CLIENT PREFERENCES AND THE SPECIFIC VERSUS COMMON FACTORS DEBATE

By

JOSHUA KEITH SWIFT

Bachelor of Science in Psychology
Brigham Young University
Provo, UT
2005

Master of Science in Clinical Psychology
Oklahoma State University
Stillwater, OK
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Dissertation Approved:

Jennifer Callahan, Ph.D.

Dissertation Adviser

James Grice, Ph.D

Thad Leffingwell, Ph.D..

Brandt Gardner, Ph.D.

A. Gordon Emslie, Ph.D.

Dean of the Graduate College

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CHAPTER I

INTRODUCTION

Psychotherapy, a treatment for mental disorders dating back to the 19th century, has a large body of research supporting its effectiveness (Lipsey & Wilson, 1993; Luborsky, Singer, & Luborsky, 1975; Matt & Navarro, 1997; Shapiro & Shapiro, 1982; Smith & Glass, 1977; Westen & Morrison, 2001). The effectiveness of psychotherapy has been shown in studies comparing it to wait-list controls, to placebo treatments, and to medication (Lambert & Ogles, 2004). Further, psychotherapy's effectiveness is seen to generalize to children and adolescents (Weisz, Weiss, Alicke, & Klotz, 1987; Weisz, Weiss, Han, Granger, & Morton, 1995) and to typical clinical settings (Hunsley & Lee, 2007; Matt & Navarro, 1997; Seligman, 1995).

Although research has consistently found that psychotherapy is an effective treatment method for psychological disorders, indicating which factors contribute to the effectiveness of psychotherapy has been the source of a long-standing debate. On one side of the debate are those who support the use of specific factors, via empirically supported treatments, in clinical practice. This side indicates that the use of specific effective treatments leads to the best outcomes in therapy, above and beyond the use of other common factors.

The question as to whether the use of specific effective treatments leads to the best outcomes in therapy has received particular attention since the release of the 1995 report by the American Psychological Association Division 12's Task Force on

Promotion and Dissemination of Psychological Procedures (Chambless et al., 1995). This task force believed that in order for clinical psychology to survive in competition with biological psychiatry, a new emphasis needed to be placed on recognizing psychotherapies with proven efficacy. They proposed that psychological treatments be placed in one of three categories (well established treatments, probably efficacious treatments, and experimental treatments) based on the level of empirical support for a particular treatment.

A number of criticisms have been raised against the Division 12 task force report and the sole use of empirically supported treatments or specific factors in clinical practice. These criticisms concern the task force's failure to recognize the literature that indicates that all psychotherapies are equally effective (Luborsky et al., 1975; Smith & Glass, 1977; Wampold et al., 1997), the emphasis on the use of manualized treatments (Bein et al., 2000; Duncan & Miller, 2006; Lambert & Ogles, 2004), the emphasis on efficacy as shown by randomized controlled trials as compared to effectiveness (Hansen, Lambert, & Forman, 2002; Stirman, DeRubeis, Crits-Christoph, & Brody, 2003), and the neglecting of common factors that may explain a greater amount of the variance in therapy outcomes (Wampold, 2001).

On the other side of the debate are those who emphasize the importance of common factors or techniques that are common to all forms of therapy. These common factors include variables that are related to the therapist, therapy setting, and client that are not specific to any given treatment. Supporters on this side indicate that the best outcomes in therapy are found through the use of these common factors.

A number of theories or models concerning the definition of common factors in psychotherapy have been proposed. Rogers (1957) believed that there were six "necessary and sufficient" causes of change in psychotherapy, which included accurate empathy and unconditional positive regard. Frank (1976) proposed the importance of instilling hope in the client by providing a healer, a healing setting, an understanding of the problem, and a set of methods prescribed to help overcome the problem. More recently, Weinberger (1995) emphasized five common factors that have received support in the literature, including: (a) the therapeutic relationship, (b) expectations of therapeutic success, (c) confronting or facing the problem, (d) providing an experience of mastery or cognitive control over the problematic issue, and (e) attributing of the therapeutic success to the client. In a more comprehensive model, Lambert and Ogles (2004) separated a list of over 30 common factors into categories of support factors, learning factors, and action factors. According to this model support factors provide a client with an increased sense of safety and lead to the learning factors which contribute to changes in the understanding of problems which, in turn, leads to action factors encouraging the client to act differently in an attempt to master and overcome the problems.

This literature identifies a number of different areas that lend support to the role of common factors in psychotherapy change. First, many of the meta-analyses examining the effect of psychotherapy show no differences between treatments and therapies that are theoretically different (Luborsky et al., 1975; Smith & Glass, 1977; Wampold et al., 1997), thus indicating that common factors may be causing the effect. Also in support of common factors, clients often respond to treatment before the specific active ingredients have been provided (Ilardi & Craighead, 1994) or without the use of specific active

ingredients at all (Grissom, 1996; Stevens, Hynan, & Allen, 2000). Finally, component analysis has shown that specific factors do not add to the effect (Ahn & Wampold, 2001; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996), and common factors play a larger role in treatment outcomes (Wampold, 2001; Wampold et al., 1997).

