**Psychotherapy Preferences of Laypersons and Mental Health Professionals:**

**Whose Therapy is It?**

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Author Note

**Abstract**

What do patients prefer in their psychotherapy? Do laypersons and mental health professionals (as patients) want the same, or different, things? The authors systematically examined patients' psychotherapy preferences and quantitatively compared two samples of laypersons ($N = 228, 1305$) with one sample of mental health professionals ($N = 615$) on the four dimensions of the Cooper–Norcross Inventory of Preferences (C-NIP): Therapist Directiveness vs. Client Directiveness, Emotional Intensity vs. Emotional Reserve, Past Orientation vs. Present Orientation, and Warm Support vs. Focused Challenge. On average, laypersons wanted therapist directiveness and emotional intensity. Robust differences were found between laypersons' and professionals' preferences on these two dimensions: mental health professionals wanted less therapist directiveness than laypersons ($g$s $= 0.92$ and $1.43$ between groups) and more emotional intensity ($g$s $= 0.49$ and $1.33$). Females also wanted more warm support than males ($g$s $= 0.40$ and $0.57$). These findings suggest that psychotherapists should be mindful of their own treatment preferences and ensure that these are not inappropriately generalized to patients.

*Keywords*: client preferences, therapy preferences, psychotherapy, psychotherapy process, psychotherapy outcome, therapeutic alliance

**Clinical Impact Statement**

**Question:** What do laypeople prefer in psychotherapy, and do mental health professionals want the same in their own therapy? **Findings:** Our results demonstrate huge variations in therapy preferences but that in general laypersons prefer more direction and less emotional intensity than their psychotherapists. **Meaning:** Mental health professionals should consider assessing their patients' activity preferences, accommodating them when clinically and ethically feasible, and guarding against projecting their own desires onto their patients. **Next Steps:** Future practice and research will increasingly ask whose preferences prevail and under which circumstances should therapists' preferences supersede those of their patients.

## Psychotherapy Preferences of Laypersons and Mental Health Professionals:

## Whose Therapy is It?

What do patients want in their psychotherapy? Transformations in health care have converged to emphasize a patient-centered philosophy (Kazak, Nash, Hiroto, & Kaslow, 2016), in which patient values and preferences are now considered a co-determining factor in psychological and medical treatments (National Collaborating Centre for Mental Health, 2010; Norcross, Hogan, Koocher, & Maggio, 2017; The Health Foundation, 2014). The international movement of evidence-based practice (EBP) considers patient values as one of the three essential evidentiary sources, along with best research evidence and clinical expertise, which require consideration and integration. The American Psychological Association (2006) definition of EBP explicitly expanded "patient values" into "patient characteristics, culture, and preferences," thereby placing clients in a more active, prominent position in mental health. In all circumstances, the inclusion of client preferences is a defining and necessary feature of EBP.

This shift towards a patient-centered approach is supported by the best research evidence. Two meta-analyses have demonstrated that adapting psychotherapy to patient preferences leads to improved treatment outcomes and decreased dropout rates. Clients who receive their preferences, as compared with clients who do not, show better treatment outcomes and satisfaction and lower dropout rates at a ratio of almost one-to-two (Lindhiem, Bennett, Trentacosta, & McLear, 2014; Swift, Callahan, Cooper, & Parkin, 2019). Specifically, in the meta-analysis of 51 studies (16,000+ patients) comparing the outcomes of clients matched vs. non-matched to their preferences, Swift and colleagues (2019) reported a $d = 0.28$ in favor of clients matched to their preference. Patients receiving their psychotherapy preferences were almost half as likely to drop out of therapy prematurely (OR $= 1.79$).

It is therefore incumbent upon psychotherapists to be aware of the therapy preferences of their patients. In addition, it is important for psychotherapists to understand their own preferences because, as the research indicates, mental health professionals' conduct psychotherapy primarily on the basis of their own personal preferences, theoretical orientations, clinical experiences, and personal therapy (e.g., Arthur, 2001; Beutler, Williams, Wakefield, & Entwistle, 1995; Norcross & Prochaska, 1983; Orlinsky & Ronestad, 2005; Safran, Abreu, Ogilvie, & DeMaria, 2011; Stewart & Chambless, 2007; Morrow-Bradley & Elliott, 1986). Hence, psychotherapists may unwittingly "project" onto clients their own psychotherapy preferences and conduct treatment accordingly. Psychologically, this is a variant of the *false consensus effect*, whereby individuals see their own behavioral choices and judgments as more common than they actually are (Mullen et al., 1985; Ross, Greene, & House, 1977). Such an effect may be particularly problematic if there are wide divergences in the psychotherapy preferences of the members of the psychotherapeutic dyad.

Three types of client preferences have been identified in the literature (Swift et al., 2019). *Therapist preferences* refer to patients' desires that psychotherapists will have specific personal characteristics, such as gender, ethnicity, or religion. *Treatment preferences* refer to desires for a particular kind of treatment method, such as cognitive-behavioral therapy or a person-centered approach. Finally, *activity preferences* refer to particular behaviors, methods, and styles of intervention within the therapeutic work, such as group versus individual therapy or the use of homework (Cooper & McLeod, 2011; Watsford & Rickwood, 2014). In the meta-analytic research (Swift et al., 2019), neither the preference dropout effect nor the preference outcome effect differed depending on the type of preference.

To date, research into patients' preferences has been mainly at the treatment level. Overall, this tends to show that lay patients prefer more active and structured forms of psychotherapy over more insight-based ones. King and colleagues (2000), for instance, found that approximately 60% of patients who wanted to choose their treatment expressed a

preference for CBT, while 40% chose non-directive counselling. In another study (Bragesjo, Clinton, & Sandell, 2004), a random sample of 500 Swedish individuals were asked which of three therapies—CBT, cognitive therapy, and psychodynamic therapy—they would choose if they needed psychological help. Again, CBT proved the most popular, with around 35% opting for this treatment, 27% for cognitive psychotherapy, and 16% for psychodynamic therapy. By contrast, Cole and colleagues (2018) found a significantly greater preference for psychodynamic therapy over CBT in a sample of 315 American men (Hedges's $g = 0.20$).

