strong preferences for high- or low- directive (the authors did not further define high- or low-directive) counselor style on the Therapist Behavior Scale. The Therapist Behavior Scale consists of 40 items that represent either high- or low-directive counselor behavior. In addition, students were asked to volunteer for the study only if they had a current significant personal problem to discuss in a single session with a counselor. Four experienced male third-year doctoral students conducted the sessions. Each counselor was assigned to the high- or low-directive response style on the basis of his typical counseling style, as determined by both the experimenters and the counselors.

The 48 participants were randomly assigned to the met or unmet preference conditions. Each counselor saw 6 clients whose preferences matched their style and six clients whose preferences did not. Following the 30 minute sessions, clients completed post-test measures and were debriefed. Dependent measures were duration of client

utterance, interviewee satisfaction, relationship satisfaction, and competence satisfaction. The independent variables were counselor style and client preference.

Results indicated that there were no significant interactions on any of the speech or satisfaction variables, thus demonstrating no evidence of any significant adverse effects of failing to meet client preference for the level of counselor directiveness. With the exception of competence satisfaction, there was a significant effect for each variable on counselor style. Clients of the highly directive therapists had significantly shorter mean utterance units, shorter response latencies, more silence, and greater satisfaction with the therapeutic relationship than did clients who saw the low-directive counselors.

There were a number of limitations to this otherwise well-conducted study. First, the investigators only recruited clients on the extreme ends of preferences for high- or low-directiveness. While this clarified their results, it may not be representative of clients in general who likely express a wide range of preferences for therapist behavior. Participants were selected for their strong preferences, and thus there is little variability. Perhaps by including participants with weaker preferences, we might see different results. Because of the selection criteria, these results are only generalizable to clients who already have high preferences for the directiveness of their counselor.

In addition, the authors claim that they selected the 24 students who expressed the highest preferences for high-directiveness and the 24 students who expressed the highest preferences for low-directiveness. They also happened to end up with 24 male and 24 female students assigned randomly to the conditions. I find it suspicious that the division of male and female participants happened to fall so evenly across levels of directiveness.

In another study, VandeCreek and Angstadt (1985) investigated the effects of client preferences (as determined by an adaptation of the Self Disclosure Expectation Scale (Tinsley, Workman, & Kass, 1980) which assessed long-term preference) and anticipations (based on exposure to a videotape) on client perceptions of the counselor and counseling process regarding counselor self-disclosure using a videotape analogue approach. There were two hypotheses. First, participants would rate the self-disclosing counselor more favorable than the non-disclosing counselor. Second, participants whose anticipations and preferences were confirmed by viewing a disclosing or non-disclosing counselor would give higher ratings of the counselor than participants whose preferences and anticipations were disconfirmed.

Participants were 120 female undergraduate psychology students who were pre-selected to participate based on their responses to a Preference for Self Disclosure Scale. This scale asked participants to describe their preferences about counselors' self disclosure regardless of how they might expect the counselor to act. Students scoring in the top fourth (preference for high disclosure) and in the bottom fourth (preference for low disclosure) and who had no previous counseling experience participated. The participants in both the high and low preference groups were randomly assigned to one of four experimental conditions: (a) high anticipation of counselor self-disclosure/self-disclosure present, (b) high anticipation/self-disclosure absent, (c) low anticipation/self-disclosure present, and (d) low anticipation/self-disclosure absent. Thus, there were 15 participants in each cell.

In the high anticipation conditions, clients were told via videotape instruction what counselor self-disclosure was, and were led to believe that counselors generally

think it is beneficial. In the low anticipation condition, clients were told via videotape instruction that counselors generally do not think self-disclosure is effective in counseling. The clients then viewed a videotape of a session and were asked to imagine that they were the client. The clients in the self-disclosure conditions viewed a tape in which there were six counselor disclosures. The clients in the non-disclosure conditions viewed the same tape except without the disclosures. They were then asked to fill out the dependent measures (counselor-client relationship, counselor personality, manipulation checks) and were debriefed.

Results indicated that the first hypothesis, that participants would rate the self-disclosing counselor more favorably than the non-disclosing counselor, was confirmed (there was a main effect for self-disclosure on all the outcome measures). The second hypothesis (that participants whose preference and anticipation are aligned with a disclosure condition will produce higher ratings of the counselor than will participants whose preferences and anticipations are not aligned) was not confirmed on any outcome measures. The three-way interaction between preference, anticipation, and self-disclosure was significant for both the counselor-client relationship and the counselor personality outcome variables. Participants gave higher ratings of the counselor when they preferred disclosure, anticipated disclosure, and then viewed a disclosing counselor. However, participants with low preferences and low anticipations who viewed a non-disclosing counselor (confirmed condition) gave lower ratings of the counselor than did participants who viewed a disclosing counselor. The authors suggested that the presence or absence of self-disclosure may be a more powerful variable than preference or anticipation.

Limitations to this study include its analogue nature and its generalizability to actual counseling. Watching a portion of a session on a videotape portraying a client's concern makes it difficult for a participant to imagine themselves as that client, particularly given that these participants were selected because they had no counseling experience. A significant part of counseling sessions is the relationship, and it is hard for an observer of a videotape to imagine a relationship with the counselor similar to that of a client.

Another limitation to this study is the audiotaped instructions that were prepared to instill an anticipation about the likelihood of a counselor using a self-disclosure. In the videotapes, the counselors either said that they believe self-disclosure is beneficial, or is not beneficial. They did not give any indication as to the likelihood of self-disclosure occurring, rather they gave an opinion about its effectiveness. As VandeCreek and Angstadt acknowledged, "informing participants about what counselors believe may not be the same as informing them about how counselors behave. In addition, this anticipation manipulation may have provided criterion that participants then used to evaluate the counselor" (p. 212). It is very possible that the participants were being primed for something other than preferences (for example, how much value they place on authority).

A final limitation to this study is that, similar to the previous studies, participants were selected on the basis of their strong preferences for either a high- or low-disclosing therapist. Because of restricting the variability of strength of preference, these results can only be generalizable to clients who already have strong preferences for the level of disclosure of their therapist.

In their study, Atkinson, Worthington, Dana, and Good (1991) proposed to (a) identify clients' beliefs about the causes of psychological problems and identify their preferences for counseling, and (b) determine if the beliefs and preferences are related to each other or to the sex of the client. There were two parts of the study. Participants in Part 1 were 232 clients (45 men, 186 women, 1 undisclosed) who sought counseling at a major West Coast university counseling center. Participants in Part 2 were 69 clients (7 men, 62 women) who completed the follow-up measure (a subset of participants in Part 1).

In Part 1, clients were administered the initial client questionnaire which contained three sections before receiving treatment. The first section requested basic demographic information. The second section assessed the respondent's beliefs about the causes of psychological problems. The third section asked participants for their preference for counseling orientation based on the thinking, feeling, and acting schema presented by Hutchins (1984). The authors presented Hutchins' descriptions of each orientation and asked the clients to rank their preferences for each on a scale from *highest preference* (1) to *lowest preference* (3). Clients then received between one and 12 sessions of counseling.

In Part 2, clients were administered the follow-up client questionnaire following treatment, which contained four sections. The first section asked clients to rate their therapists on the Counselor Effectiveness Rating Scale (CERS; Atkinson & Wampold, 1982). In the second section, the clients were asked to rate their satisfaction with counseling on the following three items: "How satisfied are you with the counseling you received from this counselor?", "How satisfied are you with the counseling orientation

used by this counselor?”, and “Indicate how well you feel this counselor understood your problem”. The third section was a follow-up measure either given to clients on their termination session, or mailed to clients when they failed to return. Clients again ranked the causes of psychological problems and their preferred counseling orientation. In the final section, clients (a) indicated the counseling orientation that they thought best represented the orientation used by their counselor; (b) rated how similar to their own beliefs they judged their counselor’s beliefs about the causes of psychological problems; and (c) identified their counselor by name.

The therapists in the study were counselors in a counseling center with a range of experience. They completed a questionnaire consisting of three sections. The first section contained demographic questions. In the second section, they ranked their beliefs about the six causes of psychological problems, and in the third section they ranked their preference for counseling orientation. Counselors were only asked to complete the questionnaires at the outset of the sessions, assuming that their beliefs and preferences did not change over the course of counseling.

Results indicated that clients and therapists both ranked feelings orientation as their most preferred counseling orientation, followed by thinking. Belief about the causes of psychological problems and client ethnicity (i.e. minority or nonminority) were not related to preferred counseling orientation. Sex, however, was significantly related to client preferences. Specifically, women disproportionately preferred a feeling orientation, whereas men disproportionately preferred the thinking and acting orientations.

The authors found significant differences for sex and age in clients who responded to the follow-up questionnaire and the clients who only completed part 1.

Respondents who were female and older were more likely to return the second questionnaire. There was no relationship between preference match/mismatch and CERS ratings or satisfaction ratings. In addition, simultaneous multiple-regression analyses revealed that perceived-belief similarity was a significant predictor of total CERS, satisfaction with counseling, satisfaction with counseling orientation, and feeling understood, such that those who believed that their etiology belief was similar to that of their counselor had higher satisfaction with counseling.

Although there were many aspects of this study that were methodologically sound and even sophisticated, there were also a few areas in which more information was needed. In the participants section, the authors collected a number of different demographic variables, but one that would have been important to know is whether the clients were seeking or receiving career counseling and/or emotional-social counseling. The type of counseling they were expecting to receive may have impacted their preferences as well as their ideas about the etiology belief.

Another limitation of this study was their use of Hutchins' counseling orientation categories. The reader would have benefited from more information about this measure and particular items on the measure in order to better understand the results. It is also concerning that Hutchins' categories do not seem to distinguish counselors in terms of their preferred theory of psychotherapy (i.e. psychodynamic, humanistic, cognitive behavioral), especially since they continually refer to client and counselor responses to Hutchins' categories as their counseling orientation. In addition, in the second part of the follow-up questionnaire, clients are asked to rate how satisfied they are with their counselor's orientation. It seems presumptuous to assume that clients are familiar with



the term *counselor orientation*, and I wonder if clients used a common definition of that term to answer the question.

Yet another major limitation to the methodology of this study has to do with the authors' assumption that counselors were unlikely to change etiology beliefs or preferences over the course of the study. One of the counselors in the study was 24 years-old, and likely either a trainee or a new employee, and it is possible that over the course of an academic year, she/he may have shifted beliefs and preferences. The authors are assuming that the social influence process only goes one way (therapist to client), but fail to test the alternative hypothesis.

The procedure section was detailed and informative, though it still had some limitations. They included both clients who had never been seen for counseling before and clients who had been to counseling before with a different therapist, however they did not test for differences. A test of differences on the main study variables for clients with previous therapy experiences and new clients probably would have been a valuable addition to the study, in order to know what effect (if any) previous therapy has on outcome.

The results indicate that the data collection procedure was not very well controlled. The authors reported that some clients completed the follow-up measure after up to 12 sessions, while the protocol was to collect them after only 3 sessions or fewer. The authors did not test for any differences between clients who saw their therapists for more or fewer sessions. It is possible, for example, that clients who saw their counselors for longer before completing the follow-up measure would experience more of a shift

toward their counselor's etiology beliefs than those who only saw their counselors for one session.

Another problem with this study involves the very low response rate (30%) for the follow-up questionnaires. It is possible that the clients who returned the follow-up measures had a higher rate of satisfaction with their therapy experience. In this case it would have been easier for clients to return the paperwork if they received it from their counselor at their planned termination than if they received it by mail months later (if they did not return for a termination session).

One major concern with the results has to do with the analyses using sex as a variable. The original sample size was very imbalanced (45 men, 186 women), and the sample size after follow-up was most likely inadequate to use for sex analyses, as there were only 7 men in the sample. Yet the authors conducted analyses using both these samples. The results from these analyses should be greatly qualified by a discussion of the low sample size, and yet the authors did not mention this in the results section.

Another concern with the results section is the authors' collapsing categories in order to perform chi-squares. They collapsed ethnicity to just two categories: minority and non-minority. While collapsing categories may have been necessary because of the sample size, there is a lot of empirical evidence that demonstrates that clients of different ethnic backgrounds and acculturation levels have different preferences for counseling styles (Li & Kim, 2004; Kim, et al., 2002).

The authors also fail to take into account nesting issues with the data, given that only 17 counselors saw 69 clients. Thus, each counselor was likely to see more than one participant in the study, and yet none of the analyses controlled for these effects. What is

more, the authors didn't report the range of the number of clients that each counselor saw.

The fourth study in this area was conducted by Elkin et al. (1999) and tested for congruence between a patient's treatment assignment and his or her predilection for a particular form of treatment. While Elkin et al. (1999) refer to the client's predilection, the term is congruent with the definition of preference in this literature review. They define predilection as "both the patient's beliefs about the causes of their problems, and about what will be helpful in treating their depression" (p. 439).

The assumption underlying this study was that certain patients are more suitable for certain treatments because of the way in which they conceptualize their problems. Elkin et al. hypothesized that congruence between predilection and treatment assignment would be related to (a) patients' remaining through the first four weeks of treatment, (b) more positive scores on a measure of the patient's perception of the therapeutic conditions provided by the therapist, (c) higher ratings of patient's contribution to the therapeutic alliance, and (d) lower scores on a measure of depressive symptomology.

This study was conducted as part of the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program (TDCRP) which involved 250 patients randomly assigned to four treatment conditions: Cognitive Behavior Therapy (CBT), Interpersonal Psychotherapy (IPT), Imipramine plus Clinical Management (IMI-CM), and a Placebo plus Clinical Management (PLA-CM).

Participants in the study were experiencing a current episode of Major Depressive Disorder and had a high score on the Hamilton Rating Scale for Depression (HRSD).

The 28 therapists who took part in the study were carefully selected and trained to carry

out their manualized treatment of the particular condition they to which they were assigned.

Clients completed the predilection measure which asked for a clients' preferences for certain types of treatments. In order to identify patient's predilections for a certain treatment, they used a profile of their mean scores on the three scales. They identified 43 patients with a CBT profile, four patients with an IPT profile, and 24 patients with a Medication profile. Twenty-eight patients had high scores on both CBT and IPT but not Medication, and were labeled as a "psychotherapy profile." Thus, the data analysis focused on these 99 patients who had identifiable predilection profiles. Clients who were not included in the study had no identifiable predilection profile.

The hypothesis that patients with treatment assignments congruent with their predilections would be less likely to be early terminators was supported. The hypothesis that patients in the congruent group would have more positive scores on the patient's perception of therapeutic conditions and higher ratings of the patient's contributions was also supported. Finally, the hypothesis that patients with treatment assignments congruent with their predilections would have lower scores on a self report measure of depressive symptomology was not supported.

Although the amount of variance accounted for was small, Elkin et al.'s results suggest that patient-treatment fit is indeed important to consider in treatment. There are, however, a few limitations to this study. One limitation has to do with the treatment used. The treatments were manualized which limits the external validity of the results. In most actual therapy, there is an interaction between client and therapist, with each responding to one another. A manualized treatment limits the spontaneity of the session.

It assumes that a client enters therapy with a preference, but that the therapist never acknowledges or adjusts to that preference because he or she is limited in what he or she can do.

Another limitation of this study is the possible restricted variance in the preferences of the patient sample. Only participants who were willing to be randomly assigned participated, indicating that perhaps there were clients with very strong preferences about one of the treatments who could not participate because of their lack of agreement with random assignment. Thus, the sample of participants may have had preferences that were weaker or stronger than a general population.

A final limitation, much like the previously critiqued studies, is the lack of variance in strength of preferences. Participants were selected because of the strength of their preferences, and thus any conclusions must be tempered by the limited generalizability to clients who show strong preferences for certain treatment types.

Bakker et al. (2000) conducted the fifth study in this area. They investigated the influence of preference on outcome of panic disorder patients by comparing cognitive therapy (CT) by allocation (clients who were randomly assigned to receive CT) versus CT by preference (clients who chose to receive CT). Thirty-five patients were randomly assigned to CT as part of a randomized trial of medication versus CT. Thirty-one patients who had refused randomized treatment because they were unwilling to take medication were assigned to the condition of CT by preference (they would not take medication but would receive CT). The clients were predominantly female (74%), the mean age was 33.9 years (SD 8.3), and the average duration of complaints was 7.3 years (SD 6.8).

The CT consisted of 12 weekly 45-minute sessions by experienced psychologists and psychiatrists. The treatments were standardized by a treatment manual following Clark's (1986) version of CT, and the sessions were discussed weekly with a supervisor to ensure that treatment was delivered correctly. No further information was provided in the article regarding the therapists (i.e. age, gender, experience, style, etc.), nor the treatment.