One major criticism that has been raised against the supporters of common factors is that they over-emphasize a common thing. Chambless and Crits-Christoph (2006) have recently argued this point. They agree that the common factors play a role in psychotherapy outcome; however, they also believe that the specific factors have an additive effect. They indicate the additive effect is shown in highly controlled individual studies where advantages for one treatment over another are typically found. Further, Chambless and Crits-Christoph feel that because the common factors do not explain 100% of the variance in treatment outcome, it is also important to understand and apply specific factors when treating mental disorders.

Although many researchers and clinicians have taken the middle ground stressing the importance of both specific and common factors in psychotherapy, a number of psychologists are still camped on each of the polar extremes of the debate. The outcome of the debate between the relative importance of specific and common factors in the effectiveness of psychotherapy has many important implications for the field of clinical psychology. If one of these sets of factors (specific or common) show to contribute more to the outcome of therapy than the other, then that set of factors should also be emphasized more in the field through a number of actions, including but not limited to: accredited graduate programs should teach those factors didactically and provide clinical training in the use of those factors; accredited internships should likewise focus a fair

amount of training on those factors; workshops and seminars should be provided for continuing education training in those factors; clinicians should focus on using those factors in their practice, especially when evaluating their cases; and researchers should focus their scientific efforts on understanding those factors in greater detail; as well as many other implications.

Although a large amount of research has examined the issue comparing specific and common factors and how they relate to the overall effectiveness of psychotherapy, little or no research has been conducted examining client preferences on the debate. It is possible that clients may show a preference for the use of specific factors or show a preference for the use of common factors in their treatment. Numerous studies have indicated that clients do indeed indicate preferences toward the treatment they receive, both in the medical field and in the mental health field setting (Aita et al., 2005; Ertly & McNamara, 2000; Riedel-Heller, Matschinger, & Angermeyer, 2005). However, clinicians in both settings do not always consult their clients concerning these preferences (Benbassat, 1998; Charles, et. al, 1997; Ford, 2006; Shiloh, 2006). This failure to consult is an unfortunate error, due to the fact that client preferences have been found to play a role in the process and outcome of the treatments that are provided (Devine & Fernald, 1973; Mendonca & Brahm, 1983; Rokke et al., 1999; Swift & Callahan, 2009).

The importance of client preferences has further been emphasized by the Institute of Medicine (2001) and the American Psychological Association (2005). Both organizations have made specific statements that stress the incorporation of client preferences in evidence based practice. According to the policy statement issued by the American Psychological Association, evidence based practice in psychology is “the

integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273; APA Presidential Task Force on Evidence-Based Practice, 2006). The policy statement further states that it should be a central goal to maximize patient choice and that clinical decisions should be made in collaboration with the patient.

Since clients do show preferences concerning the treatment they receive and that these preferences play a role in outcome regarding the efficacy of the treatment, it is thus important to understand client preferences with regards to the use of specific versus common factors in psychotherapy. As in other areas of client preference (Fairhurst, 1996; Mendonca & Brahm, 1983; Rokke et al., 1999; Wong et al., 2003), understanding and implementation with regards to specific and common factor preferences may lead to better treatment decision making, increased client satisfaction, greater treatment follow through, and improved general outcome.

A delay-discounting model is one way to examine preferences with regards to the use of specific or common factors in treatment. Delay-discounting has been used to refer to an individual's preference between two rewards: a smaller immediate reward and a larger delayed reward. In this type of model, a larger delayed reward may be subjectively appraised as less valuable than a smaller immediate reward due to the passage of time (Wileyto, Audrain-McGovern, Epstein, & Lerman, 2004). For example, individuals may prefer $50 today (smaller immediate reward) as compared to $100 one year from now (larger delayed reward). The measurement of discounting typically involves finding the point at which subjects view the smaller immediate reward as equal to the larger delayed reward; often called the "indifference point". In the before mentioned example

individuals may prefer the smaller immediate reward; however, if the larger delayed reward were increased to $150 one year from now, some individuals may not show a preference between the two rewards. An exact indifference point is found by systematically manipulating the value of the rewards until the individual no longer shows a preference for one over another.

While delay-discounting procedures have long been used in the field of economics to improve marketing strategies and in the field of cognitive psychology as a measure of impulsivity, in recent years researchers in the medical field have begun to use these procedures to examine health and medical decision-making. Researchers in the medical field have used delay-discounting to examine both preventative behaviors that require an upfront cost to achieve a long term benefit, and destructive behaviors that produce an upfront reward at a long term cost (e.g., Chapman et al., 2001; Heil, Johnson, Higgins, & Bickel, 2006; Ohmur, Takahashi, & Kitamura, 2005; Ortendahl & Fries, 2005). Researchers in the medical field have also used delay-discounting to examine patient preferences and decision making with regard to treatment options (e.g., Chapman, Nelson, & Hier, 1999; Hayman, Weeks, & Mauch, 1996). An example of a delay-discounting instrument used to examine decision making concerning treatment options might ask participants to choose between a treatment that lasts one week and alleviates 25% of the symptoms and a treatment that lasts one year and alleviates 100% of the symptoms.