There is some evidence that these preferences are moderated by demographic and personality factors. Bragesjo et al. (2004) found that individuals with prior treatment for psychological distress showed an increased preference for psychodynamic therapy—a finding replicated in a subsequent study (Frovenholt, Bragesjo, Clinton, & Sandell, 2007), though not in another (Petronzi & Masciale, 2015). Lee (2009) found significant treatment preference differences between males and females, with 74% of males expressing a preference for CBT, but 64% of females expressing a preference for non-directive counselling. Petronzi and Masciale (2015) found that increased preferences for psychodynamic therapy were associated with higher levels of openness and secure attachment, while decreased preferences for CBT were associated with higher levels of fearful attachment.

Although the *activity* preferences of mental health professionals have not been studied directly, there is plentiful research on their *treatment* preferences. Research indicates that there is a tendency for psychotherapists to opt for psychodynamic or psychoanalytic therapies for their own treatment. Across studies and countries, 40% to 60% of personal treatment has historically been in that tradition (Norcross, 2005). Integrative and humanistic therapies have also proven popular.

Mental health professionals, not surprisingly, tend to choose personal therapies similar to their own theoretical orientation. For instance, Norcross, Bike, and Evans (2009) found that 95% of psychoanalytic therapist–patients selected psychoanalytic or

psychodynamic therapy for themselves. Controversially, research has indicated that behavior therapists do not tend to choose that orientation for their own therapy (Lazarus, 1971). Across studies, fewer than one in five behavior therapists chose behavioral treatment for themselves (Norcross, 2005; Norcross et al., 2009). Concurrently, few non-behavioral psychotherapists—3% to 10%, depending on the study—elected to undergo behavior therapy themselves (Norcross, 2005). This research suggests that, while lay patients may express preferences for more directive and structured forms of psychotherapy, the same is probably not true for psychotherapists.

In terms of clinical value, preference research at the treatment level is limited. Psychotherapists may only be skilled in a small range of therapeutic models, such that accommodating patients' preferences in multiple treatment methods may not prove possible. The situation is similar with therapist preferences, where psychotherapists' ability to modify their personalities or demographic characteristics is highly limited. However, adapting to patients' activity preferences proves easier as psychotherapists can accommodate to each individual patient: adopting, for instance, a more directive or less directive stance. This may be particularly true for integrative, eclectic, and pluralistic psychotherapists, who make up a large proportion of the mental health work force (Norcross & Goldfried, 2019).

Evidence on patients' activity preferences (both lay and mental health professionals), however, is virtually non-existent. The sole exception, to our knowledge, is a study by Berg, Sandahl, and Clinton (2008), which invited clients to indicate their preferences for particular therapeutic activities using the Psychotherapy Preferences and Experiences Questionnaire. However, the study was small scale, the patients were experiencing generalized anxiety disorder and, indeed, actual preferences were not reported.

The aims of the present study were to: (a) systematically identify lay patients' activity preferences for psychotherapy, (b) quantitatively compare the preferences of lay patients and

psychotherapist patients, and (c) tentatively examine how these preferences may vary by demographic factors.

## Method

### Study 1: Convenience Sample

The first study sought to understand the psychotherapy preferences, as patients, of both psychotherapists and laypeople. To maximize the representativeness of our sample, we recruited participants at various levels of involvement with psychotherapy. We employed four recruitment strategies. First, notices were placed on social media websites. Second, we posted invitations on the websites of a range of therapy/counseling services and directories, inviting prospective consumers to access the survey. Third, undergraduates at two universities, one in the United States and one in the United Kingdom, were invited to participate. Fourth, we sent emails to professional contacts in the mental health field asking them to complete the inventory themselves and to forward it to any clients, trainees, or colleagues that might be interested in participating.

Over the course of two months, 1,105 individuals accessed the survey, and 860 (77.8% of those accessing) participated, with 713 completing all preference items. Of the 860 respondents, 615 indicated that they were mental health professionals (71.5%) and 228 indicated that they were not (subsequently referred to as "laypersons"; 26.5%), with 17 (2.0%) not responding to this item (and thus removed from further analysis; leaving 843). The mental health professionals self-identified as counsellors (45.2%), psychotherapists (26.9%), and psychologists (10.6%). Seventy-one percent of the mental health professionals were qualified/licensed; the remainder were in training.

Table 1 summarizes the demographic characteristics of the 843 Study 1 participants, both laypersons and mental health professionals. Their mean age was 44.9 years (SD = 12.7), and they were primarily female (82%). A large majority of participants were of White ethnicity (93%), with smaller numbers of Asian, Hispanic/Latino, and Black participants. Of

the full sample, 62% had been in psychotherapy in the past, 32% were currently in therapy, 4% were about to start or had just started therapy, 3% had completed therapy in the past month, and only 8% had never attended therapy.

The laypeople were significantly younger than the mental health professionals, $F(1) = 30.54$, $p < .001$. There were also significant differences in nationality ($\chi^2 (1) = 52.60$, $p < .001$), with higher proportions of laypersons in the United States. The laypersons were less likely than the mental health professionals to have attended counseling or psychotherapy in the past (50% vs 68%; $\chi^2 (1) = 22.62$, $p < .001$).

An online survey was created and hosted using the Qualtrics Survey Software program. The survey consisted of an information page, consent form, demographics questionnaire, and a series of therapy preference items (40 in total, of which 18 were used for the present analysis). The demographics questionnaire asked participants to indicate their gender, age, country of residence, and ethnicity (fixed response set). Participants checked one or more boxes to indicate their history of receiving psychotherapy. They then indicated if they were a mental health professional in training or in practice. If they indicated in the affirmative, they indicated their specific profession and whether they were in training or a qualified/licensed practitioner.

To assess patients' activity preferences, we adopted a relatively new, brief, and multidimensional measure designed for use in routine clinical practice: the Cooper–Norcross Inventory of Preferences (CNIP, Cooper & Norcross, 2016, see Appendix). Constructed through principal component analysis of both United States and British samples, the 18-item instrument yields subscores on four dimensions along which therapists may adapt their activities. Those scales are Therapist Directiveness vs. Client Directiveness (TD–CD), Emotional Intensity vs. Emotional Reserve (EI–ER), Past Orientation vs. Present Orientation (PaO–PrO), and Warm Support vs. Focused Challenge (WS–FC).