Patients' frequency and intensity of panic attacks and agoraphobia were measured using a number of scales administered before and after completion of the sessions. The authors reported that there were no significant differences at pretest between the preferred and allocated treatment groups on any of the demographic variables or the efficacy measures. At posttest, both treatment conditions demonstrated significant time effects on all measures except two, indicating that in both conditions, anxiety, agoraphobia, and social disability were somewhat reduced, thus the treatment generally was efficacious. However, there were no differences between the randomly assigned group and the preference group on any of the efficacy measures at posttest.

Another significant limitation to this study is their operationalization of the term *preference*. In this study, the authors categorized any client who refused randomized treatment because they were unwilling to take medication as preferring CT. There are a number of flaws to this contention. First, the participants may not have been expressing a preference for cognitive therapy, specifically as there are a few other possibilities as to why they would refuse randomization. Perhaps they were not expressing a preference for CT as much as they were expressing a disliking of medication. Another possibility is that there may have been characteristic differences between groups that were not tested for.

One that comes to mind is reactance. Perhaps the people in the preference for CT group were not expressing a preference for CT, but rather they were more reactant to being told what to do. Alternatively, perhaps the preference group was expressing a desire to control their treatment, instead of being randomly assigned. It is inaccurate to say that clients are choosing CT because of the limitation of choices. The patients instead were accepting psychological treatment as opposed to pharmacological treatment, but there are many different kinds of psychological treatment available. It would be informative to know how the patients were presented with these choices, because it is possible that the presentation of these choices may have influenced their decisions.

Another limitation of this study is that none of the clients were assigned to a group for which they did not have a preference. For example, none of the people preferring a psychological treatment (refusing randomized treatment) were actually assigned to take medication. Conversely, none of the patient's preferring medication were assigned to the CT condition. We also do not know the intensity of people's preferences. Did the people in the preferences condition have stronger preferences than the people in the randomized group, or were they just more confident or assertive in their ability to say what they want?

Although most of the research conducted on client preferences for type of treatment and outcome has been done by psychologists, medical research has also participated in the debate. For example, a study by Chilvers et al. (2001), examined whether outcomes were similar for patients with randomly allocated treatment and those expressing a treatment preference for either antidepressant therapy or traditional talk therapy.

Patients were aged 18-70 and met the criteria for major depressive disorder. One hundred and three of these patients were randomized to either a medication or counseling condition, and 220 patients were recruited to their preferred condition. Patients who refused randomization (because they didn't want drugs) but agreed to participate were given their treatment of choice, which was the counseling condition. Patients in the counseling condition were given six sessions of counseling by experienced counselors who used whichever theoretical approach they felt was most appropriate. Patients in the medication condition were given appropriate medication. All patients completed depression measures before sessions, and at a follow-up (8 weeks and 12 months). Outcome measures were the Beck Depression Inventory, time to remission, global outcome, and research diagnostic criteria for the DSM-IV.

Because there was no evidence for an interaction between treatment type and preference, the randomized and patient preference groups were combined. There were no differences in global outcome between the randomized or patient preference conditions when outcome was split into good or moderate versus poor. Patients treated with antidepressants recovered more quickly than those receiving counseling, but patients preferred counseling to antidepressants. The investigators concluded that counseling seems to be as effective as drugs when people are mildly to moderately depressed, but patients receiving antidepressants may improve more quickly. They also concluded that general practitioners should allow patients to have their preferred treatment (although they had no findings that supported this recommendation).

Their conclusion that general practitioners should allow patients to have their preferred treatment is surprising given the lack of clarity of their results. They found that



there was no evidence for an interaction between treatment type and preference, so they combined the randomized and patient preference groups. This seems to suggest that they would conclude that it is not important for patients to have their preferred treatment. They did find that 80% of patients choosing counseling and 85% of patients choosing antidepressants had recovered at 12 months, but they failed to compare this to the randomized sample. Thus, the validity of their conclusions seems flawed.

The fact that they did not investigate the effect of giving an alternative treatment to those with a specific preference is a significant limitation to this study. Because of this, their study only compared clients who *had* a preference and clients who did not. However, they interpreted their results as a comparison between clients who *received* and *did not receive* their preference.

The lack of significant results may be related to the lack of control in the study. They do not specify the number of patients who refused to participate in randomization, but they allowed these clients to participate in the patient preference conditions of the study. Hence, people who were randomized were likely to be people who had fewer or weaker preferences for a type of treatment. In addition, the findings that patients receiving antidepressant treatment recovered faster than the patients receiving counseling may be skewed by the fact that a lot of the outcome evaluation was provided by physicians who provide more antidepressant therapy. These physicians may be looking for outcomes or symptom reduction that is more indicative of response to antidepressants than to counseling.

Summary. Out of the seven studies reviewed in this section, two found positive results indicating some relationship between preference-treatment congruency and

outcome. Devine and Fernald (1973) found that preferred therapy produced significantly more fear reduction than nonpreferred therapy. VandeCreek and Angstadt (1985) found that when both preferences and anticipations were met, clients rated disclosing counselors higher.

Three out of the seven studies reviewed in this section did not find any relationship between preference-treatment congruency and outcome. Bakker et al. (2000) found no differences between subjects receiving cognitive therapy by preference or by allocation. Atkinson et al. (1991) found no relationship between preference match or mismatch and outcome. Finally, Duckro and George (1979) found no evidence of significant adverse effects of failing to meet client preference for the level of counselor directiveness.

Two of the studies had mixed results. Elkin et al. (1999) found that congruence between predilection and treatment assignment was negatively related to patients' attrition, positively related to facilitative conditions, and therapeutic alliance, but not related to change in depression. Finally, although Chilvers et al. (2001) found no immediate impact for congruency of preference and treatment on outcome, at 12 months more patients in their preferred group receiving counseling were recovered.

Hence, it appears that this body of literature is mixed. While some studies have found a relationship between preference-treatment congruency and outcome, others have not. Because of the inconsistency of results, one might wonder if there are variables that may mediate or moderate the relationship between preference-treatment congruency and outcome. In the next section, I explore Strong's (1968) social influence theory as yielding one possible mediator in this line of research.

### Social Influence Theory

Strong's (1968) social influence theory posits a two-stage process of interpersonal change as a framework for understanding how attitude change takes place in counseling. The first stage occurs when the counselor gains influence power by enhancing his or her perceived credibility. Credibility can be thought of as consisting of at least three factors. The first is counselor expertness. The expert counselor is rational and knowledgeable and exhibits confidence in his or her presentation. Expertness can also be conveyed to the client by the presence of diplomas and certificates on the counselor's office wall. A second factor is counselor trustworthiness, which is conveyed in the counselor's reputation for honesty. The counselor is seen as sincere and open with a perceived lack of motivation for personal gain. Strong felt that, other things being equal, trustworthiness is more important than expertness. (Strong, 1968). A third factor to counselor credibility is counselor attractiveness. This is the perception on the part of the client of the counselor's likability, similarity, and compatibility. All of these factors set the stage for the influence process to take place. The second stage of the social influence theory is when the counselor makes maximum use of the influence power he or she has built in the first stage to bring about the desired changes in the client.

Empirical studies have attempted to validate the social influence theory. Barak and La Cross (1975) studied counselor ratings by 202 subjects using a measure of credibility based on the theory. Participants rated counseling films by Rogers, Perls, and Ellis. Ratings were factor analyzed. The findings supported the existence of the perceptions of varying degrees of counselor expertness, trustworthiness, and attractiveness. In another study, the relationship between expertness and attractiveness in

determining counselor influence was examined. Strong and Dixon (1971) found that expertness masks the influence of attractiveness and that, without expertness, attractiveness matters. Most studies of the theory have focused on the first stage of the influence process, setting the stage for influence (Heppner & Claiborn, 1989). The second stage of the influence theory, the actual influence process itself has not received much, if any, empirical attention.

Strong's (1968) social influence theory may have implications for determining how clients' preferences change during therapy. The second stage of the theory involves the counselor using the power they have established with the client to influence change. One of the variables that the therapist likely influences is the clients' original perceptions of what he or she would have preferred in counseling. Perhaps even when a client's preference is incongruent with the therapist's style, a positive outcome can still be achieved if the therapist makes use of the power they have established and influences the client's perception of what is helpful in therapy.

Because of the possibility of therapists influence on clients preferences, an investigation of exactly if or how clients' preferences change is provided in the following section.

#### *Change/Maintenance of Preference Before and After Therapy*

While the studies above examine the relationship between preference-treatment congruency and outcome, another important consideration to this line of research is the actual stability or malleability of these preferences over time. Perhaps preferences change over the course of treatment is a result of the outcome of the treatment. That is, if treatment is successful, perhaps preferences shift towards being more consistent with the

type of treatment received. Conversely, perhaps preferences become less consistent with the received treatment when the treatment outcome is negative.

Why does this matter? Duckro et al. (1978) reasoned that “if clients’ preference could be easily shaped by experimental manipulation, then there would be less reason to believe it to be an important event in therapy” (p. 300). Conversely, if clients’ preferences are not easily shaped by therapy, and if giving clients their preferred treatment results in a positive outcome, it may be efficacious to allow clients to choose their preferred treatment. Thus, in order to thoroughly address the relationship between client preferences for type of therapy and outcome, we must also address the relative stability or malleability of client preferences across the course of treatment.

In an early study of changes in clients’ preferences during counseling, Pohlman (1961) differentiated between client preferences and expectations, arguing that “studies of changes in client expectancies do not tell us about changes in client preferences” (p. 340). Pohlman recruited clients from a pool of students from a “how-to-study” course. Thirty-eight clients participated in the counseling condition, and 70 clients were in the non-counseled condition. The students were able to decide for themselves which condition (counseling or non-counseled) they preferred to be in. Eleven counselors conducted the counseling sessions.

Thirty statements of counselor behavior were listed and were hypothesized to represent three areas of prediction. Examples include “tell me what he thinks I should do” and “understand my true feeling.” Before counseling, and after a maximum of eight interviews, clients rated how often they would like each behavior to occur. After a maximum of eight interviews, clients also rated how often the behavior had actually

occurred. Controls in the non-counseled condition rated before and after the period of counseling how often they would like each behavior to occur if they were to see counselors.

Pohlman tested four hypotheses. For the first hypothesis that “the over-all change in client preferences will be significantly greater than the change in control preferences” (p. 340-341), significant differences in the predicted direction were indeed found. For the second hypothesis that “there will be significant item shifts in client preferences during counseling, in consistent directions for particular items” (p. 341), there were nine significant item shifts in client preferences for the counseling condition, whereas controls showed significant shifts on only three items. That is, clients shifted their preferences more than participants who did not receive counseling. The third hypothesis, that “as a whole, client preferences after counseling will be closer to what counselors actually did (as reported by clients) than client pre-counseling preferences” (341-342) was not confirmed. For the nine items with significant shifts in client preferences, eight shifts moved away from what counselors actually did. Finally, the fourth hypothesis that “there will still be significant item differences at the end of counseling between client preferences and reports of what actually happened, consistent in direction predicted for each item” (p. 342) was supported. Clients shifted their preferences over the course of counseling.

There were many limitations to this article, but probably the most disconcerting one was the brevity of the article and the lack of detailed information. Almost no information was provided on the 11 counselors who participated in the study. Toward the end of the article, it mentions that the counselors were beginners, however we do not

know exactly how much or what kind of experience and training they had, their theoretical orientation, or the instructions they were given before conducting the sessions. We also do not know the gender of the therapists. This may seem trivial, however the behavioral rating system consistently uses the pronoun “he/him/his” to refer to the counselor.

In addition, we do not know how many sessions each of the counselors conducted (there were 11 counselors and 38 sessions). Nesting may have been an important factor in analyzing the data, however there is no indication that this was taken into consideration. It is theoretically possible that one counselor conducted a disproportionate number of the sessions, and that this counselor may have impacted their client’s preferences differently than the other counselors.

The information provided on the client participants in this study was also scarce. The author only says that they were recruited from a “how-to-study” class. No information is provided about their age, gender, education level, or about the particular issue they discussed in therapy. We could expect that the instructions clients received about what to discuss in the session could influence their preferences for certain behaviors. If they were told that their counselor would help them solve a particular problem, we would expect that clients would prefer more directive interventions and would maintain those preferences. However, if clients were told that they were expected to discuss an emotional issue with an impartial listener, they might prefer the less directive interventions.

Another limitation has to do with the coding system used to classify client behaviors. Not only did the author provide no information on how this behavioral coding

system was developed or validated, but the measure seems to assume that every counselor did the same behavior identically. For example, one of the behaviors listed was [my counselor] “tells me what he thinks I should do” however it is important to realize that this intervention could be delivered in a variety of different ways depending on the context of the session. There is a big difference between a counselor giving a tentative suggestion for action after a number of sessions of thorough exploration of the client’s issue and a counselor making a harsh suggestion for action within the first five minutes of the session. Clients may prefer that their counselor display this behavior in a certain way before the session, but after the session be displeased with the way it was displayed and thus not prefer it. In that case, the preference would reflect the manner in which the intervention was delivered as opposed to the actual intervention.

A final limitation is that the students were able to decide for themselves whether they wished to participate in a counseled or non-counseled condition. Not only does this violate the assumption of random assignment, but it also may have influenced the participants’ selection of preferences. The participants choosing to engage in the counseling condition may have had more distinct preferences for counselor behaviors than the participants who chose not to be clients.

Duckro, Beal, and George (1978) also investigated the malleability of client’s preferences for type of therapy. They proposed to attempt to establish preference for either a highly-directive or low-directive therapist’s style for randomly assigned groups. Because of the brevity and vagueness of the article, it is very difficult to determine exactly what took place in this study. The authors claim that 62 undergraduate psychology students were randomly assigned to six experimental groups, however they



failed to mention what the six experimental groups were. Three pre-test conditions completed the Therapist Behavior Scale which measured participants' preferences for high or low directiveness of their counselors. The Therapist Behavior Scale consists of 40 items that represent either high- or low-directive counselor behaviors. The other three conditions completed filler measures. Three weeks later four treatment groups (again, it is unclear which groups) viewed one of two videotaped psychotherapy sessions, and then each of the members in all 6 conditions completed the Therapist Behavior Scale.

Results indicated that significant differences were found across the experimental conditions, such that people exposed to the high directiveness videotape reported greater preference for that style than did the group shown less directive therapy, and, to a lesser extent, the control group. Thus, the implication is that preference for high or low directiveness in a therapist is not necessarily a strongly held view because it could be shaped by the videotape.

One must be very hesitant in interpreting these results because of the many limitations to this study. The main limitation in this study is that the authors did not explain their methods or results very clearly and the article is very difficult to understand. For example, in the Instrument section, the authors say that a higher total score on the Therapist's Behavior Scale represented a greater preference for the therapist's directiveness. However, the table in the results section claims that the pretest score for the *more directive* condition was 83.7, while the pretest score for the *less directive* condition was 100.0. Furthermore, the table identifies conditions 1 and 2 as more directive, conditions 2 and 3 as less directive, and conditions 5 and 6 as control groups, but fails to differentiate between the conditions in each category. It can likely be assumed that the

conditions in each category each received a different intervention, but nowhere in the article does it describe which condition received which intervention.

A less severe limitation of this study is the use of a videotape analogue methodology, which limits its external validity. Participants viewing a videotape of a therapy session may not have the same motivation or reactions as a client actually sitting face-to-face with a therapist, and thus we must be careful in generalizing these results to a counseling setting.

Summary. In both of the studies reviewed in this section, it appears that preferences are malleable. Duckro et al.'s (1978) study is very difficult to interpret, but it appears that they found that preferences are malleable. Pohlman (1961) found that client preferences shifted away from what counselors did. After counseling, Pohlman found that there were significant differences between what clients preferred and what they received.

Pohlman's (1961) study contributed to the field of client preferences due to its differentiation between client preferences and expectations, and its effort to break down client preferences into different aspects of the therapy session. A thorough investigation of clients' preferences for different behaviors yielded results that set the stage for future research. Though most future research studies in the preferences area focused on a broader investigation of client preferences, Pohlman's study should not be forgotten, as it illustrated that change in preference was significantly greater in the therapy condition, and that there were significant differences between what clients preferred after counseling and what they received. While Duckro et al.'s (1978) study was difficult to interpret, it contributed to the literature by using an experimental methodology to

examine an important question. It is likely that if the study were more adequately described, the results could be interpreted more confidently.

*Review of Research Articles Combining the Congruency Hypothesis and the Shift Hypothesis*

As explained above, in order to thoroughly address the relationship between client preferences for type of therapy and outcome, we must also address the relative stability or malleability of client preferences across the course of treatment. An ideal study would combine the congruency hypothesis and the shift hypothesis into one study. Very few studies have undertaken this responsibility, but the following two studies attempt to draw together the literature by combining the two areas of study.