Delay-discounting procedures have recently been demonstrated as applicable to the mental health field in examining client preferences and decision-making with regard to psychological treatment options. Swift and Callahan (2008) have used this model to

compare treatments that differ in effectiveness (in terms of rate of recovery) across differing amounts of time (number of requisite sessions of therapy). This type of question may also be used to assess participants' preferences with regards to the use of specific versus common factors in the treatment process. An example of this type of measure comparing one common factor to a specific factor might ask participants to choose between a treatment that is relatively high in efficacy (specific factor) and low in the presence of a given common factor to another treatment that is lower in effectiveness but higher in the presence of that common factor. By systematically altering the effectiveness (specific factor) for the two treatments, one that is provided with a greater level of a given common factor and one that is provided with a lesser level of that factor, the relative values or preferences that participants provide to these factors can be found.

This study was designed to examine client preferences with regards to the use of specific factors versus common factors in psychotherapy by using a delay-discounting model. It was hypothesized that (1) clients on average would indicate specific preferences in this model (i.e., endorse a willingness to receive a significantly less effective treatment in order to ensure the presence of a given common factor). Additionally, it was hypothesized that (2) clients would indicate greater preferences for the common factors that are tied more closely to psychotherapy outcome in the literature. Further, it was hypothesized that (3) the expressed preferences would indicate a greater degree of difference than what is seen in many comparative treatment studies, illustrating that treatment decisions based solely on outcomes from comparative treatment studies may not always match with client preferences.

CHAPTER II

REVIEW OF LITERATURE

The Effect of Psychotherapy

Psychotherapy has been identified as a method of treatment for mental disorders since the 19th century. Since its proposal as a treatment, psychotherapy has received much attention in the literature with regards to its effectiveness. One early study that sparked much interest in the area of psychotherapy's effectiveness was conducted by Eysenck (1952).

In a 1952 review, Eysenck questioned the value of training clinical psychologists in the use of psychotherapy, reporting that the effectiveness of psychotherapy had not yet been shown. In order to further expound on this point, Eysenck examined the effectiveness of psychotherapy across 24 studies covering over 8,000 cases. The cases considered met a diagnosis of what was then obtusely termed "neurosis" and included common psychological disorders and other disorders such as organ neuroses, psychopathic states, and character disturbances; and excluded schizophrenic, manic-depressive, and paranoid states. The cases in each of these studies were classified under one of four categories: (a) cured, or much improved; (b) improved; (c) slightly improved; and (d) not improved. Using this classification method, Eysenck found that 44% of clients treated by means of psychoanalysis and 64% of clients treated by means of an eclectic method were improved (cured, or much improved; or improved) by the end of treatment. Eysenck's results for each of the four categories can be found in Table 1.

Table 1.

Eysenck's (1952) summary of the effectiveness of psychotherapy.

	N	Cured; much improved	Improved	Slightly improved	Not improved	% Cured or improved
Psychoanalytic (5 studies)	760	176	159	161	264	44%
Eclectic (19 studies)	7293	1705	2956	1346	1286	64%
Baseline (no therapy)						72%

Note. Adapted from "The effects of psychotherapy: An evaluation," by H. J. Eysenck, 1992, *Journal of Consulting and Clinical Psychology, 60*, p. 661. Copyright 1992 by the American Psychological Association.

At first glance Eysenck's (1952) results would appear to support the effectiveness of psychotherapy: approximately 64% of clients recovered by the end of treatment. However, Eysenck further compared this data to a rate of spontaneous recovery or recovery without the use of psychotherapy. For spontaneous recovery rates Eysenck referred to two prior studies completed by Landis (1938) and Denker (1946). Landis found that 72% of neurotic patients in New York state mental hospitals were ameliorated and discharged within a given year period. Denker found that 72% of clients who were also treated by physicians with "sedatives, tonics, suggestions, and reassurance, but in no case … 'psychotherapy'" (p. 659) were recovered by the end of a two year period. Esyenck then compared psychotherapy's effectiveness (64%) to a baseline of spontaneous recovery as reported by Landis and also Denker (72%). In making this comparison Eysenck concluded that an inverse correlation between recovery and psychotherapy exists; "the more psychotherapy, the smaller recovery rate" (p. 660). Eysenck's findings and conclusions appeared to be a damaging blow to the utility and effectiveness of psychotherapy.