The instructions for the C-NIP read: "On each of the items below, please indicate your preferences for how a psychotherapist or counsellor should work with you. Please click on the appropriate number on each item." Participants respond on a seven-point, Likert-type scale (3 to 0 to 3) with labels: "3 indicates a strong preference in that direction"; "2 indicates a moderate preference in that direction"; "1 indicates a slight preference in that direction." Zero was marked on each scale as indicating "No preference." Example items are, "Focus on specific goals"—"Not focus on specific goals" (TD–CD scale scale) and "Focus on my life in the past"—"Focus on my life in the present" (PaO–PrO scale).

Scale scores equaled the unweighted sum of each of the items constituting the individual scales. In each case, a higher score indicated a greater preference for the first term in the scale title. Cut points for strong preferences on each of the four scales were based on midpoints between (a) the empirical lower and upper quartiles of the sample distributions of each scale score, and (b) the quartile cutting points based on standardizing the scores to the scale mean (0) and sample standard deviation, assuming normal Gaussian distributions. These preliminary cut-off scores are indicated on the instrument itself (see Appendix).

Scale reliabilities for the C-NIP in this sample were TD–CD: professionals $\alpha = .82$, laypersons, $\alpha = .79$; EI–ER: professionals' $\alpha = .66$, laypersons' $\alpha = .66$; PaO–PrO: professionals' $\alpha = .71$, laypersons' $\alpha = .77$; WS–FC: professionals' $\alpha = .62$; laypersons' $\alpha = .55$.

**Study 2: Representative Sample**

The aim of Study 2 was to obtain responses from laypersons representative of both UK and US populations in terms of age, sex, and ethnicity. Sample representativeness was based on the United Kingdom Census (2011a, b) and the United States Census (2010a, b), with recruitment targeted towards gathering 600 responses from individuals in each country. Within each national sample, representation was categorized according to sex (female/male), and bracketed into three groups by age. These brackets approximated population age

groupings for females and males to within 5% tolerance for the US sample and to within 1% for the UK sample, based on the proportions of eligible adults reported by the census in each country. A further layer, representing the ethnicity of each country, was applied with respect to the five main categories detailed by UK Census data (White, Black, Asian, Mixed, and Other).

Recruitment was conducted via Prolific.ac, an online platform designed for connecting researchers with potential participants, which compares favorably with Amazon's Mechanical Turk (Palan & Schitter, 2018). Sixty adverts were placed on the Prolific site— one for each of the demographic combinations (2 nationalities * 2 genders * 3 age groups * 5 ethnicities)—which directed people to our online survey. As in Study 1, this online survey was created and hosted using the Qualtrics Survey Software program, and consisted of an information page, consent form, demographics questionnaire, and the 18 C-NIP preference items (along with attention check items, and five additional preference items that are not included in this analysis). Participants were offered the equivalent of UK minimum wage for taking part in the 6-minute study, either signing up via their dashboard on Prolific.ac or via weekly "open-studies" adverts sent out by Prolific. We closed recruitment to participants from each demographic combination once the target number for that combination was achieved. However, as recruitment to some demographic combinations was slow, and we had adverts running for several months in attempting to gain full representation, we chose to close the study at eight months with some groups still under-recruited (see below).

In total, 1,679 Prolific users signed up for the study, and 1,616 completed the survey (96.2%). Of these, 34 duplicate responses were removed (with only the participants' first entry retained) and another 50 responses were removed because participants identified as mental health professionals. A further 227 responses were removed as a result of participants failing to respond to either of two items checking their attention ($n = 197$), and/or failing to

correctly answer a question regarding the survey content and instructions (*n* = 30). That left 1,305 laypersons in Study 2.

Table 1 summarizes the demographic characteristics of these 1,305 participants. The age of participants ranged between 18 and 84 years old (*M* = 44.1, *SD* = 14.6), and the composition of the sample (50.3% female) closely approximated national population statistics for the UK and US (50.8% female). Approximately 43% indicated that they had been in counseling or psychotherapy in the past, with a further 9.6% just about to start therapy, in therapy, or recently completed. Sample composition with regard to ethnicity approximated national statistics for individuals in the UK (88%, 2%, 6%, 2% , 1% sample vs. 86%, 3%, 8%, 2%, 1% population) and in the US (75%, 10%, 3%, 3%, 8% sample vs. 72%, 13%, 5%, 3%, 7% population) with respect to the aforementioned ethnicity categories. Variations between sample and population statistics can be explained by difficulties in recruiting older (55+) non-white participants via Prolific.ac and by choosing to retain all successful responses, as discrepancies between pre-screening information and participant responses regarding ethnicity resulted in over-recruitment of some demographic categories (typically white males).

Participants also reported their education level with respect to their national education system. In the UK sample, 21.1% of participants were educated to GCSE or below, a further 19.5% having completed A-levels, 15.6% were between this and first degree, 25% reporting having a first degree, and 18.7% were qualified at post-graduate level or above. In the US sample, 10.9% were educated to high school level or below, 25.5% reported some college education, 10.5% had an associate degree, 36.4% had a bachelor's degree, and 16.7% reported being educated at masters level or above.

As expected, in comparison with Study 1, laypersons in Study 2 were significantly more representative of the male population (14% vs 49.4% respectively), of laypersons from the United States (20.2% vs 50.1%), and of those having never attended therapy (20.2% vs

50.7%). The ethnicity distribution in Study 2 also provides better representation than Study 1 with regard to Asian (+1.7%), Hispanic/Latino (+1.7%), and Black laypersons (+5%), with comparatively fewer responses gathered from Whites (-5.1%). For ease of identification, we characterize the laypersons participating in Study 1 as the "convenience sample" and the laypersons in Study 2 as the "representative sample."

Scale reliabilities for the C-NIP in this sample were generally lower than in the convenience sample. Specifically, TD–CD: $\alpha$ = .54, EI–ER $\alpha$ = .51, PaO–PrO $\alpha$ = .80, WS–FC $\alpha$ = .61. The implications of these alpha coefficients are considered in the Discussion.