In their 1988 study, Tracey and Dundon examined the difference between role expectations and preferences, the relationship between preference-treatment match or mismatch and outcome, and changes in client role preferences as a function of outcome and treatment length. As reviewed earlier, thirty-three clients met with 11 counselors representing different experience levels (e.g. practicum students, interns, doctoral level counselors) in a large university counseling center. The clients were nonpsychotic and had an average Brief Symptom Inventory Global Severity Index *T* score of 49. The treatments lasted an average of 13 sessions, with the range between 1-34 sessions. The assignment of clients to counselors was made by a treatment team that tried to make the most appropriate match (though no detail on criteria for an appropriate match was provided).

Before beginning treatment, and after each session, clients completed the Brief Symptom Inventory, as well as the Psychotherapy Expectancy Inventory-Revised with

respect to how they anticipated counseling to be and with respect to how they preferred counseling to be. Following each session, the counselors filled out measures of satisfaction and measures rating the client's functioning. Several measures were used as indicators of final outcome, including client self-report, therapist report, premature termination, and change in index scores.

The first research question concerning the relation among initial client role anticipations and preferences revealed that there were significant differences between anticipations and preferences. Clients preferred less approval than they anticipated receiving, whereas they preferred more advice and relationship than they anticipated receiving.

The second research question comparing disconfirmation-outcome models examined three indicators of negative outcome (e.g. client satisfaction, counselor satisfaction, and premature termination status) in their relation to each of three hypothesized models of disconfirmed role expectations and preferences. Counselors were more satisfied with clients whose behavior was more in line with the client's preferences of a relationship than with the client's expectations. Only combining role preferences, anticipations, and behaviors into a bidirectional discrepancy model yielded any results. Thus, the implication is that in order to gain a more complete understanding of the influence of expectations and preferences on outcome, one must study both preferences and expectations together.

The third research question examined changes in client preferences over the course of treatment. The investigators dropped the clients who met for fewer than five times, feeling that they did not meet long enough to yield much change. They found that

longer treatments were not associated with any changes in preferences. However, preferences did vary over time in different patterns for the successful and less successful groups, and particularly there were significant differences in preferences for approval, audience, and relationship. Specifically, from the beginning to the middle session, preference for approval increased in the good outcome group, whereas it decreased for the poor outcome group. From the middle session to the last, preference for approval decreased for the good outcome group and increased for the poor outcome group.

The failure to randomly assign clients to counselors may have influenced the internal validity of the study. The assignment of client to counselor on the basis of appropriate match may have inadvertently taken into account clients' preferences for type of counselor, as well as counselor's preference for type of client, which in turn may have influenced satisfaction ratings. A related limitation is that the clients had already participated in an intake counseling session before being assigned to a counselor, which may have significantly impacted their preferences for a counselor. Particularly if counselors in this counseling center have similar theoretical orientation or a similar culture, the measurement of client preferences may have been more similar to their expectations based on the intake session. So although the results showed that anticipations and preferences differ, the results might have been more extreme if the preferences had not been influenced by an intake session.

Another limitation was that the investigators dropped the clients who met for fewer than five times, feeling that they did not meet long enough to yield much change. However, in most other studies in the literature measuring change in client preferences, far fewer sessions are included (i.e. Pohlman, 1961; Duckro, Beal, and George, 1978;

Van Dyck and Spinhoven, 1997). The authors then went on to create a median split based on outcome, and on sessions (5-15 and more than 15). By excluding the clients who participated in under 5 sessions, they may have missed a large part of the variability in sessions.

Van Dyck and Spinhoven (1997) investigated the contribution of patient's preference to the outcome of therapy, as well as patients' shifts of preference over the course of treatment. Sixty-four agoraphobic patients were included in the study, and the therapists were two psychiatrists, one senior resident, one psychologist, and one social worker.

A crossover design was used, and patients were presented with a videotape description of both in vivo therapy with hypnosis (combined treatment) and in vivo therapy without hypnosis (in vivo treatment alone) and asked to specify their preference. They were informed that the order in which they received the treatment would be randomized. Half the patients were given their preferred treatment first and the other half were given their nonpreferred treatment first. Before the first sessions, at midpoint, and at termination, patients completed self report measures of fear, depression, preference, and imaginative capacity, and observers rated their fear, avoidance, and hypnotizability. An in vivo measurement of an act avoided by agoraphobics was also conducted. At the intermediate test, therapies were crossed over so each patient received each therapy.

Regarding their research question about the contribution of preference to the outcome of therapy, no significant main effect for order or preference was found. If preference for one of the therapy conditions had improved the effect of the preferred therapy, this would have resulted in a significant interaction effect of preference order

and time, but this interaction was not found. The authors acknowledge that perhaps the results would have been different had the degree of the preference been measured and taken into account.

In their investigation of the evolution of preference, Van Dyck and Spinhoven found a shift in preference in favor of the combined therapy. Clients' preferences shifted towards the combined therapy, although the combined therapy was not found to be superior to the in vivo treatment alone.

Limitations for this study include the fact that they measured which treatment clients would prefer, but failed to take into account the strength of the preference. An alternative explanation for the finding that clients' preferences shifted towards the combined therapy could be that clients' started out with only slight preferences for the combined therapy and strong preferences for the in vivo therapy, and thus there was more of an opportunity for the preferences for combined therapy to be strengthened.

Again, in this study, the relationship between strength of preference and preference shift was not examined. A client's preference for a therapy may not change over the course of treatment, for example, but perhaps the strength of that preference would change. Incorporating measures of strength of the preferences examined would be a valuable contribution to this article.

The investigators also failed to explore the relationship between hypnotizability and preference. It is possible, and perhaps likely that patients with low hypnotizability would have preferences for the in vivo treatment without the hypnosis treatment, or that patients with high hypnotizability would prefer the combined treatment. Thus, the shift in

preferences may be more indicative of their actual hypnotizability as opposed to their outcome.

Summary. Findings for the two studies in this area were not consistent. Tracey and Dundon (1988) found that counselors were more satisfied when clients' behavior was in line with his or her preferences, but that only combining role preferences, anticipations, and behaviors into one model yielded any results. They also found that while clients shifted their preferences for certain therapist roles, there were different patterns in different outcome groups. Thus, these results seem to reveal that, at least from the therapists' standpoint, outcome is enhanced when clients' preferences and behaviors match. In addition, client preferences are malleable and the degree and direction of malleability is in part determined by treatment outcome. In contrast, Van Dyck and Spinhoven (1977) found no effect of preference-treatment congruency on outcome, but did find a shift of preferences. Thus, the literature on preference-treatment congruency remains inconclusive, although all of the studies examining preference malleability indicates that preferences are indeed malleable. One possible reason that the results on congruency remain inconclusive is because of the lack of mediating and moderating variables included in these studies.

#### *Limitations and Suggestions for Future Research*

One common limitation with many of these studies was the failure to determine the strength of the preferences. Many studies simply determined whether or not the client had a preference for particular form of therapy, but failed to differentiate between people who had relatively stronger or weaker preferences. It is expected that clients entering



therapy may have different strengths of preferences, and their reaction to therapy might not only depend on which preference they have but on the strengths of their preferences.

A related limitation with the research on the malleability of clients' preferences is that these studies examined the change in the type of the preference, but failed to examine the change in the strength of the preference. A client's preference for cognitive therapy may not change over the course of treatment, for example, but perhaps the strength of that preference would change. Incorporating measures of strength of the preferences examined would be a valuable contribution to this field of study.

Another common methodological limitation with these studies was the failure to nest data. Many studies included multiple clients the same therapists, and thus the assumption of independence that should have been met for their analyses was not adequately met. In many of these analyses, clients should be nested within therapists in order to control for differences across dyads.

A significant limitation with this area of research is the lack of process research investigating this phenomenon. All of the studies reviewed demonstrated that clients shift their preferences over the course of therapy, however none of the studies demonstrated how this process actually takes place. Investigating the microprocess of a therapy session in which clients' preferences either shift or maintain would be a valuable contribution to the field of counseling psychology.

Probably the most significant limitation of the body of research included in this review is the inconsistent definitions of preference. Although the studies selected for this review have similar definitions of preference, within these studies there is still some variation in definitions. The field has yet to build up a substantive body of preference

literature that is independent from the literature on expectations. Although this expectations literature will undoubtedly be helpful in developing theories and hypotheses for preference research, it will be important for research on preferences to develop its own firm definition of preference through both empirical and theoretical work.

Another valuable area for future research would be examining the mediating factors in the relationship between preferences and outcome. A common finding in many of these studies was that when clients' preferences for style of therapy is met, there is a more positive outcome. However, possible mediating factors in this were not thoroughly examined. For example, perhaps outcome was improved not necessarily because the clients' preferences were met, but perhaps these therapists were more likely to spend time addressing the actual issue in therapy instead of negotiating on the process of therapy. Another possible mediating factor is client perception of client-therapist similarity. Perhaps clients have better outcome when their preferences are met because they feel that they and their therapists have similar world-views. Future research would do well to address the presence of mediating factors in the relationship between preference and outcome.

The mixed findings for preference-treatment congruency and outcome leave us with a lot of questions. In some ways, the idea is intuitive—if clients get what they want, they will be happy. However the common findings that client preferences are malleable suggest that perhaps the idea is not as clear-cut as it originally seems. Perhaps clients are more satisfied with therapy if they get what they prefer, but it is possible that their preferences change during treatment as a result of the influence of the therapist. Thus,

future process research on how therapy influences client preferences would be a promising new area.

As noted in a previous section, social influence theory could also provide a valuable contribution to the understanding of how clients and therapists negotiate their preferences in a therapy setting. The social influence theory suggests that client perceptions of counselor credibility, which is influenced by client perceptions of counselor expertness, attractiveness, and trustworthiness, lead to client change. It is possible that clients feel that counselors who behave in alignment with their preferences are more credible. Thus, further investigation of the application of this theory to the process of negotiating preferences may be an important contribution to future research.

#### *Insight- and Action-Oriented Therapies*

Three major therapy styles are client-centered, insight, and action oriented therapy according to Hill's (2004) Helping Skills Model. This model involves three stages that occur over the course of counseling. The first stage is exploration, in which counselors help clients explore their thoughts, feelings, and actions. The second stage is insight, in which counselors help clients understand their thoughts, feelings, and actions. The final stage is action, in which counselors help clients decide what action to take on the basis of exploration and insight. Each of these stages emphasize particular skills that counselors implement.

According to the Helping Skills Model successful counseling involves all three of these steps, however many traditional counseling theories are largely insight- or action-oriented. The insight and action stages of the Helping Skills Model provide a condensed description of what insight- and action-oriented therapy might look like. In both insight

and action, counselors first explore the clients' problem. In this section I provide an introduction to the theoretical models and particular skills associated with both the insight and action stages. Next, I summarize the outcome of the two therapy orientations, and finally I argue for the importance of treatment matching for these variables.

Insight-Oriented Therapy. Elliott et al. (1994) defines insight as seeing things from a new perspective, making connections between things, and gaining an understanding of why things happen as they do. During the insight stage of Hill's (2004) Helping Skills model, helpers assist clients in coming to new understandings of themselves and their problems. Frankl (1958) emphasized the importance of understanding ourselves when he argued that our greatest human need is to find a core of meaning and a purpose in life (1959).

The roots of this stage are in Freud's (1940/1949) theory of psychosexual development. Freud believed that manifestations of unresolved problems are repeated throughout the client's life. A goal of psychoanalytic therapy then, is to recognize these repeated manifestations and understand how they influence the client's life. Dealing with problems in the therapeutic relationship is also important in psychoanalytic therapy, as it provides clients with the skills necessary to handle relationships outside of therapy more effectively.

In order to assist the client in coming to new understandings of themselves and their problems, the counselor implements a number of particular skills. One intervention a counselor may use in insight-oriented therapy is *challenge*. A challenge points out discrepancies or irrational beliefs of which the client is unaware, unwilling, or unable to change. An example of a challenge is "you're feeling happy that you're divorce is finally

complete, but I wonder if you are also feeling sad at the loss of your marriage.” Another intervention used in this type of therapy is *interpretation*, which is a statement that goes beyond what the client has recognized and gives new meaning or explanations for thoughts, feelings, and behaviors. An example of an interpretation is “I wonder if you are angry with me because I remind you of your mother who was very critical of you.” In insight-oriented therapy, counselors may also use *self-disclosure for insight* which is when the counselor presents a personal experience in which he or she gained some insight. An example of a self-disclosure for insight is “in the past I used to avoid getting close to people I was dating, and I realized that it was because I was afraid of being rejected.” Another intervention used in insight-oriented therapy is *immediacy*, which is when the counselor discloses immediate feelings about the client or their relationship in the session. An example of immediacy is “I feel like you are pushing me away right now.” Exploration skills such as attending and listening, restatement, reflection of feelings, open questions, and silence are also used in insight-oriented therapy and set the stage for more insight-oriented interventions.

**Action-Oriented Therapy.** Clients often come to therapy because they are experiencing anxiety or stress over a decision or problem. In action-oriented therapy, the counselor attempts to help the client solve the problem using a number of different interventions. The focus then, of action-oriented therapy is to help the client make changes in behaviors, thoughts, and feelings, and exploring barriers to change. The action stage of Hill’s (2004) model is based on behavioral and cognitive theories, which generally focus on overt behaviors and cognitions rather than unconscious motivations. They focus on what creates and maintains symptoms rather than on what caused them,

and assumes that behaviors and cognitions are learned. They focus on the present as opposed to the past, and value a more active and directive counselor approach than in insight-oriented therapy.

In order to assist the client in changing, the therapist implements different interventions. One intervention used in action-oriented therapy is *information*, which involves supplying data, opinions, facts, resources, and answers to questions. An example of information is “the career center on campus is located in Hornbake and they have information about different careers.” Action-oriented therapists also give *feedback about the client*, which involves giving the client information about the impact his or her behaviors have on others. An example of feedback about the client is “I could tell you were much more relaxed during that exercise because your breathing was slower and your hands were less tense.” Another intervention used is *process advisement*. Process advisement refers to counselor directives for what the client should do within the session. Oftentimes, counselors will engage the client in problem-solving, role-playing, behavioral rehearsal, or relaxation exercises and advises the client about how to participate. An example of *process advisement* is “relax and close your eyes and imagine that you are at the beach.” Another intervention used is *direct guidance*, which involves the helper giving suggestions or advice to the client. An example of this is “this week why don’t you visit the career center and research three different careers you are interested in.” Finally, *disclosure of strategies* is when the helper presents an action that he or she has used in the past to cope with a problem. For example, “when I was very angry at an ex-boyfriend, I found it helpful to write a letter to him telling him how much he hurt me. I sealed the letter in an envelope and put it in my journal.”

Insight- and Action-Oriented Therapy and Outcome. Any discussion of the relative efficacy of different types of bona fide psychotherapies ultimately concludes with the well-known dodo bird hypothesis. In 1936, Rosenzweig proposed that common factors were ultimately responsible for the efficacy of psychotherapy and quoted the Dodo bird from *Alice in Wonderland* (Carroll, 1865/1962) to explain that “Everybody has won, and all must have prizes” (p. 412). Thirty-nine years later, Luborsky, Singer, and Luborsky (1975) reviewed the psychotherapy outcome literature and found that the psychotherapies reviewed were generally equally effective in terms of their outcomes and confirmed the Dodo bird hypothesis. In 1997, Wampold et al. (1997) again confirmed the Dodo bird hypothesis in a meta-analysis of outcome studies. They found that the distribution of effect sizes produced by comparing two bona fide psychotherapeutic treatments was consistent with the hypothesis that the true difference is zero. Thus, the research generally seems to point to the conclusion that all bona fide therapies are equally effective, though individual studies may find slight advantages for a certain type of therapy (Geller, Brown, Zaitsoff, Goodrich, & Hastings, 2003).

The dodo bird hypothesis favors the common factors approach to psychotherapy outcome, and many different lists of common factors now exist in the literature (i.e. Beutler, Clarkin, Crago, & Bergan, 1991; Elkin, 1995; Hill, 1995). However, there is much more work to be done in defining the variables that may mediate therapy effects and outcome. As noted in previous sections, client variables important to explore, and client preferences for style of psychotherapy is a particularly valuable variable to examine.

### *Aptitude by Treatment Interaction*

Although the research does not support the enhanced outcome of one approach over another, it is possible that insight-oriented approaches are more appropriate for some people than action-oriented approaches, and vice versa. Clarkin and Levy (2004) emphasize that no two clients begin psychotherapy in the same condition and that there is a huge range of client characteristics. They state that “not only are their different types and sources of client variables, but these variables function in different ways in relation to psychotherapy process and outcome” (p. 196). The emphasis on client variables in psychotherapy has led to an interest in aptitude by treatment interaction (ATI) research by counseling psychologists (Beutler, Machado, & Neufeldt, 1994). ATI research combines correlational methods, which generally look at the relationship between some pretreatment variable with outcome, and experimental methods, through which the average effectiveness of different therapies are compared. The assumption behind this approach is that attempts to account for outcomes by either just client characteristics or just therapist characteristics alone is unsatisfactory, and that any attempt to predict and explain therapeutic outcome must consider the interaction between client and therapeutic characteristics (Shoham-Salomon & Hannah, 1991). Although there is little research supporting the notion that the individual client should be matched to a particular treatment tailored to that client’s difficulties and other characteristics (Kopta, Lueger, Saunders, & Howard, 1999), most psychotherapy studies lack sufficient power to examine potential matches between client and treatment variables (Shoham-Salomon & Hannah, 1991).