However, as expected by Eysenck himself (1952, p. 662), his study has received much criticism since its release. The majority of these criticisms can be summed under three main areas: the control or base-line group of clients was not similar to the psychotherapy groups in level of "neurosis" severity, the control group did receive some form of psychotherapy, and different standards of recovery were used between the control and therapy groups (Rosenweig, 1953). These criticisms have been widely accepted by a number of others (e.g., Bergin, 1962; Cartwright, 1955; Jacobson & Christensen, 1996; Rosenthal & Frank, 1956; Strupp, 1963). Further criticisms have also

been raised against Eysenck's original review, including: the therapists in the psychotherapy group were not all equal, some producing positive outcomes and others producing negative outcomes; the treatment groups were not all actually receiving psychotherapy; the control group clients may have recovered due to outside factors; the effectiveness of psychotherapy or no psychotherapy should be measured by some other means; etc.

Although many criticisms were raised over Eysenck's (1952) review, this landmark study has had a significant and lasting impact on psychotherapy research. Sparked by Eysenck's negative findings, much research has been conducted over the past 50 years examining the effectiveness of psychotherapy as a treatment (Meares, Stevenson, & D'Angelo, 2002). Due to the overwhelming number of studies examining the effectiveness of psychotherapy, only a few of the major influential studies and meta-analyses conducted concerning this topic are mentioned here.

Luborsky, Singer, and Luborsky (1975) examined the effectiveness of psychotherapy by comparing therapy groups to control groups from 33 studies. Luborsky et al. in their review only included studies that met a high standard of research design and methods. Among these studies the therapy groups were composed of clients who received individual psychotherapy, group psychotherapy, time-limited psychotherapy, time-unlimited psychotherapy, client-centered therapy, behavior therapy, psychoanalytic therapy, and/or other therapies; while the control groups were composed of clients who received "no psychotherapy," "wait for psychotherapy," "minimal psychotherapy," or "hospital care alone."

Luborsky et al. (1975) analyzed the data from these studies using a simple count or box score method. Using this method, if a study showed results that psychotherapy was significantly better than control, psychotherapy would get one point; if control was significantly better than psychotherapy, control would get one point; and if psychotherapy and control were not significantly different, a tie box would be given one point. This box score method made it possible to count the number of studies that showed psychotherapy to be superior to control, control to be superior to psychotherapy, and psychotherapy and control to be the same. Luborsky et al. found that psychotherapy was significantly better than control in 20 of the studies, psychotherapy was equal to control in 13 of the studies, and the control group was significantly better than psychotherapy in 0 of the studies. Similar results were found when the studies were separated by symptom severity. Results from Luborsky et al.'s box score plot can be found in Table 2. Luborsky et al. concluded from their data that psychotherapy is effective and is more effective than control groups in at least 60% of the studies. Further, Luborsky et al. explained that the ties or equal effectiveness between psychotherapy and control seen in about one third of the studies were due to the control group clients still receiving non-specific ingredients of treatment.

Table 2.

Luborsky et al.'s (1975) box score results for psychotherapy vs. control across 33 studies.

	Box score	Schizophrenic patients	Non-schizophrenic patients
Psychotherapy			
was better	20	11	9
Tie	13	8	5
Control group			
was better	0	0	0

Note. From "Comparative studies of psychotherapies: Is it true that 'everyone has won and all must have prizes'?," by L. Luborsky, B. Singer, and L. Luborsky, 1975, *Archives of General Psychiatry, 32*, p. 1003. Copyright 1975 by the American Medical Association.

Meta-analytic Reviews of the Effectiveness of Psychotherapy

Concerned about the small number of studies included in previous reviews of the effectiveness of psychotherapy and the voting or tallying method used in these those reviews, Smith and Glass (1977) used the meta-analysis method to examine the effectiveness of psychotherapy across 375 controlled studies. Smith and Glass included only studies in which at least one therapy treatment group was compared to an untreated group or to another therapy and fit the definition of psychotherapy as given by Meltzoff and Kornreich (1990). This definition, provided by Smith and Glass (p. 753), is as follows:

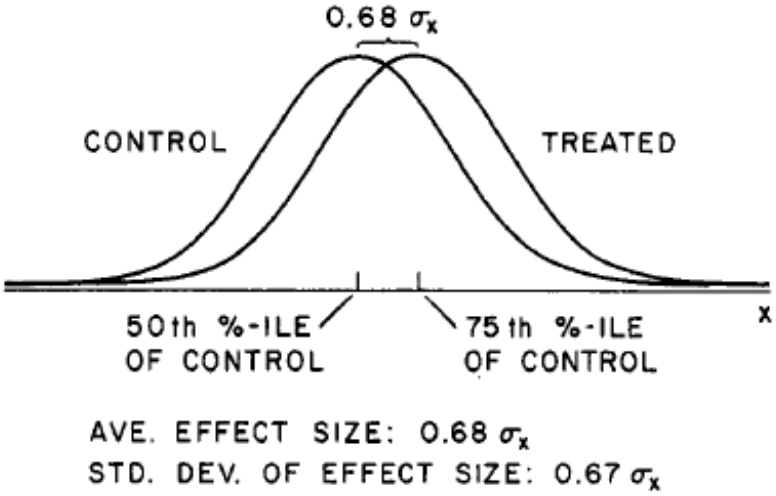
> Psychotherapy is taken to mean the informed and planful application of techniques derived from established psychological principles, by persons qualified through training and experience to understand these principles and to apply these techniques with the intention of assisting individuals to modify such personal characteristics as feelings, values, attitudes, and behaviors which are judged by the therapist to be adaptive (Meltzoff & Kornreich, 1990; p. 6).