**Statistical Analysis**

To obtain an initial indication of the response distributions, we calculated descriptive statistics on the highest loading ("marker") items on each of the C-NIP scales. As internal reliabilities for our representative sample were modest, we also examined individual item responses for this sample. The mean scores of the laypersons in Study 1, the laypersons in Study 2, and the mental health professionals were then compared on the four C-NIP scales by means of ANOVAs.

Multiple linear regression analysis was used to examine demographic predictors of activity preferences. Independent variables were the clients' gender (male vs. female), nationality (UK vs. US), age (linear), education status (degree vs. non-degree), ethnicity (Black, Hispanic, and minority ethnic backgrounds vs. white), and therapy history (not attended vs. currently or previously attended). For this analysis, we focused primarily on our representative laypersons sample. However, we also examined whether significant differences between groups were replicated in the convenience laypersons sample (excepting education level, where we did not have such data in our convenience sample).

Given the relatively large sample sizes, we decided *a priori* to characterize any group differences as "meaningful" if they evidenced both statistical significance (*p* levels less than

.05) and clinical significance (at least a small effect size, defined as Hedges's $g \geq .2$ or eta-squared $\geq .02$).

## Results

### Variation in Therapy Preferences

Figure 1 presents the frequency distributions of two marker items for the mental health professionals and the laypersons in the convenience and representative samples. As shown here, considerable variation in preferences is evident; responses covered the full range of possible responses from -3 to +3. For instance, on the "Not focus on specific goals"—"Focus on specific goals" item, between 2% and 30% of the participants selected each of the seven response options. For both professionals and laypersons, variations were considerable on this item ($SD$s = 1.4–1.8). Likewise, all response options were used on the "Encourage me to go into difficult emotions"—"Not encourage me to go into difficult emotions" item (SDs = 1.2–1.4).

### Mean Preferences

Table 2 presents the mean scores of the three samples on the C-NIP scales. On average, laypeople in both samples showed definite preferences towards therapist directiveness and emotional intensity, with scores on the other two C-NIP dimensions close to the midpoint. Mental health professionals showed a similar pattern, except that on the TD–CD scale they showed a small average preference towards client directiveness. These trends can also be seen in Table 3, which presents the percentage of individuals with strong preferences on each scale.

In terms of individual items within the representative layperson sample, the five strongest preferences (in either direction) were: being taught skills to deal with problems ($M$ = 2.4, $SD$ = 1.0), therapist support rather than confrontation ($M$ = 1.7, $SD$ = 1.4), being encouraged to express strong feelings ($M$ = 1.6, SD = 1.2), being encouraged to go into difficult emotions ($M$ = 1.3, $SD$ = 1.4), and focusing on specific goals ($M$ = 1.3, $SD$ = 1.5).

Aside from this latter item, these were also the most strongly endorsed items in the convenience layperson sample.

**Comparison of Professionals and Laypersons**

By our *a priori* criteria, two of the four C-NIP scales demonstrated meaningful differences. Specifically, laypersons favored more therapist directiveness and less emotional intensity than did the mental health professionals in psychotherapy. The magnitude of the eta squared was large (.28, .26); with Hedges' $g$s of 0.92 and 1.43 on the TD–CD scale for the therapists compared to the convenience and representative laypeople respectively, and 0.49 and 1.33 on the EI–ER scale for the same comparisons, respectively.

Figure 2 presents boxplots for these two scales for all three samples; mental health professionals and laypersons clearly differ in their activity preferences. Laypersons typically enter therapy preferring that their therapists focus on specific goals, provide structure, teach skills, and take the lead far more than the therapists themselves prefer. At the same time, compared to professionals, laypersons typically favor less emotionally intense sessions; that is, less frequently being encouraged to express strong feelings and with less focus on the therapeutic relationship.

Another way to express these large disparities is by examining the percentages of each group expressing a strong preference. Table 3 presents these percentages for the mental health professionals and the laypersons in both studies. Only 1 in 10 of the mental health professionals expressed a strong preference for therapist directiveness contrasted with 4 in 10 of the laypersons in both studies; on the other side of this dimension, less than 2 in 10 laypersons expressed strong preferences for client directiveness, in comparison with 4 in 10 professionals. On the Emotional Intensity vs. Emotional Reserve scale, about 7 in 10 professionals strongly preferred an emotionally intense therapy compared to less than half of laypersons.

By contrast, laypersons and professionals were generally in accord on their preferences for therapy emphasizing a Past Orientation vs. Present Orientation and a Warm Support vs. Focused Challenge. Although the past orientation scale did evidence a statistical difference (Table 2), the eta-squared effect size of .01 did not meet our threshold.

**Preference Predictors**

Based on our criteria for statistical and clinical significance, we found several differences in psychotherapy activity preferences on the basis of demographic and geographic factors in the representative sample. Greater emotional intensity (EI–ER) was desired by UK respondents as compared with US respondents (UK $M = 3.4$, US $M = 2.5$, $g = 0.22$) and by non-college graduates as compared with college graduates (non-graduate $M = 3.4$, graduate $M = 2.5$, $g = 0.21$). Further, ethnic minority laypersons also preferred greater emotional intensity than white participants ($M = 3.7$, white $M = 2.8$, $g = 0.21$). UK respondents showed a greater preference for past orientation as compared with US respondents (UK $M = -0.6$, US $M = -1.4$, $g = 0.20$), However, none of these findings were replicated in our convenience sample of laypersons.

Females showed a greater preference for warm support (SW–FC) as compared with males (female $M = 0.9$, male $M = -1.2$, $g = 0.40$). This finding was indeed replicated in our convenience sample (female $M = 0.2$, male $M = -2.6$, $g = 0.57$).

## Discussion

Results from each of our three samples indicate that individuals varied markedly in their therapy activity preferences. However, consistent with previous research on treatment preferences, on average, lay patients preferred relatively directive forms of psychotherapy, with a focus on goals and the acquisition of practical skills. In addition, lay patients desired a degree of emotional intensity in their work: encouraged to go into difficult emotions and express strong feelings. This suggests that the treatment preferences for CBT, found in previous studies, may be part of a more general preference for active and directive

psychotherapies. That is, lay patients want things to "happen" in their therapy: for instance, to learn skills, to express emotions, and to be challenged.