In summary, research comparing insight and action oriented therapies has mixed results, and the argument for which is more efficacious usually culminates in the Dodo-bird hypotheses, which says that all treatments are equal. However, the challenge to this explanation is the question of whether all treatments are equal for all people. ATI research has attempted to address this question, and future research examining the relationship between client-therapist congruency and outcome should be conducted.

## Chapter 3: Statement of the Problem

Client preferences for psychotherapy style have been understudied, despite their value in adding to our understanding of psychotherapy process and outcome.

Furthermore, current research trends point towards investigating the match between client and therapist in determining outcome (ATI research). One match that has not been studied as much is the match between client preference for type of therapy and therapist therapy style. Two styles that seem particularly important are insight- and action-oriented therapy, which are often distinct therapy approaches. Clients often come to counseling anticipating either receiving insight or making a plan for action. This research has implications for enhancing client outcome due to its promise to determine better client-therapist matches.

Research has shown that clients enter therapy with particular preferences for what they would like to receive, and generally they prefer more directive approaches (Galassi, et al., 1992; Tracey & Dundon, 1988). In addition, a few studies have examined the match between preferences and therapy style received on the outcome of treatment. Results for these studies have been mixed, with some studies finding that matched preference-treatment styles lead to better outcome than mismatches, and other studies finding no relationship between the match and outcome. Other studies have examined the malleability of these preferences, and have found that clients change their preferences over the course of an intervention (either treatment or analogue), but the literature is ambiguous about the direction of change. In this section, hypotheses are proposed, and then research supporting the hypothesis is briefly cited.

*Hypothesis 1: Clients who receive their preferred therapy style will have a more positive outcome than clients who do not receive their preferred therapy style.*

A collection of studies examining the relationship of client preference and therapist style to outcome revealed mixed results. While five out of the nine studies reviewed did indeed find better outcome resulted from client preference and therapist style congruency (Chilvers et al., 2001; Devine & Fernald, 1973; Elkin et al., 1999; Tracey & Dundon, 1988; VandeCreek & Angstadt, 1958), four out of the nine studies found no relationship between preference-treatment congruency and outcome (Atkinson et al., 1991; Bakker et al., 2000; Duckro & George, 1979; VanDyck & Spinhoven, 1977).

Although the literature is mixed, a small majority of the studies reviewed did find a relationship between client preference and therapist style congruency and enhanced outcome. The studies that failed to find a relationship between client preference and therapist style congruency and outcome may have had a few problems that limited their ability to get results. Such problems included failure to identify a mediating variable, varying definitions of preferences, and failure to take into account the strength of clients' preferences. Due to the small majority of studies finding a relationship between client preference and therapist style congruency and outcome, and due to intuition based on my experience working with clients with different preferences for treatment, I hypothesize that a more positive outcome will result when clients receive their preferred treatment than when they do not.

*Hypothesis 2: Credibility will be associated with better outcome.*

According to Strong's (1968) social influence theory, when the therapist is perceived as credible (expert, trustworthy, attractive), he or she has more power to influence client's attitudes and behaviors. A whole body of literature on this topic (Barak & LaCross, 1975; Heppner & Claiborn, 1989; Strong, 1968; Strong & Dixon, 1971) has found that therapists influence their client's attitudes and behaviors. Thus, it is likely that when clients perceive their therapist as credible (regardless of their preferred style), their outcomes will be enhanced.

Originally, this hypothesis implies categorizing client credibility scores into more or less credible. Because that cut-off would have been arbitrary, we decided instead to use a correlation between credibility and outcome.

*Hypothesis 3: Match between client preferences and treatment received will be a greater predictor of outcome than credibility.*

Although I hypothesize that credibility will be correlated with enhanced outcome, I believe that preference-treatment match will have an influence above and beyond credibility. Previous research has not compared the influence of these two variables. Originally, I hypothesized that among clients who receive their preferred therapy style, the match between preference and received treatment will have an influence above and beyond credibility. However, this only examines the half of the sample that matched on preference and received treatment. Thus, I revised the hypothesis before doing the analyses to include the entire sample.

*Hypothesis 4: Clients who perceive their therapists as credible will shift more towards the style received than clients who do not perceive their therapists as credible.*

Research has indicated that client preferences are malleable (Duckro et al., 1978; Pohlman, 1961; Tracey & Dundon, 1988; VanDyck & Spinhoven, 1997). Thus, we would expect that in a study of client preferences, preferences would change as a result of treatment. Strong's (1968) theorized that when clients perceive their therapist as credible (expert, trustworthy, and attractive), the therapist has more power to influence clients' attitudes and behaviors. One of the attitudes that the therapist likely influence is client preference for counseling style.

## Chapter 4: Method

### Design Statement

The present study employed an experimental laboratory method with two independent variables. The independent variables were client preferences for insight oriented therapy versus action oriented therapy, and counseling style provided (insight oriented therapy vs. action oriented therapy). Dependent variables were changes in target problem, relationship strength (RS), session depth, session evaluation (SES), therapist credibility, and change in preference for insight versus action. Control participants watched a videotape of Carl Rogers performing psychotherapy.

### Power Analysis

An a priori power analysis for multiple regression and a power equal to .80, with an alpha level equal to .05, yields a sample size of 33 to detect a large effect size,  $f^2 = .35$  (Cohen, 1988), and a sample of 77 to detect a medium effect size,  $f^2 = .15$  (Cohen, 1988). The collected sample size (64) was appropriate to detect between a medium and large effect size.

### Participants

Volunteer Clients. Participants were 64 students recruited from undergraduate psychology classes at the University of Maryland at College Park. Clients were 50 female, 7 male, and 7 missing; 41 clients were Caucasian, 8 were African American, 6 were Asian American, 2 were Hispanic, 4 were Multiracial, and 3 were other. 31 clients were psychology majors; 4 were freshman, 20 were sophomores, 10 were juniors, 29

were seniors, and 2 were other or missing. The mean age was 20.59 ( $SD = 2.19$ ). Thirteen clients were currently enrolled in an introduction to counseling psychology course, and 18 were enrolled in a helping skills course. Thirty had received previous counseling, and 8 were currently on psychotropic medications. Most participants (49) received course credit. Participants were recruited who were experiencing stress about an event or decision of their selection. It was expected that recruiting participants with specific stress issues would give the therapist an opportunity to effectively utilize either the insight or action condition, and would hopefully ensure that the counseling sessions from both conditions were comparable with each other in terms of the type of client issues.

Controls. Seventy-eight additional control participants were recruited from undergraduate classes at the University of Maryland. Clients were 62 female, 13 male, and 1 missing; 47 clients were Caucasian, 10 were African American, 10 were Asian American, 4 were Hispanic, 1 was Multiracial, and 4 were other. Thirty-five clients were psychology majors; 8 were freshman, 31 were sophomores, 18 were juniors, 18 were seniors, and 1 was other or missing. The mean age was 20.70 ( $SD = 3.20$ ). Eleven clients were currently enrolled in an introduction to counseling psychology course, and 14 were enrolled in a helping skills course. Thirty-two had received previous counseling, and 4 were currently on psychotropic medications. Most participants (62) received course credit. Participants were recruited who were experiencing stress about an event or decision of their selection.

Volunteer Therapists. Sixteen students from the counseling psychology graduate program at the University of Maryland served as therapists. Therapists were 13 females

and 3 males; 10 Caucasian, 2 African-American, 2 Asian-American, 1 Hispanic, and 1 South Asian. They were an average of 26.08 ( $SD = 3.45$ ) years old and had an average of 330.13 ( $SD = 294.61$ ) direct clinical counseling hours. When asked what how much they follow each theoretical orientation on a 5-point scale (1=not at all, 5=a lot), therapists rated cognitive/behavioral with a mean of 2.25 ( $SD = .93$ ), psychodynamic with a mean of 3.88 ( $SD = .50$ ), and client-centered with a mean of 4.44 ( $SD = .73$ ). Therapists also took the preferences measure before training, and 15 out of the 16 therapists had a clear preference for insight-oriented therapy (*Mean* for Insight = 17.38,  $SD = 3.12$ ; *Mean* for Action = 2.63,  $SD = 3.12$ ). Therapists received no reimbursement for their participation.

Judges. Three undergraduate research assistants were recruited from the psychology department and were interviewed and invited to participate for course credit. The research assistants were all female junior or senior psychology majors with an interest in pursuing graduate education, and served as raters for the manipulation check.

### Measures

Client Demographic Form. The client demographic form asked for the participant's age, gender, ethnicity, previous therapy, previous medication history, education level, and whether or not they had taken (or were currently enrolled in) a basic counseling skills course or an introduction to counseling psychology (Appendix A).

Therapist Demographic Form. The therapist demographic form asked therapists for gender, race, age, education level, previous experience, and belief in psychological theories (Appendix B).

Outcome Questionnaire-10.2. The OQ-10.2 (OQ-10.2; Lambert, Finch, Okiishi, & Burlingame, 2005) is a brief screening instrument that measures symptomatic distress. It



consists of ten items that are scored from 0 (low) to 4 (high), resulting in a range of scores from 0 to 40). Seelert (1997) reported an internal consistency value of .88 for the OQ-10.2. Lambert et al. (2005) reported test-retest reliability of .62. Lambert et al. (2005) reported the mean score for college students as 9.84 ( $SD = 5.45$ ). In this study, the mean score was 13.94 ( $SD = 5.93$ ). This measure was used to assess client level of distress.

Counseling Preference Form. This client preference form (Appendix C) was modeled after the Hill and Kellems (2003) Helping Skills Measure in which clients are asked after a counseling session how much their therapist used a particular skill. In this version, the stem is changed from “In this session, my counselor. . .” to “I prefer my counselor to. . .” and the subject is asked to choose between 20 sets of two dichotomous variables, contrasting action-oriented items (identify useful resources, discuss with me specific things I can do to make change happen, teach me specific skills to deal with my problems, figure out how to solve a specific problem, think about changes I could make in my life), and insight-oriented items (encourage me to think about changes I could make in my life, help me become aware of contradictions, help me gain a new perspective on my problem, encourage me to challenge my beliefs, help me understand reasons behind my thoughts).

This measure is scored by creating two subscales—action and insight—and assigning a value of 1 to the appropriate subscale every time a participant chose that preference over the other. If the value of the action subscale was higher than the insight subscale, the participant was said to have a preference for action. If the value of the insight subscale was higher than the action subscale, the participant was said to have a

preference for insight. If both scales were equal (each 10), the participant was said to have no preference.

In a pilot study, 54 college students from a small Canadian community college and 25 undergraduates from a large mid-Atlantic University were administered the Client Preferences Measure. In the community college sample, 37 students preferred action-oriented therapy (Action  $X = 14.51$ ,  $SD = 2.36$ ) and 6 preferred insight-oriented therapy (Insight  $X = 12.67$ ,  $SD = 1.75$ ), whereas one person had no preference (see Table 1). In the university sample, 14 students preferred action-oriented therapy (Action  $X = 15.79$ ,  $SD = 2.72$ ) and 10 preferred insight-oriented therapy (Insight  $X = 15.10$ ,  $SD = 3.41$ ), whereas two people had no preference (see Table 1). Thus, more community college students preferred action than did university students.

**Target Problem.** This measure was modeled after the Battle et al. (1966) Target Complaints measure (Appendix D) and was used in this study as an outcome measure. After the session, clients write down the primary problem, issue, or concern that they discussed in the session. They then rated their current functioning and retrospectively rated their pre-session functioning on the target problem using a scale from 1 (worst possible functioning) to 13 (best possible functioning). Change on the Target Problem (TP-Change) was calculated by subtracting retrospective pre-ratings from post-session ratings, which Howard (1980) and Bray, Maxwell, & Howard (1984) found was a more valid measure of pre-post change than subtracting actual-pre from post-session scores. Battle et al. (1966) reported test-retest reliability of .68 for this measure. The scale measures improvement, and was highly correlated with other outcome measures (Battle et al., 1966).

Table 1

*Means and Standard Deviations on Preferences Measure for Samples*

Sample	Insight	Action
2 Year College Sample ( $N = 44$ )	6.56 (3.39)	13.43 (3.39)
Preferred Insight ( $N = 6$ )	12.67 (1.75)	7.33 (1.75)
Preferred Action ( $N = 37$ )	5.49 (2.36)	14.51 (2.36)
University Sample ( $N = 26$ )	8.76 (6.16)	11.20 (6.10)
Preferred Insight ( $N = 10$ )	15.10 (3.41)	4.90 (3.41)
Preferred Action ( $N = 14$ )	4.14 (2.82)	15.79 (2.72)

In the study sample, participants identified their Target Problems as relationship problems ( $N = 20$ ), procrastination ( $N = 14$ ), plans for the future ( $N = 10$ ), anxiety ( $N = 5$ ), stress, ( $N = 3$ ), indecisiveness ( $N = 2$ ), and other ( $N = 11$ ).

Relationship Scale-Client Version. The RS (Hill & Kellems, 2002; Appendix E) assesses the client's perception of the therapeutic relationship in each session of therapy and was used as an outcome measure in this study. Each question on the RS uses the stem "In this session, I . . ." followed by each of four items (e.g. "did not feel a bond with my helper," "liked my helper," "trusted my helper", and "worked collaboratively with my helper"). The RS uses a 5-point Likert scale, ranging from strongly disagree (1) to strongly agree (5). Exploratory and confirmatory factor analyses revealed one factor, with an internal consistency of .78. The RS also has good concurrent validity as demonstrated by its correlation with the Working Alliance Inventory-S,  $r = .51, p < .001$ . Clients in our sample had a mean rating of 4.35 ( $SD = .73$ ) on the Relationship Scale. There was an alpha coefficient of .90.

Session Evaluation Scale-Client Version. The SES (Hill & Kellems, 2002; Appendix E) uses the stem "I . . ." followed by 4 items (e.g., "am glad I attended this session," "did not feel satisfied with that I got out of this session," "thought the session was helpful," "did not think the session was valuable"). It uses a 7-point scale ranging from strongly disagree (1) to strongly agree (7). Exploratory and confirmatory factor analyses revealed one factor with an internal consistency of .91. Concurrent validity was demonstrated for the SES-C, in that it correlated significantly with the client-rated SEQ-Depth,  $.51, p < .001$ ). Clients in our sample had a mean rating of 4.30 ( $SD = .86$ ) on the Session

Evaluation Scale. There was an alpha coefficient of .94. This measure was used as an outcome measure in this study.

Counselor Effectiveness Rating Scale (CERS). The Counselor Effectiveness Rating Scale (Atkinson & Wampold, 1982; Appendix F) was used to measure client-perceived therapist credibility. The CERS is a 10-item semantic differential questionnaire consisting of four dimensions related to therapist credibility (expertness, attractiveness, trustworthiness, and utility) based on Strong's (1968) social influence theory. Subjects rate each item on a 7-point bipolar scale (1 = bad, 7 = good). Atkinson and Wampold (1982) reported an internal consistency alpha of .90 for this measure.

Every other item in the scale is reverse scored, and it appears that nine out of the 64 clients were not aware of the reverse scoring. Without those nine clients' scores corrected, the alpha was .82. When those nine cases were corrected, the alpha was .85. Thus for all analyses using this scale, we will use the data with the nine cases corrected. The clients in this study rated their therapists with a mean of 6.03 ( $SD = .88$ ).

Helping Skills Measure-Client Version. The HSM-C (Hill and Kellems, 2002; Appendix E) was used as a manipulation check to see if clients indicated that their therapists used more insight or more action skills. The HSM-C is a 13-item measure designed to measure client's perceptions of helper's performance of each of the exploration, insight, and action stages (Hill & O'Brien, 1999) of the helping skills model. Each item contains the stem "In this session, my helper. . ." followed by a statement pertaining to one of the goals of one of the stages. Items on the Exploration Scale include "asked questions to help me explore what I was thinking." Items on the Insight Scale assess the client's perception of the helper's ability to assist the client in gaining insight

(ex. “encouraged me to challenge my beliefs”). Examples of items on the Action Scale include “helped me figure out how to solve a specific problem.” Items are scored on a 5-point scale ranging from strongly disagree (1) to strongly agree (5), and six of the items are negatively stated.