Not included in their review were studies examining drug therapies, hypnotherapy, bibliotherapy, occupational therapy, milieu therapy, and peer counseling. However, included in this review were dissertations and studies that previous reviews excluded due to the use of therapies that lasted only a few hours and the use of therapists that were relatively untrained.

Specifically, Smith and Glass (1977) were interested in measuring the effect size of therapy across the various included studies. Effect sizes were measured as "the mean difference between the treated and control subjects divided by the standard deviation of the control group, that is, $ES = (X_T - X_C)/ s_C$" (p. 753). This effect size was calculated for each individual study on the outcome variable that the study researcher chose to measure.

A total of 833 effect sizes for therapy were calculated from the 375 included studies. Based on these 833 computed effect-sizes, representing approximately 25,000 subjects, Smith and Glass found that the average effect for psychotherapy as compared to control groups was $\sigma_x = 0.68$. Using this effect size, Smith and Glass concluded that the average client receiving therapy was better off than 75% of the control subjects who did not receive psychotherapy. Figure 1 provides a visual representation of this effect as originally provided by Smith and Glass (Figure 1 in Smith & Glass, 1977). Further, they found that only 12% of the 833 computed effect sizes showed a negative effect, results quite discrepant to those reported by Eysenck (1952), for psychotherapy.

Figure 1. Smith and Glass's (1977) effect of psychotherapy.



Note. From "Meta-analysis of psychotherapy outcome studies," by M. L. Smith and G. V. Glass, 1977, *American Psychologist, 32,* p. 754. Copyright 1977 by the American Psychological Association.

Similar to Eysenck's (1952) review, Smith and Glass's (1977) meta-analysis was immediately met with some criticism. Eysenck (1978) found fault in their use of meta-analysis, indicating that it incorporated the results of poorly designed studies thus invalidating their findings for the overall effectiveness of psychotherapy. Criticism with the methodology employed by Smith and Glass has been raised by others as well (Gallo, 1978; Presby, 1978). Rimland (1978) criticized Smith and Glass for their conclusion that psychotherapy is effective based on the small modest effect that was found. He claims that this observed effect was so modest that it could be attributed to the poor validity of the outcome measures used. Further, Rimland points out two overlooked results from the Smith and Glass study; the duration effect size of therapy was -0.02, and the therapist experience effect size of therapy of -0.01. Rimland used these results to imply that a client could receive as much benefit from "consulting an untrained lay person for one session as he or she can from consulting a highly trained MD or PhD for many hundreds of (expensive) hours" (p. 192), and further claimed that the "death knell" for psychotherapy had been rung. However, Smith and Glass, as well as others, were able to respond to these criticisms further backing up the results of their study (Glass & Smith, 1978, 1980; Kalat, 1980). Although faults in the Smith and Glass study can be found, their 1977 meta-analysis, unlike Eysenck's 1952 review, has held up as a valid description of the effectiveness of psychotherapy (Andrews & Harvey, 1981; Lambert & Ogles, 2004; Landman & Dawes, 1982).

Landman and Dawes (1982) and Andrews and Harvey (1981) both completed meta-analyses seeking to replicate the results found by Smith and Glass (1977). Landman and Dawes used Smith and Glass's original database plus an additional 96 studies and

sought to reanalyze the data looking at only studies that met a high criterion of statistical design. This criterion for inclusion of a study was the use of random assignment into therapy and control groups. Out of the original studies 65 were randomly selected for analysis and 42 of those studies were deemed to have fit the above mention criterion. Using Smith and Glass's effect size method, Landman and Dawes evaluated 281 effect sizes calculated from the 42 well controlled studies.

Landman and Dawes' (1982) analysis found that the average effect size for psychotherapy in these studies was M_{ES} = 0.78 (SD_{ES} = 0.78), greater than the effect size originally reported by Smith and Glass (M_{ES} = 0.68, SD_{ES} = 0.67) in 1977. Further, Landman and Dawes analyzed the data to determine if the effect was altered by the time of assessment. They found that in studies (N = 225 effect sizes) that measured outcome at post test the average effect of psychotherapy was M_{ES} = 0.72 (SD_{ES} = 0.79), in studies (N = 50 effect sizes) that measured outcome at follow-up 1 (the follow-up point varied across studies, these studies included at least one follow-up assessment of outcome) the average effect of psychotherapy was M_{ES} = 1.08 (SD_{ES} = 0.70), and in studies (N = 6 effect sizes) that measured outcome at follow-up 2 (the second follow-up point varied across studies, these studies included two follow-up assessments of outcome) the average effect of psychotherapy was M_{ES} = 0.62 (SD_{ES} = 0.38). Landman and Dawes concluded that the results of their reanalysis supported the conclusions originally drawn by Smith and Glass: that including or omitting studies without adequate controls does not significantly alter the effect, and that the effectiveness of psychotherapy remains moderately high.