Consistent with previous research on the therapist's own treatment choices, mental health professionals preferred a more psychodynamic, insight-oriented style of therapy for themselves. The preferred therapy work was characterised by emotional intensity and limited therapist directiveness.

These large differences in activity preferences call for proactive discussion on how the psychotherapy dyad can best work together. Therapists should be mindful that many patients enter treatment preferring that the therapist prove directive—provide structure, offer homework, teach skills, focus on goals—more than they, themselves, would want in their own treatment. Likewise, laypersons are less likely to share therapist preferences for intense expression of feelings, focus on difficult emotions, and discussion of relationship dynamics. Less directive and insight-oriented therapists, in particular, may need to explain and frame the clinical rationale for their methods and address an initial mismatch with patient preferences. Methods for assessing patients' activity preferences—such as interview questions and formal measures (see Swift et al., 2019)—may help therapists develop a more "objective" understanding of the patient's preference profile.

In addition, these findings suggest that mental health professionals should reflect on their own activity preferences. In this way, they will better identify and "own" their personal desires, not project them onto their patients, and maintain boundaries between what they prefer and what their clients prefer. A similar set of skills as countertransference management strategies (Hayes, Gelso, Goldberg, & Kivlighan, 2018) would prove useful in this regard.

When the therapist is unable or unwilling to accommodate patient preferences, then therapeutic alternatives can be considered. These may include empathizing with patient disappointment; conducting role socialization or patient education about the value of, for

example, less directive work; and in-session discussion of patient-therapeutic relationship. Clinicians should also consider practice limits and differential referrals.

Of course, simply because a patient desires something does not mean that the therapist automatically provides it. Ethical, legal, and clinical constraints still bind the therapist to ethical and effective practice. In certain cases, for instance, the patient may be unconsciously trying to recreate a pathogenic relationship or test the therapy's frame (e.g., McCullough Jr., 2006). In addition, patients may lack *motive congruence*: their explicit, self-attributed wants and preferences bear little relation to their implicit, actual desires (McClelland, Koestner, & Weinberger, 1989). Hence, a priority for future research is to identify the particular factors—patient, context, or treatment—that may moderate the extent to which accommodating clients' preferences leads to positive outcomes.

Our finding that mental health professionals preferred a less directive and more emotionally intense approach may be consistent with evidence that, as people have more psychotherapy experience, they prefer more insight-based treatments (Bragesjö et al., 2004; Frövenholt et al., 2007). However, we did not find broader support for this conclusion. Whether or not our representative sample had previous therapy did not relate to their preferences on any of our four scales.

In terms of demographic predictors, our one robust, replicated finding was that female laypersons preferred more warm support, and less focused challenge, than male laypersons. This average difference is relatively consistent with sex role expectations (e.g., Bem, 1981), with women placing greater emphasis on "communion" as opposed to "agency" (Bakan, 1966).

**Limitations and Future Directions**

A limitation of our study was the low internal reliability of the C-NIP, in our representative sample, particularly on the therapist directiveness and emotional intensity scales. This indicates that the measure is in need of development, and work is underway on a

revised version of the C-NIP, such that it can demonstrate adequate psychometric properties even with a few items. It is not clear why the internal reliability of the measure dropped from the convenience to the representative sample. One possibility is that the laypersons in the representative sample were less well informed about psychotherapy than those in the convenience sample, and therefore did not understand the items as well. Another possibility is that participants who completed the measure for payment, via Prolific.ac, completed the survey in a less attentive manner. However, as well as removing participants who failed attention checks, we found no association between scale reliabilities and the participants' survey completion times.

Low internal reliabilities on the therapist directiveness and emotional intensity scales mean that comparisons between mental health professionals and laypersons on these dimensions should be treated with some caution. However, these differences were found in the convenience sample as well as the representative one. In addition, *post hoc* analyses indicated that, on all five individual TD–CD items, mental health professionals scored significantly lower than laypersons, with effect sizes ($g$) ranging from 0.54–1.34 compared to the representative sample, and 0.56–0.92 compared to convenience sample. Similarly, on all five EI-ER items, mental health professionals scored significantly higher than laypersons, with effect sizes ranging from 0.53–1.11 against the representative sample, and 0.18–0.43 against the convenience sample.

Our study suffered from a number of additional limitations. First, the data in Study 1 depended on the self-report of a convenience sample of laypersons. That drawback was robustly addressed in Study 2, but that sample was somewhat under-representative of older non-white individuals, and may have an over-representation of more responsive and agentic individuals (as participants needed to proactively respond to the Prolific advert or email). Second, the mental health professionals in Study 1 hailed from a convenience sample primarily consisting of UK counsellors, and was not representative of the full range of mental

health professionals. Third, these findings were restricted to individual counseling and psychotherapy in the United States and the United Kingdom, both Western, developed countries. Fourth, our study assumed that mental health professionals' own activity preferences may influence their assumptions about clients' preferences, but we did not directly test that proposition.

Finally, future research in psychotherapy preferences will need to progress from matching on macro-level preferences, such as medication versus psychotherapy or group versus individual intervention, to the types of micro-level preferences identified in the C-NIP. To some extent, this has already occurred in the research demonstrating the effectiveness of adapting psychotherapy to the client's ethnic background (Soto et al., 2018) and religious orientation (Captari et al., 2018). We anticipate and encourage more research on showing that matching clients' preferences for micro-level activities does, indeed, lead to improved effectiveness.

**Conclusions**

Despite these study limitations, our research is the first to provide evidence on the psychotherapy activity preferences of both laypersons and mental health professionals. A particular strength is that, in Study 2, evidence hailed from a large and relatively representative sample of UK and US citizens. Our study shows that patients differ markedly in what they prefer in treatment, but that there is a definite preference for more active, structured, evocative, and educational styles of intervention. Most importantly, we found that there were large and meaningful differences between what laypersons want in psychotherapy and what mental health professionals, themselves, want.

Our hope is that this line of research will increase the frequency of practitioners assessing their patients' treatment preferences and the therapy dyad deliberating in session about the value and limits of accommodating those preferences. We hope this research prompts the profession to raise uncomfortable but necessary questions. Whose therapy is it?

Whose preferences prevail? And under which circumstances can and should therapists'

preferences supersede those of their patients?