Hill and Kellems (2002) conducted both exploratory and confirmatory factor analyses and found that the 3-factor structure of the HSM was the best representation of the data. Hill and Kellems (2002) reported adequate internal consistency for each scale (Exploration  $\alpha = .73$ ; Insight  $\alpha = .71$ ; Action  $\alpha = .82$ ) as well as adequate concurrent validity for the HSM-C scales as they were significantly correlated to the corresponding scales of the Session Impact Scale (Exploration with SIS-Relationship  $r = .43, p < .001$ , Insight with SIS-Understanding  $r = .44, p < .001$ , and Action with SIS-Problem-Solving  $r = .60, p < .001$ ).

In our sample, the mean was 4.42 ( $SD = .59$ ) for the Exploration stage, 3.61 ( $SD = .93$ ) for the Insight stage, 3.77 ( $SD = 1.08$ ) for the Action stage, and 3.92 ( $SD = .30$ ) for the entire HSM. The alpha coefficient was .69 for the Exploration stage, .82 for the Insight stage, .91 for the Action stage, and .85 for the entire HSM.

Helping Skills Measure-Therapist Version. The HSM-T (Hill and Kellems, 2003; Appendix G) was used as a manipulation check to see if therapists perceived themselves as using more action or insight skills. This measure was created as a parallel to the client version. In our sample, the mean was 3.93 ( $SD = .89$ ) for the Exploration stage, 3.06 ( $SD = .89$ ) for the Insight stage, 2.89 ( $SD = 1.34$ ) for the Action stage, and 3.92 ( $SD = .66$ ) for the entire HSM. The alpha coefficient was .82 for the Exploration stage, .87 for the Insight stage, .89 for the Action stage, and .56 for the entire HSM.

Judges ratings of therapist adherence, therapist competence, and client involvement. A team of three undergraduate raters were trained by the investigator to rate therapist competence, therapist adherence, and client involvement. To assess therapist competence to either the insight-oriented or action-oriented therapy protocol, the judges rated the level of quality and engagement of the therapists' completion of the tasks of the relevant stage. To assess therapist adherence, we used items from the adherence measure presented in Hill (2004) and asked judges to rate how closely the therapist adhered to the therapy protocol. Finally, judges rated client involvement, which was defined as the amount of energy invested in tasks of the relevant stage, as manifested by the client's verbal and experiential activity, expression of affect, degree of initiative taken, and willingness to engage in the therapeutic progress (Wonnell & Hill, 2002). Ratings all used 9-point scales (1 = low, 9 = high). Interrater reliability was 0.99 for adherence, 0.78 for competence, and 0.75 for involvement.

### Procedures

Development of the Counseling Protocol. The counseling protocol was based upon the insight and action stages of the Helping Skills model (Hill, 2004). Therapists in the action-oriented condition first conducted a brief assessment of the problem, directing the client to talk about stress. Once the client explained his or her issue, the therapist informed the client that the session would focus on making a decision and/or learning to manage stress, and provided a clear rationale for using this approach (i.e. "by using this time to practice relaxation skills, you will learn to implement them on your own"). The therapist then conducted an action-oriented session in which he or she included at least two of the following interventions: 1) help the client think of changes he or she can make

in his or her life, 2) teach the client specific skills to deal with his or her problems (i.e. Relaxation, Behavioral-Rehearsal, Decision Making), 3) help the client identify useful resources (e.g. friends, parents, advisors, schools, clergy), 4) help the client figure out how to solve a specific problem, or 5) help the client make a decision using a decision making protocol. Finally, the therapist discussed with the client specific things that he or she should do to make changes happen (i.e. set goals, give homework). At the end of the session, the therapist asked the client if he or she intended to make the changes discussed, and gave the client the intent to act measure.

Therapists in the insight-oriented condition first conducted a thorough exploration of the problem the client brought in, allowing the client to describe his or her presenting problem at length. The therapist listened empathically to the client without guiding the client to discuss one topic or another. The therapist allowed the client to say what he or she believed may be the cause of his or her difficulties, using open questions (“What do you feel is the cause of difficulties with this issue”). When the problem was identified, the therapist provided a clear rationale for this approach (i.e. “by understanding the source of this conflict, we can understand more how to avoid this sort of conflict in the future”) and the client and therapist worked together to form an understanding of the problem. The therapist used at least two of the following interventions throughout the session: 1) encourage the client to challenge his/her beliefs, 2) help the client become aware of contradictions in thoughts, feelings, and/or behaviors, 3) help the client understand the reasons behind his/her thoughts, feelings, and/or behaviors, and 4) help the client gain a new perspective on his/her problem. At the end of the session the therapist asked the client for their current understanding of his or her problem.



The primary investigator conducted two insight-oriented sessions and two action-oriented sessions prior to conducting the experiment in order to fine-tune the counseling protocol. The protocol was not changed, but the primary investigator decided that it was very important to ensure that the participants had a clear idea for what they wanted to discuss in the session before being scheduled to participate in the study, and so it was decided that the primary investigator would call each participant ahead of time in order to solidify the problem they wished to discuss.

**Therapist Recruitment.** The therapists were recruited through the doctoral program in counseling psychology at the University of Maryland at College Park. The investigator asked 20 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> year students to participate in the study, 17 agreed, and 16 actually participated (one of the seventeen therapists completed two sessions and then was not able to schedule his final two sessions, so he was dropped from the study; the primary investigator also served as a therapist). Therapists were told that the study investigated insight-oriented and action-oriented counseling with psychology students. They were not informed of the hypotheses of the study, nor did they have knowledge of the dependent variables. Therapists in the study were asked to commit to attending a two-hour training session and provide 4 sessions of counseling (not including any no-shows).

**Client Recruitment.** Clients were psyc-100 students recruited from the University of Maryland Experimentrix research pool, and undergraduate psychology majors from upper level classes at the University of Maryland. For those who signed up through experimentrix, a description was posted on the website saying that qualifying students must be concerned about a situation or a decision and be prepared to discuss their

problem with a therapist for 50-minutes. When people signed up for the study, the primary investigator contacted the participant and asked him/her to briefly describe the problem he/she wished to discuss in the session to ensure that the client met the criteria for the study. For those recruited in upper level psychology classes, the primary investigator or her research assistants went into classes and told class members of the opportunity to participate in the study and read the statement that was on experimatrix. The recruiter then passed around slips of paper asking for class member's contact information, whether or not they would like to participate in the study, and their availability. The primary investigator then contacted each class member and asked him/her to briefly describe the problem he/she wished to discuss in the session to ensure that the client met the criteria for the study before scheduling them for a session.

More clients were scheduled for each research session than therapists were available to see. This was in order to minimize therapists not having a client, but also because this study called for equal numbers of clients preferring action and insight. Based on preliminary data, we knew that more clients preferred action than insight. Thus, additional participants were recruited for each research session, and the participants who were not assigned to therapy sessions were asked to complete an alternate task (described below). Participants not selected to receive a session were referred to the counseling center if they wanted to receive treatment.

Training of therapists to portray experimental conditions. Therapists were required to agree ahead of time to implement both conditions to the best of their ability, regardless of their theoretical orientation. The therapists read or re-read selected chapters from Hill (2004), and were trained during a half-day workshop facilitated by the investigator and

her advisor. The experimental conditions were discussed in depth, and therapists reviewed basic relaxation, behavioral-rehearsal, and decision-making exercises to teach to their clients in the action condition. They also reviewed insight-oriented interventions to use in the insight condition. Therapists then practiced both experimental conditions with different volunteer participants from a psychology class. Therapists were encouraged to practice the roles until they felt comfortable. The investigator observed these sessions and then interviewed each therapist to assess their level of competence and allegiance to the condition. If therapists had concerns or questions about the conditions, the primary investigator addressed these and worked with the therapist until she felt confident that they were implementing the conditions appropriately.

Pre-session questionnaire administration and client assignment to conditions. The sessions all took place in the counseling psychology program laboratory in room 2150 of the Biology-Psychology building. When clients arrived, they were instructed to read the informed consent, and then to complete a demographic form and the client preferences measure. They were then randomly assigned to an experimental condition or the alternate task.

Assignment to task. In order to have even numbers of clients who preferred insight-oriented therapy and action-oriented therapy, we had to give the pre-preferences measure to 140 participants. The assignment to condition was made by scoring the preferences measure and assigning the first eligible participants to the therapy session, and everyone else to the videotape condition. Participants were considered eligible if they met each of two requirements. First, participants had to have a score of the preferences measure that adequately differentiated their preferences. Eligible participants had at least a score of 12

out of 20 in the direction of their preferred treatment. Second, because each therapist had to complete sessions with two clients who preferred insight and two clients who preferred action, eligible participant had to have a preference that fit the needs of the therapist scheduled for that particular hour. Of the total sample of 140, 84 had preferences for action-oriented therapy, 46 preferred insight-oriented therapy, and 10 expressed no preference. Sixty-four participants were assigned to the counseling condition, while the other 76 participants were assigned to an alternate study watching a videotape of Carl Rogers conducting a therapy session with Gloria. Of the sample of 64 assigned to treatment, 32 had a preference for insight-oriented therapy and 32 had a preference for action-oriented therapy.

The participants who were assigned to the videotape condition were told that they were going to be watching a videotape of therapy and that they were to carefully observe the tape. It was explained that following the session, participants would be asked to fill out some measures. When all participants for the time block were ready, a research assistant started the videotape and stayed in the room while the videotape played.

**Counseling Session.** Clients participated in a 45-50 minute counseling session focusing on something that caused them stress. Therapists implemented their assigned condition.

**Post-Session Questionnaire Administration.** At the end of the counseling session, participants in all conditions completed the post-session questionnaires (HSM-C, RS-C, SES-C, CERS, Target Problems). They were informed that their therapists would not see the ratings or be affected by them in any way. Upon completion they were given a

debriefing statement. Therapists also completed post-session questionnaires (HSM-T, RS-T, SES-T).

Judge Rated Manipulation Check. Initially, the three undergraduates and the investigator listened to 4 tapes and individually rated each of the three variables (therapist adherence, therapist competence, client involvement). Then the raters and investigator discussed their ratings until they reached consensus. The investigator continued to meet with the raters while they rated 4 more tapes, until they reached an average interrater reliability on each of the three variables of at least .70. After this point, the raters met on their own without the primary investigator to rate tapes from the study.

Therapist Supervision. Throughout the study, either the investigator or the investigator's advisor were available to supervise and consult with therapists if needed. Three therapists took advantage of this opportunity to consult with the investigator about their conceptualizations of these clients.

## Chapter 5: Analyses

### Preliminary Analyses

Descriptive data. Means and standard deviations for the Insight and Action Scales of the Preferences Measure for before and after the intervention (either counseling session or videotape) are shown in Table 2. Table 3 has correlations for all measures used for the total counseling session sample. Table 4 has the means and standard deviations for the outcome measures by condition and treatment.

For all the analyses, an alpha of .05 was considered significant. Where appropriate, Cohen's  $d$  is reported as an estimate of an effect size. Cohen (1988) described effect sizes of larger than 0.80 as large, 0.5 - 0.79 as medium, and 0.2 - .49 as small. Also where appropriate, partial eta squared is used as an effect size estimate. According to Thompson (1999), partial eta squared can be interpreted according to the following guidelines: small = .01, medium = .06, and large = .14.

Examination of possible covariates. Client variables (sex, age, and race, and previous therapy) were examined for use as covariates in analyses of the hypotheses (see table 2). A variable would be deemed appropriate for use as a covariate if it correlated significantly with an independent variable or a dependent variable. None of the client variables were significantly correlated with the independent or dependant variables, and so were not used as covariates in any of the analyses.

Equivalence of Groups on Distress. Three independent samples t-tests revealed that there were no significant differences in client OQ-10 scores between clients with pre-session preferences for insight or action oriented therapists,  $t(62) = 0.68, p = .50, d = .43$ ,

Table 2

*Means and Standard Deviations for Preferences Measure for Videotape and Therapy*

*Samples.*

Sample	Preference	Condition	Preferences Measure			
			Insight Scale		Action Scale	
			Pre	Post	Pre	Post
Videotape	Insight	Rogers	13.67 (3.02)	15.81 (3.19)	6.33 (3.02)	4.12 (3.17)
	Action		5.63 (2.96)	4.77 (3.31)	14.37 (2.96)	15.23 (3.31)
	Combined		7.74 (4.28)	9.76 (6.19)	12.26 (4.28)	10.21 (6.21)
Therapy	Insight	Insight	14.81 (3.14)	12.63 (7.48)	5.19 (3.14)	7.38 (7.48)
		Action	15.50 (2.80)	10.56 (5.77)	4.50 (2.80)	9.44 (5.77)
		Combined	15.16 (2.95)	15.78 (3.17)	4.84 (2.95)	4.22 (3.17)
	Action	Insight	4.88 (2.22)	8.00 (6.20)	15.13 (2.22)	12.00 (6.20)
		Action	5.19 (4.35)	4.44 (4.38)	14.81 (4.35)	15.56 (4.38)
		Combined	4.53 (2.49)	3.54 (2.74)	15.47 (2.49)	16.46 (2.74)
	Combined	Insight	9.84 (5.71)	10.31 (7.15)	10.16 (5.71)	9.69 (7.15)
		Action	10.34 (6.36)	7.50 (5.92)	6.66 (6.36)	12.50 (5.91)
		Combined	9.87 (6.00)	8.90 (6.67)	10.16 (6.00)	11.09 (6.67)
Total	Total	Total	8.70 (5.23)	9.37 (6.41)	11.30 (5.22)	10.61 (6.42)

Note: Videotape sample is the participants who were not assigned to receive a counseling session. Of the 76 participants assigned to the videotape condition, 15 preferred insight, 52 preferred action, and 9 had no preference. The therapy sample is the participants who were assigned to receive either an insight or action oriented counseling session. Of the 64

participants, 32 preferred insight before the session, and 27 preferred insight after the session. Thirty-two preferred action before the session, and 25 preferred action after the session.



Table 3

*Correlation Table for Study Variables.*

	M	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1	20.59	2.19																	
2	1.12	.33	-.03																
3	2.00	1.75	.07	-.01															
4	.47	.50	.24	.09	.02														
5	13.94	5.93	-.01	.14	.02	.08													
6	9.91	6.00	-.17	-.03	-.12	-.15	-.04												
7	10.09	6.00	.17	.03	.12	.15	.04	-1.00*											
8	2.98	2.34	.16	-.17	-.09	.16	.01	.11	-.11										
9	11.09	6.67	-.10	.03	-.15	-.04	-.02	.50*	-.50*	-.05									
10	8.91	6.67	.10	-.03	.15	.04	.02	-.50*	.50*	.05	-1.00*								
11	6.03	.88	.21	-.11	.16	.05	-.15	-.04	.04	.22	-.05	.05							
12	3.92	.30	.05	-.13	.14	.08	-.07	.06	-.06	.28	.02	-.20	.59*						
13	4.35	.73	.21	-.08	.11	.20	-.19	-.18	-.18	.27	-.22	.22	.77*	.66					
14	4.30	.86	.17	-.13	.15	.15	-.10	-.04	.04	.44*	-.15	.15	.68*	.76*	.80*				
15	3.92	.66	.05	-.13	.14	.08	-.07	.06	-.06	.28	.02	-.02	.59*	.49	.66*	.76*			
16	.722	.50	-.01	.08	-.09	-.07	.02	-.08	.08	-.17	-.16	.16	-.01	-.04	.10	-.02	-.04		
17	6.30	.69	.12	.16	-.10	.22	-.06	-.15	.15	.09	-.03	.03	.29	.08	.23	.24	.08	-.13	
18	5.16	2.94	-.12	-.11	-.28*	-.09	-.18	-.03	.03	-.15	-.21	.21	-.07	-.43*	-.15	-.27*	-.43*	.04	.07

Notes: 1 = age, 2 = gender, 3 = race, 4 = previous counseling, 5 = OQ-10.2 total, 6 = pre-preference action, 7 = pre-preference insight, 8 = target change, 9 = post-preference action, 10 = post-preference insight, 11 = credibility, 12 = HSM-Client total, 13 = RS-Client, 14 = SES-Client, 15 = HSM-Therapist total, 16 = Competence, 17 = Involvement, 18 = Adherence. \*  $p < .05$

Table 4

*Means and Standard Deviations on Outcome Measures for Preference and Treatment Conditions.*

Preference	Outcome Measure	Treatment Condition		
		Insight	Action	Combined
Insight ( <i>N</i> = 32)	Therapist-rated	3.84 (1.11)	4.06 (0.84)	3.95 (0.97)
	Client-rated	4.19 (0.71)	4.56 (0.67)	4.38 (0.70)
	Target Problem Change	2.44 (2.10)	3.31 (2.41)	2.88 (2.27)
Action ( <i>N</i> = 32)	Therapist-rated	3.94 (0.79)	3.95 (0.77)	3.94 (0.77)
	Client-rated	4.13 (0.86)	4.42 (0.75)	4.28 (0.81)
	Target Problem Change	2.94 (2.64)	3.25 (2.29)	3.10 (2.44)
Combined ( <i>N</i> = 64)	Therapist-rated	3.89 (0.95)	4.00 (0.79)	3.95 (0.87)
	Client-rated	4.16 (0.77)	4.49 (0.71)	4.33 (0.75)
	Target Problem Change	2.69 (2.36)	3.28 (2.32)	2.98 (2.34)

NOTE: Therapist-rated means therapist-rated outcome. Client-rated means client-rated outcome.

or between clients who received their preferred treatment and clients who did not receive their preferred treatment,  $t(62) = 0.72, p = .47, d = .45$ . There was a significant difference, however, between client OQ-10 scores of clients who received an insight session and clients who received an action session,  $t(62) = 2.07, p = .043, d = 1.30$ , with clients who received an action session having higher OQ-10 scores than clients who received insight sessions.