Similarly, Andrews and Harvey (1981) also sought to reanalyze Smith and Glass's (1980) larger data-base using only a select subset of the studies. Andrews and Harvey were concerned that Smith and Glass's (1977) earlier results included too wide of variability in the types of clients seen among the studies. In their analysis, Andrews and Harvey included only studies of clients who would normally seek psychotherapy (i.e., patients with neuroses, true phobias, depressions, and emotional-somatic disorders who had entered treatment by seeking services themselves or by referral), thus excluding analogue phobics, psychotics, delinquents, felons, drug habitués, handicapped persons, and normal persons who were committed or solicited for treatment directly or by advertisement. This selected subset of the original data included 81 control trials comprised of over 2,200 cases. The average effect size for psychotherapy of the 292 included effect sizes was 0.72, thus indicating that the average "client similar" subject after treatment was better than 76% of the control group subjects assessed at the same time. Andrews and Harvey concluded that Smith and Glass' conclusions about the effectiveness of psychotherapy are applicable for neurotic clients that are typical of those seen in actual treatment settings.

Noting a number of criticisms that had been made about the meta-analysis conducted by Smith and Glass (1977), Shapiro and Shapiro in 1982 sought to further add to the literature on the effectiveness of psychotherapy by conducting their own meta-analysis. Specifically, their meta-analysis aimed at replicating the Smith and Glass comparison using a more current database and corrections to the methods in light of the criticisms that had been raised. These corrections to the methods are summarized under five main areas: (a) consider only studies including untreated or minimally treated control

group, (b) consider only studies that made a simultaneous comparison between two or more treatments and a control group, (c) consider a more exhaustive review of the literature including all published controlled comparisons between 1975 and 1979, (d) exclude dissertations from the analysis, and (e) incorporate refinements in the categories and dimensions used to characterize outcome measurement.

Based on the above mentioned refinements, Shapiro and Shapiro (1982) analyzed the results from 143 outcome studies, which included 414 treatment groups and 1,828 effect sizes. The mean value of these effect sizes was 0.93 (SD_{ES} = 1.16), indicating that the average treated client improved more than 82% of the untreated clients. When accounting for the 540 null effect sizes, Shapiro and Shapiro indicated that the overall mean effect size was reduced to 0.72. Further, when 177 effect sizes associated with minimal or placebo treatments were omitted the overall mean effect size was increased to 1.03. Shapiro and Shapiro also noted that, of the 1,828 effect sizes, only 206 (11.3%) were negative, a percentage similar to that found by Smith and Glass (1977). Shapiro and Shapiro concluded that an independent database of recently published comparative outcome studies indicates that psychotherapy is effective, even after correcting for many of the criticisms raised concerning previous meta-analyses looking at this effect.

Recognizing the large number of meta-analyses that had been completed, Lipsey and Wilson (1993) used the meta-analysis method to evaluate previous meta-analyses examining the effectiveness of psychological, educational and behavioral treatments. Some of the included treatments under review were psychotherapy, parent effectiveness training, medical patient education, smoking-cessation programs, job enrichment, computer-aided instruction, science curricula, and open classrooms to name a few. In

total, results from 302 meta-analyses were compared. Using the same effect-size measurement, only 6 of the meta-analyses produced negative mean effect sizes, while more than 90% of the mean effect sizes were 0.10 or larger and 85% were 0.20 or larger. Feeling that these results may represent potential distortions from the wide variety of analyses included, Lipsey and Wilson calculated mean effect sizes after controlling for some of these distortions. Their resulting data can be viewed in Table 3.

Table 3.

Lipsey and Wilson (1993) effect size estimates.

	Effect Size		
Comparison	*M*	*SD*	*N*
Control/comparison designs			
Random studies	0.46	0.28	74
Non-random studies	0.41	0.36	74
Design type			
Control/comparison	0.47	0.29	45
One-group pre-post	0.76	0.40	45
Control group type			
No treatment control	0.67	0.44	30
Placebo treatment control	0.48	0.26	30
Meta-analyses used			
All studies	0.50	0.29	302
Selected studies	0.47	0.28	156

Note. Adapted from "The efficacy of psychological, educational, and behavioral treatment: Confirmation from meta-analysis," by M. W. Lipsey and D. B. Wilson, 1993, *American Psychologist, 48,* p. 1181-1209. Copyright 1993 by the American Psychological Association.