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**Table 1.** Participant Characteristics

| | Study 1 Convenience MH Professionals ($n = 615$) | Study 1 Convenience Laypersons ($n = 228$) | Study 2 Representative Laypersons ($n = 1305$) |
|---|---|---|---|
| Gender | | | |
| Female | 81.3% | 84.2% | 50.3% |
| Male | 18.0% | 14.0% | 49.4% |
| Other/not stated | 0.7% | 1.8% | 0.3% |
| Nationality | | | |
| United Kingdom | 80.2% | 67.5% | 49.9% |
| United States | 4.9% | 20.2% | 50.1% |
| Europe (except UK) | 8.1% | 5.7% | 0% |
| Other/not stated | 6.8% | 6.6% | 0% |
| Ethnicity | | | |
| White | 90.6% | 86.7% | 81.6% |
| Asian | 1.5% | 3.1% | 4.8% |
| Hispanic/Latino | 1.6% | 1.8% | 3.5% |
| Black African/West Indian | 1.8% | 0.9% | 5.9% |
| Mixed and other | 2.6% | 4.4% | 3.5% |
| Not disclosed | 2.0% | 3.9% | 0.6% |
| Therapy status* | | | |
| About to start/just started | 3.3% | 4.4% | 3.5% |
| Currently in therapy | 33.8% | 30.3% | 5.4% |
| Recently completed | 3.6% | 1.3% | 0.7% |
| Attended in past | 67.8% | 50.0% | 42.8% |
| Never attended | 1.6% | 20.2% | 50.7% |
| Mental Health Profession* | | | |
| Counsellor | 63.2% | | |
| Psychotherapist | 37.6% | | |
| Psychologist | 14.8% | | |
| Social worker | 1.4% | | |

*Total %s equaled more than 100% as participants could endorse more than one response.

**Table 2.**

Comparison of C-NIP Scale Scores for Mental Health Professionals and Laypersons

| | Study 1 Mental Health Professionals M (SD) | Study 1 Convenience Laypersons M (SD) | Study 2 Representative Laypersons M (SD) | F value (df) | Effect Size (eta) |
|---|---|---|---|---|---|
| Therapist vs. Client | -1.83 | 4.54 | 6.01 | 404.9** | 0.28 |
| Directiveness | (7.03) | (6.56) | (4.55) | (2,2012) | |
| Emotional Intensity vs. | 8.57 | 6.44 | 2.97 | 365.8** | 0.26 |
| Emotional Reserve | (4.22) | (4.65) | (4.21) | (2, 2104) | |
| Past Orientation vs. | -0.45 | 0.35 | -1.00 | 12.1* (2, | 0.01 |
| Present Orientation | (3.43) | (4.15) | (4.28) | 2120) | |
| Warm Support vs. Focused | 0.38 | -0.25 | -.13 | 2.29 | 0.00 |
| Challenge | (5.12) | (4.91) | (5.23) | (2,2110) | |

*Note.* Higher scores indicate greater preference for left-hand term in title.

*p < .05
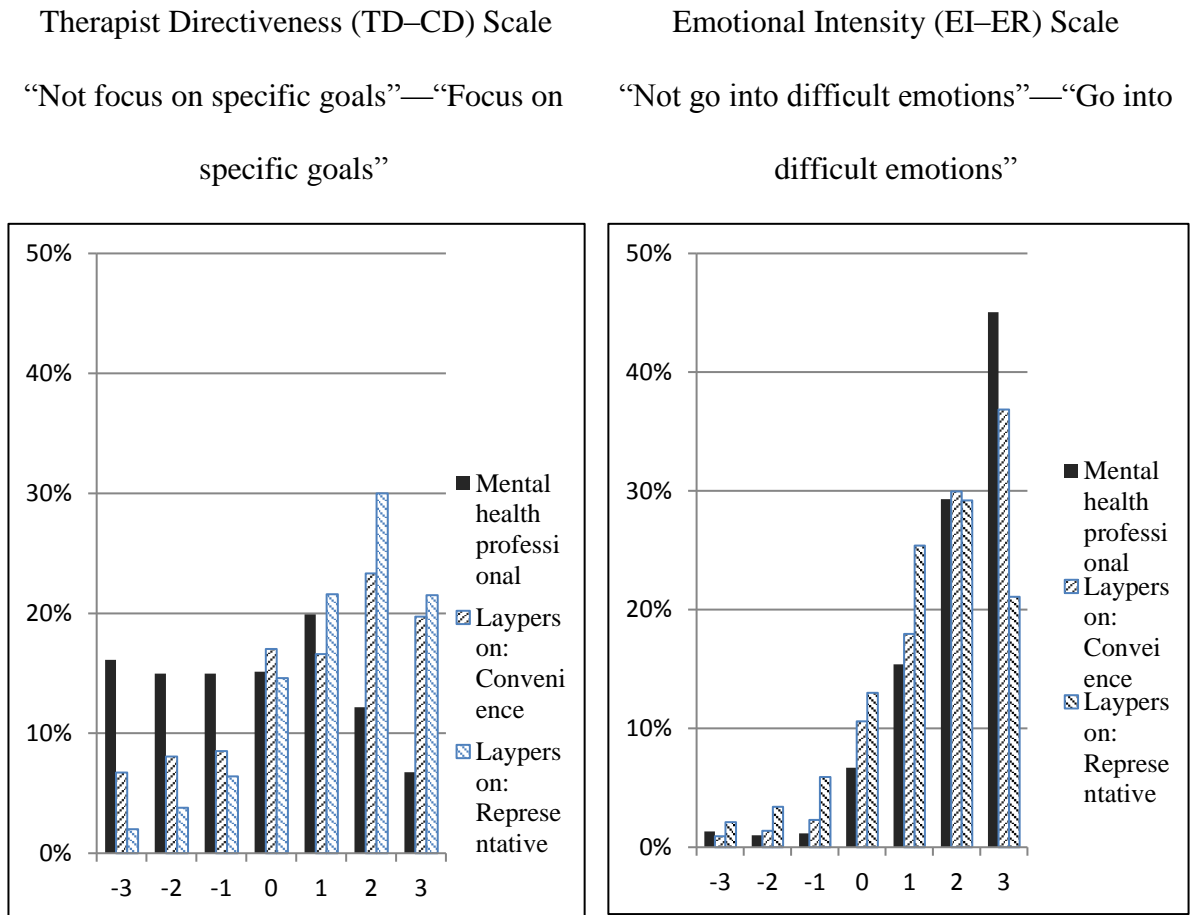
**p < .05 and clinically significant