Examination of Therapist Effects. Four separate one-way 1 x 16 analyses of variance were conducted to see if there were significant therapist differences in outcome or credibility variables. Results indicated that there were no significant differences between therapists in therapist-rated outcome,  $F(15) = .44, p = .96$ , client-rated outcome,  $F(15) = 1.62, p = .10$ , change in target problem,  $F = .68, p = .79$ , or in credibility,  $F = 1.51, p = .14$ . Because there were no outcome differences between therapists, because it was demonstrated that therapists followed protocol with a high level of adherence, and because of the similarity of the training and demographics of therapists, clients were not nested within therapists for the analyses.

Manipulation Check. Three judges coded each session on therapist adherence. On a 9-point scale from 1 being action oriented to 9 being insight oriented, the action sessions were rated with a mean of 2.58 ( $SD = 1.51$ ) and a range of 1.00 – 4.33 and the insight sessions were rated with a mean of 7.74 ( $SD = 1.24$ ) with a range of 5.67 – 9.00. An independent sample t-test showed that the difference between these two means was significant,  $t(62) = -14.95, p = .00, d = 4.40$ . The mean competence rating for all the sessions was 7.22 ( $SD = 0.50$ ) with a range of 5.00 - 9.00 on a 1 (low competence) to 9 (high competence) scale, indicating that the therapists performed their tasks competently.

An independent sample t-test between the competence ratings for the action sessions and the insight sessions was not significant,  $t(62) = 1.05, p = .23, d = .17$ . The mean client involvement was 6.30 ( $SD = 0.69$ ) on a 1 (low involvement) to 9 (high involvement) scale, indicating that the clients were involved in the sessions. An individual sample t-test between the mean client involvement in actions sessions and the mean client involvement in insight sessions was not significant,  $t(62) = .13, p = .54, d = .03$ . In sum, results revealed that all 64 sessions conformed to the assigned experimental condition. Furthermore, therapists performed equally competently and clients were equally involved in both types of sessions.

Target Complaints Ratings. The mean client retrospective pre rating on the target problem was 5.41 ( $SD = 2.32$ ), and after the session was 8.39 ( $SD = 2.50$ ), with 1 being the worst possible functioning and 13 being the best possible functioning. This difference was significant in a paired samples t-test,  $t(63) = 10.20, p < .01, d = 1.92$ , indicating that on average, clients found the sessions helpful in resolving their target complaint.

Outcome measures. Correlations among outcome variables (Session Evaluation Scale, Relationship Scale, and Target Problem Change) were computed to examine if measures were correlated. Client scores on the Relationship Scale and the Session Evaluation Scale were highly correlated, as were therapist scores on the Relationship Scale and the Session Evaluation Scale (see Table 3). However, therapist scores and client scores on these measures were not correlated highly. Furthermore, target Problem Change was not correlated highly with any of the measures. Thus, we created one outcome index for therapists (Relationship Scale-therapist version and Session

Evaluation Scale-therapist version;  $\alpha = .83$ ), one for clients (Relationship Scale-Client version and Session Evaluation Scale-client version;  $\alpha = .88$ ), and kept the Target Problems Change as a separate measure.

### Main Analyses

*Hypothesis 1: Clients who receive their preferred therapy style will have a more positive outcome than clients who do not receive their preferred therapy style.*

The mean client-rated outcome for clients whose preferences matched their received treatment was 4.35 ( $SD = .79$ ) and the mean client-rated outcome for clients whose preferences did not match their received treatment was 4.30 ( $SD = .73$ ). An independent sample t-test comparing the client-rated outcome for clients who received their preferred treatment to the client-rated outcome of clients who did not receive their preferred treatment revealed no significant differences,  $t(62) = .23$ ,  $p = .82$ ,  $d = .06$ . Hence, clients who received their preferred therapy style did not rate their outcome as significantly better than clients who did not receive their preferred therapy style.

The mean therapist-rated outcome for sessions in which clients' preferences matched their received treatment was 3.89 ( $SD = .94$ ) and the mean therapist rated outcome for sessions in which clients' preferences did not match their received treatment was 4.00 ( $SD = .81$ ). An independent sample t-test comparing sessions of clients whose preferences did and did not match their received treatment revealed no significant differences,  $t(62) = .48$ ,  $p = .63$ ,  $d = -.12$ . Hence, therapists did not rate sessions in which clients received their preferred treatment significantly higher than sessions in which clients did not receive their preferred treatment.

The mean target problem change score for sessions in which clients received their preferred treatment was 2.84 ( $SD = 2.20$ ) and the mean target problem change score for sessions in which clients did not receive their preferred treatment was 3.13 ( $SD = 2.50$ ). An independent sample t-test comparing sessions of clients whose preferences did and did not match their received treatment revealed no significant differences,  $t(62) = .48$ ,  $p = .63$ ,  $d = .19$ . I also conducted an ANCOVA with pre-treatment target problem scores as the covariate. Pre-target problem change was significant,  $F(2, 62) = 12.99$ ,  $p = .00$ . Match was not significant,  $F(2, 62) = 0.00$ ,  $p = .93$ . Hence, there was no significant difference in clients' target problem change between sessions in which they received their preferred treatment and sessions in which they did not. Therefore, hypothesis one was not supported.

*Hypothesis 2: Credibility will be associated with better outcome.*

The Pearson correlation coefficient between client-rated outcome and credibility was .76 ( $df = 62$ ), which was significant at the .01 level (2-tailed), and the effect size was 2.34, which was large. Thus, clients who perceived the therapist as more credible rated their outcomes as better than those who perceived the therapist as less credible.

The Pearson correlation coefficient between therapist-rated outcome and client-rated credibility was .25 ( $df = 62$ ), which was significant at the .05 level (2-tailed), and the effect size was .52, which is medium. Thus, client-rated credibility and therapist-rated outcome was significantly related.

The Pearson correlation coefficient between target problem change and client-rated credibility was .22, which was not significant,  $p = .09$ ,  $d = .45$ ,  $df = 62$ . Thus, client-rated therapist credibility and target problem change were not significantly related.

When we correlated credibility and target problem change and partialled out pre-session target problem scores, the variables were still not significantly correlated,  $r = .28$ ,  $p = .02$ ,  $df = 62$ .

Hence, hypothesis 2 was partially supported. Clients who perceived their therapists as more credible rated their own outcomes as higher than clients who perceived their therapists as less credible. And therapists of clients who perceived their therapists as more credible also rated the outcome higher than did therapists of clients who perceived their therapists as less credible, both supporting hypothesis 2. However, client-rated therapist credibility and target problem change were not significantly related, which does not support hypothesis 2. Thus, hypothesis 2 was partially supported.

*Hypothesis 3: Match between client preferences and treatment received will be a greater predictor of outcome than credibility.*

A hierarchical regression analysis was conducted to study the main effects of the two independent variables (credibility and match) on each of the three dependant variables (client-rated outcome, therapist-rated outcome, and target problem change). For each regression, credibility was entered in step 1, and match was added in step 2.

The results of the hierarchical regression analysis revealed a significant main effect for credibility on client-rated outcome,  $F(1, 62) = 86.30$ ,  $p = .00$ ,  $R^2 = .58$ , and on therapist-rated outcome,  $F(1, 62) = 4.08$ ,  $p = .048$ ,  $R^2 = .25$ , but not on target problem change,  $F(1, 62) = 3.07$ ,  $p = .09$ ,  $R^2 = .22$ . When pre-session target problem score was added into the regression, pre-session target problem score was significant,  $p = .00$ , and credibility was significant,  $p = .03$ , but match was not,  $p = .89$ . Specifically, the higher

the client rated the therapist's credibility, the better the outcome (as evidenced by the positive betas). See Table 5.

Effect sizes (partial eta squared) for credibility on client-rated outcome, therapist-rated outcome, and target problem change, were .58, .06, and .05, respectively. Thus, credibility by itself accounted for 58% of the overall (effect + error) variance in client-rated outcome, 6% of the overall (effect + error) variance in therapist-rated outcome, and 5% of the overall (effect + error) variance in target problem change. Thus, the effect size for credibility on client-rated outcome was large, the effect size for credibility on therapist-rated outcome was medium, and the effect size for credibility on target problem was small.

There was not, however, a significant additive effect for the models when match was added to credibility for client-rated outcome,  $\Delta R^2 = .00, p = .98$ , therapist-rated outcome,  $\Delta R^2 = .07, p = .85$ , or target problem change,  $\Delta R^2 = .00, p = .67$ . Effect sizes for match on client-rated outcome, therapist-rated outcome, and target problem change in step two of the models were all .00, indicating that match accounted for none of the overall (effect + error) variance once credibility was accounted for (see Table 4).

To compare the strength of the predictor variables on each of the outcome variables, we used Meng, Rosenthal, and Rubin's (1992) method of comparing correlated correlations. Results indicated that credibility was a significantly greater predictor of therapist outcome,  $p = .04$ , and client outcome,  $p = .00$ , than match. According to this statistical method, credibility was not a significantly greater predictor of target problem change than match,  $p = .06$ . This finding indicates that, while credibility is still a



Table 5

*Results of Hierarchical Regression Analysis of the Three Dependant Variables.*

Variable	$\beta$	$t$	$R^2$	$F$	$\Delta R^2$
Client-Rated Outcome					
Step 1			.58	86.30**	.58
	.76	9.29**			
Credibility					
Step 2			.58	42.46**	.00
	.76	9.21**			
Credibility	-.00	-.03			
Match					
Therapist-Rated Outcome					
Step 1			.25	4.08*	.06
	.25	2.02*			
Credibility					
Step 2			.25	2.11	.00
	.25	1.99			
Credibility	-.05	-.43			
Match					
Target Problem Change					
Step 1	.22		.22	3.07	.05
		1.75			
Credibility					

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Step 2			.22	1.61	.00
	.22	1.73			
Credibility	-.05	-.43			
Match					

---

*Note:* Credibility is the client's perception of the counselor's credibility. Match is the presence or absence of a match between the client's preferences for treatment and the treatment received.

\*  $p < .05$ , \*\*  $p < .01$

stronger predictor than match for target problem change, the difference may not be statistically significant.

Hence, match between client preferences and treatment received was not a greater predictor of outcome than credibility for any of the outcome variables. However, the difference in prediction strength of credibility and match was not statistically significant for target problem change. Hypothesis 3 was not supported.

*Hypothesis 4: Clients who perceive their therapists as credible will shift more towards the style received than clients who do not perceive their therapists as credible.*

First, the change score for each participant was calculated using the number of points he or she shifted on the preferences measure toward the style of the treatment received. The change score was then correlated with the participant's rating of the therapist's credibility. Credibility was significantly skewed (3.31), and so we attempted a number of transformations to reduce skewness. Unfortunately, skewness was too significant to be reduced to an acceptable level through any transformation. Thus, we ran the results with credibility significantly skewed. Results indicated that the correlation between change score and credibility was  $r(62) = -.10$ , which was not significant,  $p = .43$ , and an effect size of .20, which was small. Thus, clients who perceived their therapists as credible did not shift more towards the style received than clients who did not perceive their therapists as credible. Hypothesis 4 was not supported.

#### Additional Analyses

Target Problem Change Score. A 2 x 2 ANCOVA was conducted to determine whether pre-session Target Problem score was a significant covariate in predicting the preference shift from Target Problem change. Pre-session Target Problem score was a

significant co-variate,  $F(1, 62) = 5.23, p = .026$ , and Target Problem change score was a significant predictor,  $F(1, 62) = 2.49, p = .02$ .

**Preferences Shifting.** I compared differences in shifting of preferences between those who had a match between their preference and their treatment condition and those who did not. Participants who received their preferred treatment shifted a mean of 1.22 ( $SD = 5.44$ ) points on the preferences measure towards their received treatment, whereas those who did not receive their preferred treatment shifted their preferences a mean of 4.09 ( $SD = 5.41$ ) points towards their received treatment. This difference was significant,  $t(62) = -3.92, p < .01$ , and the effect size was large,  $d = -1.23$ , indicating that those clients who did not receive their preferred treatment shifted more in their preferences than those clients who did receive their preferred treatment.

The change score was also significantly correlated with two of the three outcome measures (client-rated outcome, therapist-rated outcome, and target problem change). Results indicated that the correlation between change score and therapist-rated outcome was not significant  $r(62) = .17, p = .19, d = 0.35$ . However, client-rated outcome was significantly correlated with change score,  $r(62) = .25, p = .05, d = .05$ , and target problem change was significantly correlated with change score,  $r(62) = .25, p = .05, d = .05$ . Thus, therapists did not rate the session outcome as significantly related to the client's shift towards the treatment received, however clients did rate this relationship as significant. Furthermore, clients who experienced greater improvement in their target problem had a greater shift in preferences towards the treatment received.

**Outcome Comparison across Treatment Conditions.** We were also interested in how outcome varied across conditions. Because initial OQ-10 scores were significantly

correlated with treatment condition, OQ-10 scores were covaried. After adjusting for initial OQ-10 scores, treatment condition was a significant predictor of client-rated outcome,  $F(2, 62) = 4.76, p = .03, d = .08$ . Specifically, clients who were in the action condition rated their outcome higher than clients in the insight condition. Treatment condition was not, however, a significant predictor of therapist-rated outcome,  $F(2, 62) = 1.15, p = .29, d = .02$ , or of change in target problems,  $F(2, 62) = 1.06, p = .31, d = .02$ .

Outcome Comparison across Treatment Condition and Pre-treatment Preference. We were interested in whether there was an interaction effect between treatment condition and pre-treatment preference. Therefore, an ANOVA was conducted with pre-treatment preference and treatment condition as predictors of therapist-rated outcome, client-rated outcome, and target problem change. Therapist-rated outcome was not significantly predicted by pre-treatment preference,  $F(2, 62) = .00, p = .96$ , treatment condition,  $F(2, 62) = .26, p = .61$ , or by an interaction of pre-treatment preference and treatment condition,  $F(2, 62) = .23, p = .64$ . Client-rated outcome was not significantly predicted by pre-treatment preference,  $F(2, 62) = .03, p = .61$ , treatment condition,  $F(2, 62) = 3.12, p = .08$ , or by an interaction of pre-treatment preference and treatment condition,  $F(2, 62) = .05, p = .82$ . Target problem change was not significantly predicted by pre-treatment preference,  $F(2, 62) = .14, p = .71$ , treatment condition,  $F(2, 62) = 1.00, p = .32$ , or by an interaction of pre-treatment preference and treatment condition,  $F(2, 62) = .23, p = .64$ . Therefore, there was not a significant interaction effect of treatment condition and pre-treatment preference on outcome.

Videotape Condition. As described above, participants not selected to participate in the counseling condition were assigned to a videotape condition, in which they viewed

Rogers doing a therapy session with Gloria. The video was selected because it is largely accepted as an example on insight oriented therapy. The 76 participants in this condition were administered the demographic measure, the OQ-10, the pre-preferences measure, the post-preferences measure, and the Counselor Effectiveness Rating Scale. These measures were used to examine if client preferences shifted from pre to post viewing of the tape.

Before viewing the videotape, 9 of the participants had no preference for type of therapy, 52 preferred action, and 15 preferred insight. After viewing the videotape, 5 participants had no preference, 39 preferred action, and 32 preferred insight. The distribution pattern of client preferences before watching the videotape differed significantly from the distribution pattern of client preferences after watching the videotape,  $\chi^2_{(2)} = 9.42, p < .01$ . Participants' preferences shifted an average of 2.03 ( $SD = 5.87$ ) points towards preferring more insight than from before they viewed the videotape to after they viewed the videotape.

A regression analysis was conducted to study the main effects of the credibility and OQ-10.2 score on preference change. The results of the regression analysis revealed a significant main effect for credibility on preference change,  $F(1, 74) = 10.84, p = .00$ . Specifically, the higher the client rated the therapist's credibility, the more he or she shifted towards preferring insight-oriented therapy. The effect size (partial eta squared) for credibility on preference shift was medium at .13, and indicates that credibility by itself accounted for 13% of the overall (effect + error) variance in client preference shift toward insight. There was not, however, a significant main effect for OQ-10.2 score on preference change,  $F(1, 74) = .002, p = .96$ .