After making adjustments to control for the variety of meta-analyses included, Lipsey and Wilson (1993) reanalyzed the data from a smaller subset of studies. This subset used only control or comparison group designs, used both published and unpublished studies, and included only one meta-analysis, the broadest, from any given database. This selective subset included 156 meta-analyses representing about 9,400 individual treatment effectiveness studies and more than one million individual subjects. Lipsey and Wilson found that the treatment effect for this sample was 0.47 (the average treated client was better than 68% of the untreated participants) with 83% of the effect sizes being 0.20 or greater (the average treated client was at least better than 58% of the untreated participants) and only one with a negative effect size. Lipsey and Wilson concluded that these results indicate that the psychological, educational, and behavioral treatments generally have positive effects.

Although recognizing the positive effects that were found, Lipsey and Wilson (1993) were concerned whether or not these results were clinically meaningful. In order to examine the clinical significance of their results, Lipsey and Wilson performed a similar meta-analysis on widely used and accepted treatments in the medical field. They found that treatments involving a "life-and-death issue" yielded effect sizes (0.08 to 0.47) below the mean effect size found for psychological treatments. Treatments that were judged to be beneficial and did not involve a life-and-death issue showed effect sizes ranging from 0.24 to 0.80, comparable with the range of effect sizes seen in psychological treatments. Finally, accepted medical interventions on psychological or behavioral outcomes showed effect sizes ranging from 0.11 to 0.96, also similar to the range of effect sizes seen in psychological treatments. Lipsey and Wilson concluded that

their broad review of meta-analytic evidence indicates that psychological treatments have not only positive effects, but also clinically meaningful effects.

A more recent meta-analysis on the effectiveness of psychotherapy was completed by Westen and Morrison (2001). In this analysis Westen and Morrison were interested in evaluating the effect of empirically supported treatments for depression, panic, or generalized anxiety disorder (GAD) over the last decade (1990-1999). Included in this meta-analysis were only methodologically strong studies that tested the efficacy of a specific psychosocial treatment against a waiting-list control condition, an alternative psychotherapy, a pharmacotherapy, or some combination of those (N = 34). These included studies were required to use valid measures of outcome for the primary symptoms, be experimental in design, and to test primarily face-to-face psychosocial treatments.

Westen and Morrison (2001) reported the results of 34 highly controlled studies. Of those studies that used a control group (N = 13) the mean effect size for depression was 0.50, for panic 0.70 and for generalized anxiety disorder 1.20. Of the studies who measured outcome through pre-post measures the mean effect size was 2.2 for depression, 1.5 for panic, and 2.1 for generalized anxiety disorder. Westen and Morrison further reported effect sizes for those studies that measured follow-up outcomes at 12 months and 24+ months. These results can be seen in Table 4. Westen and Morrison concluded that the average empirically supported treatment leads to clinically meaningful improvements that are comparable to the effect of psychotherapy that has been found over the past 2 decades.

Table 4.

Westen and Morrison's (2001) effect sizes for empirically supported treatments.

	Depression			Panic			Generalized anxiety		
Time and method of outcome measurement	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*
Outcome at termination									
With control group	0.5	1.1	3	0.7	1.1	7	1.2	0.6	3
Pre-post measurement	2.2	0.8	8	1.5	1.2	14	2.1	0.8	5
Outcome at 12 months									
With control group	--	--	--	--	--	--	0.7	--	1
Pre-post measurement	2.5	0.2	2	1.0	0.3	3	3.3	--	1
Outcome at 24+ months									
With control group	--	--	--	--	--	--	--	--	--
Pre-post measurement	1.9	--	1	2.1	2.5	2	--	--	--

Note. Blanks (--) indicate that no data was given. Adapted from "A multidimensional meta-analysis of treatments for depression, panic, and generalized anxiety disorder: An empirical examination of the status of empirically supported therapies," by D. Westen and K. Morrison, 2001, *Journal of Consulting and Clinical Psychology, 69,* p. 881-883.

The Effect for Children and Adolescents

While the majority of studies examining the effectiveness of psychotherapy have used a largely adult population, a number of studies have also examined psychotherapy's effectiveness when treating children. Weisz, Weiss, and colleagues conducted back (1952 to 1983; Weisz, Weiss, Alicke, & Klotz, 1987) to back (1983 to 1993; Weisz, Weiss, Han, Granger, & Morton, 1995) meta-analyses on the effectiveness of psychotherapy with children and adolescents. In the 1987 study Weisz et al. analyzed results from 108 well-designed outcome studies (compared treated to control group) with 4 to 18-year-old participants. Across these studies the average effect size was 0.79, indicating that the average treated child had improved more than 79% of the untreated children. Further, Weisz et al. (1987) found that only 10 (6%) of the 163 computed effect sizes were negative. Using the same methods and inclusion requirements over the subsequent decade Weisz et al. (1995) computed effect sizes for 150 studies involving 244 different comparisons. This analysis yielded a mean effect size of 0.71, similar to that found in their previous study. Taking in mind the current findings as well as the findings from the previous study (Weisz et al., 1987), Weisz et al. (1995) concluded that psychotherapy with children and adolescents produces positive effects of respectable magnitude.