**Table 3.**

Distribution of Strong Preferences for Mental Health Professionals, Convenience Laypeople, and Representative Laypeople

| | MH Professionals | | Laypeople (convenience) | | Laypeople (representative) | |
|---|---|---|---|---|---|---|
| | L. Strong Preference | R. Strong Preference | L. Strong Preference | R. Strong Preference | L. Strong Preference | R. Strong Preference |
| TD–CD | 9.6% | 44.8% | 38.6% | 17.2% | 40.2% | 4.0% |
| EI–ER | 68.5% | 2.4% | 49.5% | 7.5% | 20.0% | 18.6% |
| PaO–PrO | 17.1% | 25.2% | 31.8% | 26.9% | 19.7% | 38.4% |
| WS–FC | 25.9% | 20.9% | 19.0% | 22.6% | 23.2% | 25.4% |

*Note.* L. Strong Preference = Strong preference for left-hand term in title; R. Strong Preference = Strong preference for right-hand term in title. Higher scores indicate greater preference for left-hand term in title. TD–CD = Therapist Directiveness vs. Client Directiveness, EI–ER = Emotional Intensity vs. Emotional Reserve, PaO–PrO = Past Orientation vs. Present Orientation, WS–FC = Warm Support vs. Focused Challenge.

**Figure 1.**

Frequency Distribution of Responses on Marker Items of Two C-NIP Scales



Therapist Directiveness (TD–CD) Scale

"Not focus on specific goals"—"Focus on specific goals"

Emotional Intensity (EI–ER) Scale

"Not go into difficult emotions"—"Go into difficult emotions"

*Note.* Higher scores indicate greater preference for therapist directiveness/focus on specific goals, and for emotional intensity/go into difficult emotions

**Figure 2.**

Boxplots for Laypersons and Mental Health Professionals on Therapist Directiveness and Emotional Intensity Scales
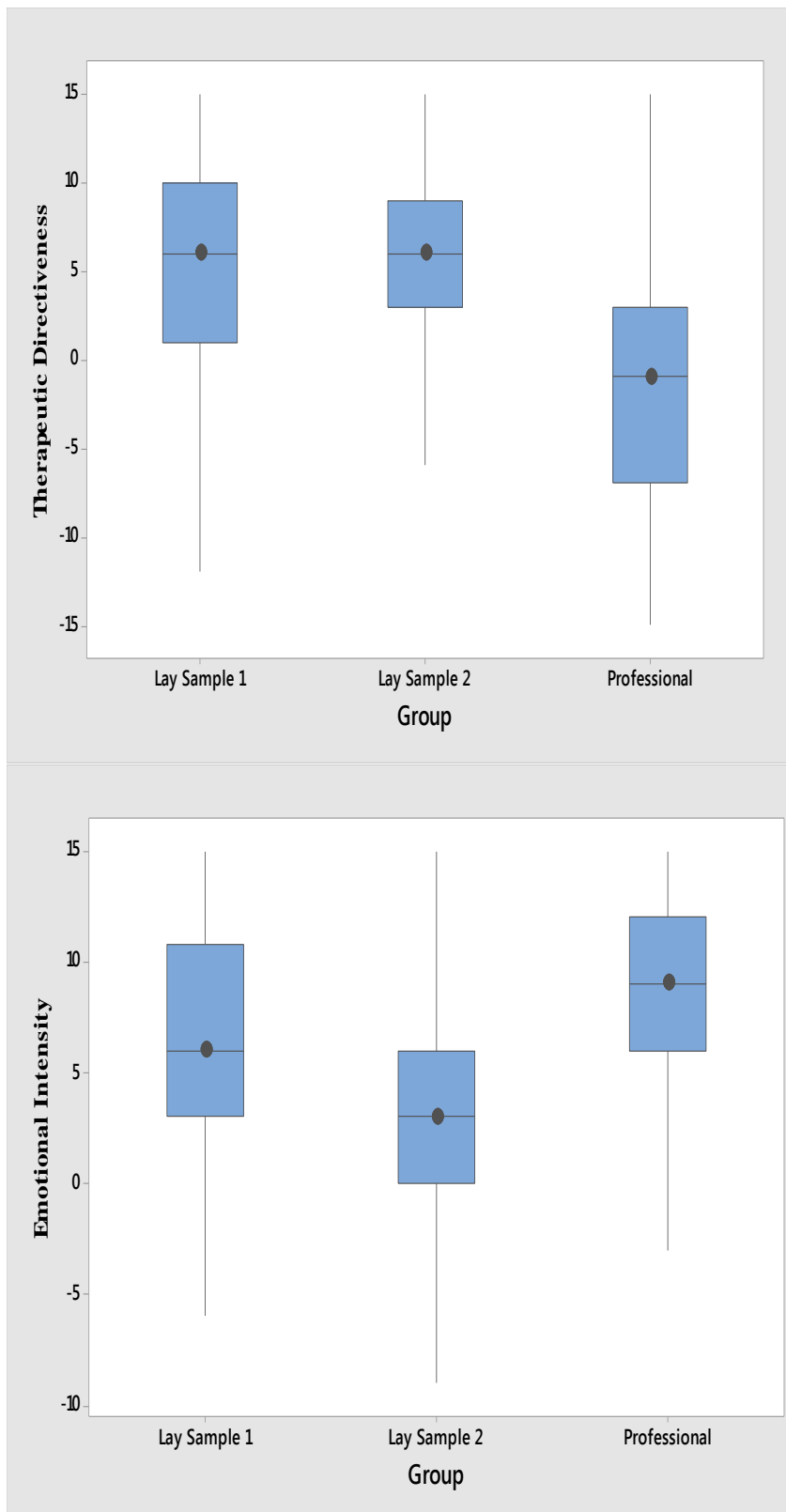
**Appendix: The Cooper–Norcross Inventory of Preferences**

## Cooper – Norcross Inventory of Preferences (C-NIP)

On each of the items below, please indicate your preferences for how a psychotherapist or counsellor should work with you by circling a number. A 3 indicates a *strong* preference in that direction, 2 indicates a *moderate* preference in that direction, 1 indicates a *slight* preference in that direction, 0 indicates no preference in either direction/an equally strong preference in both directions.