There also was not a significant additive effect for the model when OQ-10.2 score was added to credibility for preference shift,  $F(1, 74) = .01, p = .92$ . The effect size (partial eta squared) for OQ-10.2 score on preference shift was .00, indicating that OQ-10.2 score did not account for any of the overall (effect + error) variance in client preference shift toward insight.

## Chapter 6: Discussion

In the present study, I investigated the effects of matching client preferences for insight and action oriented therapy on therapist style, the malleability of client preferences, and the effect of credibility on outcome of matched and mismatched pairs of therapists and clients. In this chapter, I discuss the findings for each of the hypotheses and additional research questions; discuss the limitations of the study; and offer implications for practice and research.

*Hypothesis 1: Clients who receive their preferred therapy style will have a more positive outcome than clients who do not receive their preferred therapy style.*

Analyses suggested that there were no significant differences in client-rated outcome, therapist-rated outcome, or target problem change between clients who received their preferred therapy style (insight vs action) and clients who did not receive their preferred therapy style. This was somewhat surprising given the slight trend in research of finding significant relationships between preference-treatment congruence and match. These results are, however, consistent with the findings in four out of the nine studies reviewed in Chapter 1 (Atkinson et al., 1991; Bakker et al., 2000; Duckro & George, 1979; VanDyck & Spinhoven, 1977). The results of the current study suggest no benefits to matching clients and therapists based on preferences for insight or action. These results also disconfirmed Tracey and Dundon's (1988) linear discrepancy model, which predicted that if client preferences and therapist style matched, outcome would be enhanced.

It is possible that match is indeed a strong predictor of outcome, but that this study did not adequately capture the relationship. Clients likely base their preferences for



insight vs action on a variety of factors such as exposure to media portrayals of therapy, others' reports of therapy experience, culture. It is possible that because of the age of these clients (college-age), they had limited exposure to experiences that might shape their preferences for therapy type. Thus, it is possible that, although they expressed preferences on the preferences measure, their preferences were somewhat arbitrary and they were more open to the influence of their therapists. This calls for further validation of the preferences measure used in this study.

It is also possible that matching is still a valid concept, but that matching based on preferences for received treatment style is not as important as matching on other variables. Some authors (e.g. Atkinson et al., 1991) have suggested that for a preferred treatment to be most effective, its conceptualization of the etiology of psychopathology should match that of the client. Thus, perhaps matching on other variables would lead to a better outcome.

Of the seven studies reviewed in chapter one, two found significant results on outcome for matching. However, participants in both studies (Devine & Fernald, 1973, VandeCreek & Angstadt, 1985) watched videotapes of different therapists using different techniques, and thus were given a lot more information about the different therapeutic styles before expressing their preference. Thus, it may be that in order for the match between client preferences and treatment modality to predict outcome, clients need to have more information about each option so that they can make an informed decision.

*Hypothesis 2: Credibility will be associated with better outcome.*

Analyses suggested that clients who perceived the therapist as being credible rated the session outcome highly. Therapists also rated the session outcome higher when

clients rated the therapist credibility higher. However, client-rated therapist credibility was not related to target problem change, so there was only partial support for this hypothesis.

The finding that client-rated credibility was significantly related to client and therapist-rated outcome is consistent with Strong's (1968) social influence theory which theorizes that a therapists' influence on the process of therapy is based on his or her credibility, and that even when a client's preference is incongruent with the treatment s/he receives, the client may have a positive outcome because of the client's perception of the therapists' credibility. Alternatively, one reason for the high correlation of credibility with client- and therapist-rated outcome, but not with target problem change, may be that the outcome and credibility measures are similar in format in that they both were self-report measures that contained questions about the relationship.

The nonsignificant correlation between target problem change and client-rated counselor credibility is puzzling and led us to wonder whether clients' perception of counselor credibility is important in client change. Strong's (1968) social influence theory suggests a two-stage process in which a counselor establishes credibility with the client and then uses that credibility to influence change. It may be that one session of counseling was not enough for the counselor to progress to the second stage of social influence theory, in which he or she makes use of the credibility s/he has obtained to influence client change. Or it may be that clients like therapists who are credible but that does not help them make behavioral changes.

*Hypothesis 3: Match between client preferences and treatment received will be a greater predictor of outcome than credibility.*

Match between client preferences and treatment received was not a greater predictor of outcome than credibility for client-rated outcome, therapist-rated outcome, or target problem change. This again is consistent with social influence theory which posits that counselor credibility is a strong predictor of outcome. It is also consistent with the findings of hypothesis 1 that matching had minimal influence on outcome.

This was surprising, however, given the previous research that indicates the importance of preference-treatment congruence. There could be a number of possible reasons why the data did not support our hypothesis. Perhaps credibility was more important to this particular group of volunteers because they were aware that they were meeting with graduate students and their expectations for credibility were lower. Thus, when their counselors were found to be credible, clients rated their outcomes as higher. It is also possible that clients in this particular study had less salient preferences for therapy, and thus the match between their preferences and treatment received was a weaker predictor of outcome.

*Hypothesis 4: Clients who perceive their therapists as credible will shift preferences more towards the style received than clients who do not perceive their therapists as credible.*

Clients who perceived their therapists as credible did not shift preferences more towards the style received than clients who did not perceive their therapists as credible. This finding is surprising because one would assume that because constructs such as competence, skill, and willingness to see the counselor in the future are part of the credibility measure, clients would connect credibility with a preference for the type of therapy that therapist provided. However, the present results indicate that while clients

may rate their therapists as credible, they did not change preferences significantly. It is possible that a single session of therapy was not a large enough dose to significantly alter what the client preferred in therapy. Again, these results may be consistent with Strong's (1968) two-stage theory, which suggests that initially counselors establish credibility, and secondly they use the credibility to influence the change process. It is possible, again, that in just one session the counselors did a good job of establishing credibility, but were not able to utilize that credibility to influence the client's preferences.

### *Additional Analyses*

An additional analysis indicated that those clients who did not receive their preferred treatment shifted their preferences more towards the treatment received than those clients who did receive their preferred treatment. Although some of this finding can be accounted for by ceiling effects (clients who already had strong preferences for the treatment received had less room to shift ( $X = 14.81$ ,  $SD = 3.75$ ; range of 11-20) than clients who had preferences in the other direction), it is interesting to note that clients did shift towards the treatment they received when they received their non-preferred treatment. It is also possible that being exposed to their non-preferred treatment style showed clients that the treatment was actually pretty good, so there was an educational impact to being exposed to a non-preferred treatment.

Also regarding the shift of clients' preferences, therapists in this study did not rate the session outcome as significantly related to the client's shift towards the treatment received; however clients did rate their outcome as significantly related to a shift towards the treatment they received, such that the more their preferences shifted toward the treatment received, the higher they rated their session outcome. It makes sense that the

more clients get out of counseling, the more likely they will be to want something similar in the future. Furthermore, clients who experienced greater improvement in their target problem had a greater shift in preferences towards the treatment received. The correlation between client rated outcome and target problem change makes sense. The better outcome that the clients received from the session, the more their future preferences may reflect the treatment they received. Client probably continue to seek out what has been helpful in the past, even if it is not consistent with their beliefs. It is interesting, however, that therapist-rated outcome was not significantly related to the shift of clients' preferences. This makes sense, given that therapists were likely not aware of the clients' shift in preferences.

### Limitations

There were several limitations to the current study. The first limitation was that the treatment groups were significantly different on OQ-10.2 scores, even though treatment condition was a randomly assigned variable. In the additional analyses, however, when we covaried OQ scores in the analyses of differences between treatment conditions, no significant effects were found for the covariate.

Another limitation of this study was that clients participated in only one session, which may not have been enough to test for the influence of match and credibility on outcome. It may require several sessions (a larger dose) for the effect to manifest. One might wonder, if clients were expecting to meet again with the counselor, whether they would have rated the outcome differently. Also, counselors may have rated outcome differently if they were expecting to meet with the client again (perhaps they would have

placed more emphasis on establishing a relationship or gaining insight than on symptom relief).

The generalizability of this study extends only to college students (primarily psychology students) who were volunteering for a research study. Clients who are actually seeking counseling might have stronger and less malleable preferences, because they may have greater distress and more specific needs. It is also possible, however, that students who were not mainly psychology students would not have as strong of preferences because they would have been less educated about the possibilities and thus their preferences would be more malleable.

While the sample size in this study was appropriate to detect medium and large effect sizes, a larger sample size would be needed to allow us to detect small effect sizes. Given that effects might be small because of lots of other uncontrolled variables, it would be important to replicate the results with a larger sample.

Another limitation to this study is the preferences measure used. This measure was created for the current study, and although it had good psychometrics in this study, it has yet to be validated elsewhere. Perhaps the preferences measure is not an adequate way of getting at preferences.

Another limitation is that counselors were conducting sessions within certain parameters dictated by the counseling protocol and thus the sessions were not reflective of actual counseling sessions in which counselors usually exercise more freedom in conducting sessions. For example, counselors in the insight session were instructed to help clients explore the roots of their problems, whereas counselors in the action condition were instructed to help clients solve their problems. Two opposite conditions

were thus created, whereas in unstructured therapy, counselors may combine aspects of both a directive and nondirective style in a session. The parameters dictated by the counseling protocol may have produced counselors who, though competent and credible, may have been less responsive to the needs of clients than they would have been if they been free to conduct therapy according to their own preferences and styles. However, competency ratings for insight oriented and action oriented sessions were not significantly different.

Counselors in this study were also insight-oriented therapists who endorsed items on the preferences measure suggesting that they value interventions that are more insight-oriented rather than action-oriented. It is possible that these results are only generalizable to clients whose therapists are insight-oriented.

### Implications

Research. Aptitude by treatment interaction research (Beutler, Machado, & Neufeldt, 1994) is a burgeoning field that invites further research. Although, in this study, clients who received a preferred treatment did not experience a significantly better outcome, it is possible that matching clients on other variables may produce significant results. Thus, future aptitude-by-treatment research might include matching on other variables such as etiology beliefs (Atkinson et al., 1991), ethnicity, age, acculturation level.

In addition, for some clients, whether the therapist uses insight vs action may be a salient issue, but it might not be salient for others. So it may be useful to assess the salience of the insight-action construct for the clients.

It also may have been that clients in this study were not well enough informed to have developed strong preferences for treatment type. Maybe first educating clients about different treatment styles by allowing them to watch or participate in different types of therapies would enhance their awareness of what the different therapies entail.

Practice. Devine and Fernald (1973) suggested that “it is reasonable to expect that as awareness of psychological treatments grows prospective patients will not select a therapy without comparing it with others (p. 104). Thus, as clients become more educated about the treatments available, it is likely that they will begin to choose therapists whose styles match their preferences. Thus, it seems important for therapists to first, assess what their client knows about therapy, and second, what they would prefer to happen in their own therapy. As clients become more and more educated about the types of treatment available, it may be important for therapists to understand more about interactions between client preferences and their style of therapy.



## Appendices

### APPENDIX A

#### CLIENT DEMOGRAPHIC FORM

Age:

Gender:

Race/Ethnicity: \_\_\_\_\_ Caucasian (non-Hispanic)  
\_\_\_\_\_ African-American  
\_\_\_\_\_ Asian-American  
\_\_\_\_\_ Hispanic  
\_\_\_\_\_ American-Indian  
\_\_\_\_\_ Other (please specify)

Highest Degree Completed:

Major:

Year in school (circle one):

Freshman

Sophomore

Junior

Senior

Other

Have you ever been in therapy/counseling before? Yes / No  
If yes, please describe (e.g. how long, group or individual, etc.)

Are you currently taking any medication that might intentionally or unintentionally affect your thoughts and feelings on a daily basis? (e.g. medication for depression or anxiety)?

No / Yes (please describe):

Are you willing to be audiotaped and videotaped, if all materials are confidential and destroyed after the study? Yes / No

Is there anything else that might affect your ability to participate in this study?

APPENDIX B

THERPIST DEMOGRAPHIC FORM

Age:

Gender:

Race/Ethnicity: \_\_\_\_\_ Caucasian (non-Hispanic)  
\_\_\_\_\_ African-American  
\_\_\_\_\_ Asian-American  
\_\_\_\_\_ Hispanic  
\_\_\_\_\_ American-Indian  
\_\_\_\_\_ Other (please specify)

Departmental Area:

Year in program:     1       2       3       4       5       6       Other \_\_\_\_\_

Approximately how many hours of direct therapy service do you have?

Please circle how strongly you adhere to each of the following theoretical orientations:

Cognitive-Behavioral

1       2       3       4       5

Psychodynamic

1       2       3       4       5

Client-Centered

1       2       3       4       5

APPENDIX C

CLIENT PREFERENCES FORM

**Client Preferences Measure**

*Please circle your answer for each item.*

If I were going to a single session of counseling for stress, I would prefer my counselor:

Item	A	OR	B
1	Encourage me to challenge my beliefs		Help me think about changes I could make in my life
2	Help me become aware of contradictions in my thoughts		Help me identify useful resources (e.g. friends, parents, advisors, schools, clergy)
3	Help me become aware of contradictions in my thoughts		Discuss with me specific things I could do to make change happen
4	Help me gain a new perspective on my problem		Teach me specific skills to deal with my problems
5	Help me think about changes I could make in my life		Help me become aware of contradictions in my thoughts, feelings, and/or behaviors
6	Help me become aware of contradictions in my thoughts		Teach me specific skills to deal with my problems
7	Help me identify useful resources (e.g. friends, parents, advisors, schools, clergy)		Encourage me to challenge my beliefs
8	Help me become aware of contradictions in my thoughts		Help me figure out how to solve a specific problem
9	Teach me specific skills to deal with my problems		Encourage me to challenge my beliefs

	<b>A</b>	<b>OR</b>	<b>B</b>
10	Help me think about changes I could make in my life		Help me understand the reasons behind my thoughts
11	Encourage me to challenge my beliefs		Help me figure out how to solve a specific problem
12	Help me identify useful resources (e.g. friends, parents, advisors, schools, clergy)		Help me understand the reasons behind my thoughts
13	Discuss with me specific things I could do to make change happen		Encourage me to challenge my beliefs
14	Help me think about changes I could make in my life		Help me gain a new perspective on my problem
15	Help me understand the reasons behind my thoughts		Teach me specific skills to deal with my problems
16	Help me gain a new perspective on my problem		Help me identify useful resources (e.g. friends, parents, advisors, schools, clergy)
17	Help me figure out how to solve a specific problem		Help me understand the reasons behind my thoughts
18	Help me understand the reasons behind my thoughts		Discuss with me specific things I could do to make change happen
19	Help me gain a new perspective on my problem		Discuss with me specific things I could do to make change happen
20	Help me figure out how to solve a specific problem		Help me gain a new perspective on my problem

APPENDIX D

TARGET PROBLEM FORM

## Target Problem—Client

Please write here the primary problem, issue, or concern that you talked about in your session:

Please check the box that best describes your current functioning on this problem **right now**:

- ☐ 1 Worst possible functioning
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13 Best possible functioning

Now please think back and check the box that best describes how you were functioning on this problem immediately **before** the session:

- ☐ 1 Worst possible functioning
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13 Best possible functioning

## APPENDIX E

### HSM, RS, SES-CLIENT VERSION

## Session Process and Outcome Measures—Client

Instructions: Indicate how much each statement reflects your experiences in this session. Please note that all of these things do not occur in every session because helpers do many different things to be helpful.

Circle one number for each item using the following scale:

**In this session, my helper...**

**Strongly  
Disagree**

**Strongly  
Agree**

#### *Helping Skills Measure*

1. asked questions to help me explore what I was thinking or feeling.....	1	2	3	4	5
2. encouraged me to challenge my beliefs.....	1	2	3	4	5
3. did <b>NOT</b> help me think about changes I could make in my life.....	1	2	3	4	5
4. did <b>NOT</b> teach me specific skills to deal with my problems.....	1	2	3	4	5
5. did <b>NOT</b> encourage me to express what I was thinking or feeling.....	1	2	3	4	5
6. helped me become aware of contradictions in my thoughts, feelings, and/or behaviors...	1	2	3	4	5
7. helped me think about my concerns.....	1	2	3	4	5
8. did <b>NOT</b> help me identify useful resources (e.g., friends, parents, clergy).....	1	2	3	4	5
9. helped me figure out how to solve a specific problem.....	1	2	3	4	5
10. helped me understand the reasons behind my thoughts, feelings, and/or behaviors.....	1	2	3	4	5
11. did <b>NOT</b> encourage me to experience my feelings.....	1	2	3	4	5
12. did <b>NOT</b> discuss with me specific things I could do to make change happen.....	1	2	3	4	5
13. helped me gain a new perspective on my problems.....	1	2	3	4	5

#### *Relationship Scale*

**In this session, I...**

14. did <b>NOT</b> feel a bond with my helper.....	1	2	3	4	5
15. liked my helper.....	1	2	3	4	5
16. trusted my helper.....	1	2	3	4	5
17. worked collaboratively with my helper.....	1	2	3	4	5

#### *Session Evaluation Scale*

**I...**

18. am glad I attended this session.....	1	2	3	4	5
19. did <b>NOT</b> feel satisfied with what I got out of this session.....	1	2	3	4	5
20. thought that this session was helpful.....	1	2	3	4	5
21. did <b>NOT</b> think that this session was valuable.....	1	2	3	4	5

## APPENDIX F

### COUNSELOR EFFECTIVENESS RATING SCALE

The purpose of this inventory is to measure your perceptions of the counselor by having you react to a number of concepts related to counseling. In completing this inventory, please make your judgments on the basis of what the concepts mean to you. For example, THE COUNSELOR'S EXPERTNESS may mean different things to different people but we want you to rate the counselor based on what expertness in counseling means to you. In recording your response, please keep the following important points in mind:

- Place your X's in the middle of the spaces, not on the boundaries.
- Be sure you check every scale even though you may feel that you have insufficient data on which to make a judgment - please do not omit any.
- Never put more than one X mark on a single scale.
- Notice that the good and bad scales are reversed every other time.