**'I would like the therapist to…'**

1. Focus on specific goals — No or equal preference — Not focus on specific goals
   3    2    1    0    -1    -2    -3

2. Give structure to the therapy — No or equal preference — Allow the therapy to be unstructured
   3    2    1    0    -1    -2    -3

3. Teach me skills to deal with my problems — No or equal preference — Not teach me skills to deal with my problems
   3    2    1    0    -1    -2    -3

4. Give me 'homework' to do — No or equal preference — Not give me 'homework' to do
   3    2    1    0    -1    -2    -3

5. Allow me to take a lead in therapy — No or equal preference — Take a lead in therapy
   -3    -2    -1    0    1    2    3

**Scale 1.** If score is 8 to 15 then strong preference for therapist directiveness. If score is -2 to 7 then no strong preference. If score is -3 to -15 then strong preference for client directiveness.

6. Encourage me to go into difficult emotions — No or equal preference — Not encourage me to go into difficult emotions
   3    2    1    0    -1    -2    -3

7. Talk with me about the therapy relationship — No or equal preference — Not talk with me about the therapy relationship
   3    2    1    0    -1    -2    -3

8. Focus on the relationship between us — No or equal preference — Not focus on the relationship between us
   3    2    1    0    -1    -2    -3

9. Encourage me to express strong feelings — No or equal preference — Not encourage me to express strong feelings
   3    2    1    0    -1    -2    -3

10. Focus mainly on my thoughts — No or equal preference — Focus mainly on my feelings
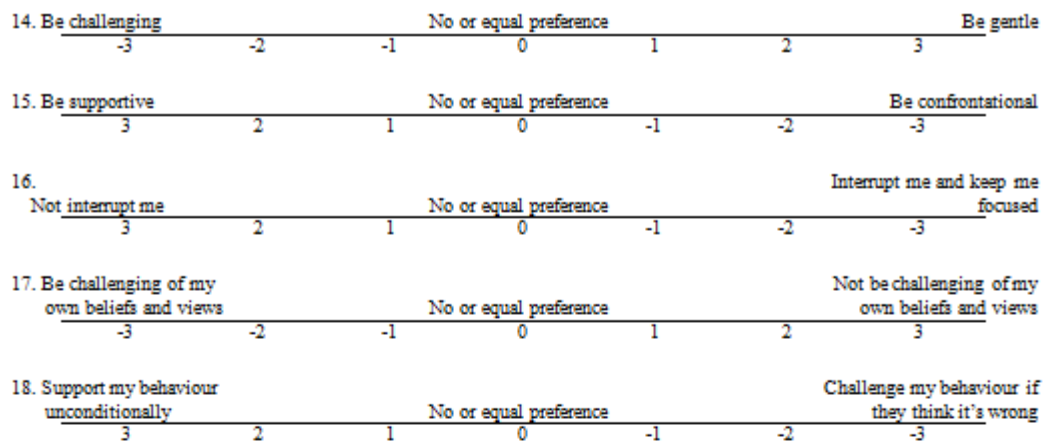    -3    -2    -1    0    1    2    3

**Scale 2.** If score is 7 to 15 then strong preference for emotional intensity. If score is 0 to 6 then no strong preference. If score is -15 to -1 then strong preference for emotional reserve

11. Focus on my life in the past — No or equal preference — Focus on my life in the present
    3    2    1    0    -1    -2    -3

12. Help me reflect on my childhood — No or equal preference — Help me reflect on my adulthood
    3    2    1    0    -1    -2    -3

13. Focus on my future — No or equal preference — Focus on my past
    -3    -2    -1    0    1    2    3

**Scale 3.** If score is 3 to 9 then strong preference for past orientation. If score is -2 to 2 then no strong preference. If score is -2 to -9 then strong preference for present orientation.

| 14. Be challenging | | | No or equal preference | | | Be gentle |
|---|---|---|---|---|---|---|
| -3 | -2 | -1 | 0 | 1 | 2 | 3 |

| 15. Be supportive | | | No or equal preference | | | Be confrontational |
|---|---|---|---|---|---|---|
| 3 | 2 | 1 | 0 | -1 | -2 | -3 |

| 16. Not interrupt me | | | No or equal preference | | | Interrupt me and keep me focused |
|---|---|---|---|---|---|---|
| 3 | 2 | 1 | 0 | -1 | -2 | -3 |

| 17. Be challenging of my own beliefs and views | | | No or equal preference | | | Not be challenging of my own beliefs and views |
|---|---|---|---|---|---|---|
| -3 | -2 | -1 | 0 | 1 | 2 | 3 |

| 18. Support my behaviour unconditionally | | | No or equal preference | | | Challenge my behaviour if they think it's wrong |
|---|---|---|---|---|---|---|
| 3 | 2 | 1 | 0 | -1 | -2 | -3 |

**Scale 4.** If score is 4 to 15 then strong preference for warm support, If score is -3 to 3 then no strong preference. If score is -4 to -15 then strong preference for focused challenge.

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**Additional client preferences for exploration and consideration (as appropriate to service provision)**

**Do you have a *strong* preference for:**

- A therapist of a particular **gender**, **race/ethnicity**, **sexual orientation**, **religion**, or **other personal characteristic**?

- A therapist/counsellor who speaks a **specific language** that is most comfortable for you?

- **Modality** of therapy: such as individual, couple, family, or group therapy?

- **Orientation** of therapy: such as psychodynamic, cognitive, person-centred, or other?

- **Number** of therapy sessions: such as four, dependent on review, open-ended, or other?

- **Length** of therapy sessions: such as 50 mins, 60 mins, 90 mins or other?

- **Frequency** of therapy: such as twice weekly, weekly, monthly, ad hoc or other?

- **Medication**, psychotherapy, or both in combination?

- Use of **self-help** books, self-help groups, or computer programs in addition to therapy?

- **Any other** strong preferences that come to mind? (and do raise them at any point in therapy)

- What would you most **dislike** or **despise** happening in your therapy or counselling?