Good				THE COUNSELOR'S EXPERTNESS				Bad	
Bad				THE COUNSELOR'S FRIENDLINESS				Good	
Good				THE COUNSELOR'S SINCERITY				Bad	
Bad				THE COUNSELOR'S COMPETENCE				Good	
Good				THE COUNSELOR'S SKILL				Bad	
Bad				THE COUNSELOR'S RELIABILITY				Good	
Good				THE COUNSELOR AS SOMEONE I AM WILLING TO SEE FOR COUNSELING IN THE FUTURE				Bad	
Bad				THE COUNSELOR'S APPROACHABILITY				Good	
Good				THE COUNSELOR'S LIKABILITY				Bad	
Bad				THE COUNSELOR'S TRUSTWORTHINESS				Good	

APPENDIX G

HSM-THERAPIST VERSION

## Session Process and Outcome Measures—Therapist

Instructions: Indicate how much each statement reflects your experiences in this session. Please note that all of these things do not occur in every session because helpers do many different things to be helpful.

*Circle one number for each item using the following scale:*

**In this session, I...**

**Strongly  
Disagree**

**Strongly  
Agree**

*Helping Skills Measure*

1. asked questions to help the client explore what s/he was thinking or feeling.....	1	2	3	4	5
2. encouraged me to challenge his/her beliefs.....	1	2	3	4	5
3. did <b>NOT</b> help the client think about changes s/he could make in his/her life.....	1	2	3	4	5
4. did <b>NOT</b> teach the client specific skills to deal with his/her problems.....	1	2	3	4	5
5. did <b>NOT</b> encourage the client to express what he/she was thinking or feeling.....	1	2	3	4	5
6. helped the client become aware of contradictions in thoughts, feelings, and/or behaviors1	2	3	4	5	
7. helped the client think about his/her concerns.....	1	2	3	4	5
8. did <b>NOT</b> help the client identify useful resources (e.g., friends, parents, clergy).....	1	2	3	4	5
9. helped the client figure out how to solve a specific problem.....	1	2	3	4	5
10. helped the client understand the reasons behind thoughts, feelings, and/or behaviors ...1	2	3	4	5	
11. did <b>NOT</b> encourage the client to experience his/her feelings.....	1	2	3	4	5
12. did <b>NOT</b> discuss with the client specific things to make change happen.....	1	2	3	4	5
13. helped the client gain a new perspective on his/her problems.....	1	2	3	4	5



## APPENDIX H

### Debriefing for Volunteer Clients

#### Project Title: Client Preferences Study

Project Directors: Melissa K. Goates-Jones, Department of Psychology, University of Maryland, 240-498-8559, [mgoates@psyc.umd.edu](mailto:mgoates@psyc.umd.edu), Clara E. Hill, Department of Psychology, University of Maryland, 301-405-5791, [hill@psyc.umd.edu](mailto:hill@psyc.umd.edu)

The study in which you just participated is an investigation of client preferences for insight- and action-oriented therapy. If you were in the counseling condition, you received either insight or action oriented therapy. If you were in the videotape condition, you viewed an insight-oriented therapy session. These different styles represented different theoretical orientations practiced by psychologists. Our purpose is to determine if there are any differences in effectiveness between the insight and action oriented therapy, and if client preferences are malleable. We want to stress that we currently do not know which condition is most effective, but both represent approaches that are commonly used with clients.

We hope that completing the measures and participating in the study was helpful to you in gaining some insight into your personal problem or concern. We hope that you will be able to use what you learned about yourself to improve some aspect of your life.

We realize that a session like this may have raised some issues for you that might be confusing, unexpected, or even unpleasant. If you wish to continue to work on what you have learned about yourself today, we strongly urge you to contact the Counseling Center or the Help Center. Counseling services are provided free of charge to all UM students. Records kept are confidential and are not part of the educational records kept by the university. The Counseling Center is located in Shoemaker Hall and can be reached at 301-314-9751. The Help Center is a telephone hotline and can be reached at 4-HELP (301-314-4357).

If you would like a copy of the published article (expected in about two years) or if you have any questions or comments regarding the study, please contact Melissa Goates-Jones, [mgoates@psyc.umd.edu](mailto:mgoates@psyc.umd.edu).

Thank you for participating in this study. We appreciate your time and effort and hope you benefited from your experience.

## References

- Acosta, F. X. & Sheehan, J. G. (1976). Preferences toward Mexican-American and Anglo-American psychotherapists. *Journal of Consulting & Clinical Psychology*, 44(2), 272-279.
- Arnkoff, D. B., Glass, C. R., Shapiro, S. J. (2002). Expectations and preferences. In J. C. Norcross (Ed). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. (pp. 335-356). London: Oxford University Press.
- Atkinson, D. R. & Wampold, B. E. (1982). A comparison of the Counselor Rating Form and Counselor Effectiveness Rating Scale. *Counselor Education and Supervision*, 22, 25-36.
- Atkinson, M. E., Worthington, R. L., Dana, D. M., & Good, G. E. (1991). Etiology beliefs, preferences for counseling orientations, and counseling effectiveness. *Journal of Counseling Psychology*, 38, 258-264.
- Bakker, A., Spinhoven, P., van Balkon, A. J. L. M., Vleugel, L., & van Dyck, R. (2000). Cognitive therapy by allocation versus cognitive therapy by preference in the treatment of panic disorder. *Psychotherapy and Psychosomatics*, 69, 240-243.
- Barak, A. & LaCrosse, M. B. (1975). Multidimensional perception of counselor behavior. *Journal of Counseling Psychology*, 22(6), 471-476.
- Battle, C.C., Imber, S.D., Hoehn-Saric, R., Strone, A.R., Nash, E.H., & Frank, J.D. (1966). Target complaints as criteria of improvement. *American Journal of Psychotherapy*, 20, 184-192.

Beutler, L. E.; Clarkin, J. F. & Crago, M.; Bergan, J. (1991). Client-therapist matching. In C. R. Snider & D. R. Forsyth (Eds). *Handbook of social and clinical psychology: The health perspective*. Elmsfort, NY: Pergamon Press, Inc.

Beutler, L. E., Machado, P. P. P., Neufeldt, S. A. (1994). Therapist variables. In A. E. Bergin & S. L. Garfield (Eds). *Handbook of psychotherapy and behavior change* (4th ed). Oxford, England: John Wiley & Sons.

Boulware, D. W. & Holmes, D. S. (1970). Preferences for therapists and related expectancies. *Journal of Consulting & Clinical Psychology*, 35(2), 269-277.  
Carroll, 1865/1962)

Chilvers, C., Dewey, M., Fielding, K., Gretton, V., Miller, P., Palmer, B., Weller, D., Churchill, R., Williams, L., Bedi, N., Duggan, C., Lee, A., & Harrison, G. (2001). Antidepressant drugs and generic counseling for treatment of major depression in primary care: Randomized trial with patient preference arms. *British Medical Journal*, 322, 722.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences*. Hillsdale: Lawrence Erlbaum.

Devine, D. A. & Fernald, P. S. (1973). Outcome effects of receiving a preferred, randomly assigned, or non-preferred therapy. *Journal of Consulting and Clinical Psychology*, 41, 104-107.

Duckro, P. N. & George, C. E. (1979). Effects of failure to meet client preference in a counseling interview analogue. *Journal of Counseling Psychology*, 26(1), 9-14.

Duckro, P., Beal, D., & George, C. (1978). Malleability of preference for therapists' response style. *Psychological Reports*, 43(1), 299-304.

Duckro, P. N., Beal, D. & George, C. E. (1979). Research on the effects of disconfirmed client role expectations in psychotherapy: A critical review. *Psychological Bulletin*, 86(2), 260-275.

Elkin, I., Yamaguchi, J. L., Arnkoff, D. B., Glass, C. R., Sotsky, S. M., & Krupnick, J. L. (1999). "Patient-treatment fit" and early engagement in therapy. *Psychotherapy Research*, 9, 437-451.

Elkin, I. (1996). Further differentiation of common factors. *Clinical Psychology: Science & Practice*, 2(1), 75-78.

Elliott, R., Shapiro, D. A., Firth-Cozens, J., Stiles, W. B., Hardy, G. E., Llewelyn, S. P., & Margison, F. R. (1994). Comprehensive process analysis of insight events in cognitive-behavioral and psychodynamic-interpersonal psychotherapies. *Journal of Counseling Psychology*, 41, 449-463.

Fancher, R. E. & Gutkin, D. (1971). Attitudes toward science, insight therapy, and behavior therapy. *Journal of Clinical Psychology*, 27(1), 153-155.

Frank, J. D., Gliedman, L.H., Imber, S. D., Nash, E. H., Stone, A. R. (1957). Why patients leave psychotherapy. *Archives of Neurology & Psychiatry (Chicago)*, 77, 283-299.

Frankl, V. (1959). *Man's search for meaning*. New York: Simon & Schuster.

Freud, S. (1949). *An outline of psychoanalysis*. (J. Strachey, Trans.). New York: Norton. (Original work published 1940).

Galassi, J. P., Crace, R. K., Martin, G. A., James, R.M. (1992). Client preferences and anticipations in career counseling: A preliminary investigation. *Journal of Counseling Psychology*, 39(1), 46-55.

- Geller, J., Brown, K. E., Zaitsoff, S. L., Goodrich, S. & Hastings, F. (2003). Collaborative versus directive interventions in the treatment of eating disorders: Implications for care providers. *Professional Psychology: Research & Practice*, 34(4), 406-413.
- Gladstein, G. A. (1969). Client expectations, counseling experience, and satisfaction. *Journal of Counseling Psychology*, 16(6), 476-481.
- Grantham, R. J. & Gordon, M. E. (1986). The nature of preference. *Journal of Counseling & Development*, 64(6), 396-400.
- Heine, R. W. & Trosman, H. (1960). Initial expectations of the doctor-patient interaction as a factor in continuance in psychotherapy. *Psychiatry: Journal for the Study of Interpersonal Processes*, 23, 275-278.
- Helson, H. (1964). *Adaptation-level theory: an experimental and systematic approach to behavior*. New York: Harper and Row.
- Heppner, P. P. & Claiborn, C. D. (1989). Social influence research in counseling: A review and critique. *Journal of Counseling Psychology*, 36(3), 365-387.
- Hill, C.E. & Kellems, I. S. (2002). Development and use of the helping skills measure to assess client perceptions of the effects of training and of helping skills in sessions. *Journal of Counseling Psychology*, 49(2), 264-272.
- Hill, C. E. (1995). What are the mechanisms of change in the common factors? A reaction to Weinberger. *Clinical Psychology: Science & Practice*, 2(1), 87-89.
- Hill, C. E. (2004). *Helping skills: Facilitating exploration, insight, and action*. Washington, DC: APA.

- Holen, M. C. & Kinsey, W. M. (1975). Preferences for three theoretically derived counseling approaches. *Journal of Counseling Psychology*, 22(1), 21-23.
- Hutchins, D. E. (1984). Improving the counseling relationship. *Personnel & Guidance Journal*. 62(10), 572-575.
- Jackson, G. G. & Kirschner, S.A. (1973). Racial self-designation and preference for a counselor. *Journal of Counseling Psychology*, 20(6), 560-564.
- June, L. N. & Smith, E. J. (1983). A comparison of client and counselor expectancies regarding the duration of counseling. *Journal of Counseling Psychology*, 30(4), 596-599.
- Kelly, G. (1955). Emerging concepts that affect interprofessional alignments in psychology. *Annals of the New York Academy of Sciences*. 63, 359-364.
- Klepac, R. K. & Page, H. A. (1974). Discrepant role expectations and interviewee behavior: A reply to Pope, Siegman, Blass, and Cheek. *Journal of Consulting & Clinical Psychology*, 42(1), 139-141.
- Kopta, S. M., Lueger, R. J., Saunders, S. M., Howard, K. I. (1999). Individual psychotherapy outcome and process research: Challenges leading to greater turmoil or a positive transition? *Annual Review of Psychology*, 50, 441-469.
- Lambert, M. J., Finch, A. M., Okiishi, J., & Burlingame, G. M. (2005). *OQ-10.2 Manual*. American Professional Credentialing Services, LLC.
- Lennard, H. L. & Bernstein, A. (1967). Role learning in psychotherapy. *Psychotherapy: Theory, Research & Practice*, 4(1), 1-6.

Locker, D. & Dunt, D. (1978). Theoretical and methodological issues in sociological studies of consumer satisfaction with medical care. *Social Science & Medicine*, 12(4-A), 283-292.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "everyone has won and all must have prizes"? *Archives of General Psychiatry*. 32(8), 995-1008.

Meng, X., Rosenthal, R., & Rubin, D. (1992). Comparing correlated correlation coefficients. *Psychological Bulletin*, 111(1), 172-175.

Pohlman, E. (1961). Changes in client preferences during counseling. *Personnel and Guidance Journal*, 40, 340-343.

Pope, B., Siegman, A. W., Blass, T., & Cheek, J. (1972). Some effects of discrepant role expectations on interviewee verbal behavior in the initial interview. *Journal of Consulting & Clinical Psychology*. Vol. 39(3), 501-507.

Rosen. R. M. (1967). Therapy of the unmotivated. *Diseases of the Nervous System*. 28(12), 824-827.

Rosenzweig, S. (1936) Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*. 6, 2-415.

Seelert, K. R. (June, 1997). *Validation of a Brief Measure of Distress in a Primary Care Setting*. Masters Thesis, University of Utah, Department of Educational Psychology.

Shoham-Salomon, V. & Hannah, M. T. (1991). Client treatment interaction in the study of differential change processes. *Journal of Consulting & Clinical Psychology*, 59(2), 217-225.

- Simons, J. A. & Helms, J. E. (1976). Influence of counselors' marital status, sex, and age on college and noncollege women's counselor preferences. *Journal of Counseling Psychology*, 23(4), 380-386.
- Strong, S. R. & Dixon, D. N. (1971). Expertness, attractiveness, and influence in counseling. *Journal of Counseling Psychology*, 18(6), 562-570.
- Strong, S. R. (1968). Counseling: An interpersonal influence process. *Journal of Counseling Psychology*, 18, 215-224
- Tessler, R. & Mechanic, D. (1978). Psychological distress and perceived health status. *Journal of Health & Social Behavior*, 19(3), 254-262.
- Thompson, B. (1999, April). Common methodology mistakes in educational research, revisited, along with a primer on both effect sizes and the bootstrap. Invited address presented at the annual meeting of the American Educational Research Association, Montreal. (ERIC Document Reproduction Service No. ED 429 110).
- Tinsley, H. E. A. & Benton, B. L. (1978). Expectations and preferences in counseling. *Journal of College Student Personnel*, 19, 537-543.
- Tinsley, H. E. A., Workman, K. R., & Kass, R. (1980). Factor analysis of the domain of client expectancies about counseling. *Journal of Counseling Psychology*, 27, 561-570.
- Tracey, T. J. & Dundon, M. (1988). Role anticipations and preferences over the course of counseling. *Journal of Counseling Psychology*, 35(1), 3-14.
- Van Dyck, R. & Spinhoven, P. (1997). Does preference for type of treatment matter? *Behavior Modification*, 21, 172-186.



VandeCreek, L. & Angstadt, L. (1985). Client preferences and anticipations about counselor self-disclosure. *Journal of Counseling Psychology*, 32(2), 206-214.

Volsky, T., Magoon, T. M., Norman, W. T., & Hoyt, D. P. (1965). The outcomes of counseling and psychotherapy. Oxford, England: U. Minnesota Press.

Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes." *Psychological Bulletin*, 122(3), 203-215.