Efficacy vs. Effectiveness

One criticism with the literature examining the effectiveness of psychotherapy, as well as all other psychotherapy outcome research, is that the findings may not represent or apply to what actually happens in actual practice. Lambert and Ogles (2004) discuss this issue when they define the difference between efficacy and effectiveness. According to Lambert and Ogles the efficacy of a treatment is determined by the results of carefully

controlled clinical trials, while the effectiveness of a treatment is determined by the results of studies which examine interventions as implemented in actual clinic situations. In discussing the difference Lambert and Ogles point out that efficacy values internal validity while effectiveness values external validity. While many of the before mentioned meta-analyses included some studies that measured effectiveness, the majority of the studies included were measures of efficacy.

In seeking to assess the applicability of efficacy studies to the clinical setting, Weisz, Weiss, and Donenberg (1992) compared the results of previously published meta-analyses examining efficacy to results from a clinic based outcome study (Weisz & Weiss, 1989). The clinic based outcome study looked at the effectiveness of treatment in 9 clinics for 93 children. On three measures of outcome (Child Behavior Checklist, severity of primary referral problems, and Teacher Report Forms) the average effect size at 6 months follow-up was -0.24, 0.24, 0.31 respectively and at 1 year follow-up was 0.19, 0.24, 0.33 respectively. Weisz, Weiss, and Donenberg indicate that the effect sizes found in the clinical setting fell well bellow the effect sizes found in previous meta-analyses.

Sparked by the discrepancy between efficacy and effectiveness found by Weisz, Weiss, and Donenberg (1992) a number of studies have more fully examined this issue. Hunsley and Lee (2007) conducted a review evaluating whether or not the results from effectiveness studies match results obtained for efficacy studies. Effectiveness was measured in 21 adult studies and 14 child studies. When examining completion rates Hunsley and Lee found that 93% of the 35 studies of effectiveness from the clinic had rates equal to or higher than rates found in efficacy studies (Wierzbicki & Pekarik, 1993).

Further, when examining outcome rates (percent of clients improved or recovered) Hunsley and Lee found that only 4 of the 35 studies of clinical effectiveness showed recovery rates lower than the literature (Asarnow, Jaycox, & Tompson, 2001; Bradley & Mandell, 2005; Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; Eddy, Dutra, Bradley, & Westen, 2004; Rodebaugh, Holaway, & Heimberg, 2004; Sheldrick, Kendall, & Heimberg, 2001; Westen & Morrison, 2001) on efficacy recovery rates. As a result of their findings Hunsley and Lee concluded that the results from efficacy studies are reasonably applicable to the clinic setting.

A unique study examining the effectiveness of psychotherapy from a clinic setting was completed by *Consumer Reports* (*CR*) in 1995 and was headed by Seligman (Seligman, 1995). This study was unique in that it used a survey method asking participants to reflect back and answer questions concerning the mental health services that they had received sometime in their life. *Consumer Reports* included this survey about psychotherapy and drugs in its annual questionnaire for 1994. In this survey respondents were asked to complete the survey "if at any time over the past three years you experienced stress or other emotional problems for which you sought help from any of the following: friends, relatives, or a member of the clergy; mental health professional like a psychologist or psychiatrist; your family doctor; or a support group" (p. 967). Out of the 180,000 surveys sent out, 22,000 were returned. Of those 22,000 who returned surveys, 7,000 had completed the mental health section. Of those 7,000, about 40% had just talked to friends, relatives or clergy, and about 60% went to some combination of mental health professionals, family doctors, and support groups. Of that 60%, 2,900 went

to a mental health professional (psychologist [37%], psychiatrist [22%], social worker [14%], and marriage counselor [9%]).

The questionnaire measured improvement in three areas: 1) specific improvement or how much the treatment helped with the specific problem that led the person to therapy, 2) satisfaction, and 3) global improvement or how respondents described their current emotional state as compared to when they started a treatment. Seligman (1995) reported on a number of results found by the survey. He reported that most respondents who were treated by a mental health professional got better: of those who began treatment feeling very poor (N = 426), 87% were feeling very good, good, or at least so-so by the time of the survey; of those who began treatment feeling fairly poor (N = 786), 92% were feeling very good, good, or at least so-so by the time of the survey. He concluded that these results matched with previous literature that found psychotherapy to be an effective treatment.

Other interesting findings reported by Seligman (1995) were that long-term therapy produced more improvement than short-term therapy, and that there was no difference between psychotherapy alone and psychotherapy plus medication for any disorder. However, not all of Seligman's findings supported the effectiveness of psychotherapy. Specifically, it was found that respondents who were seen by psychologists improved less than those who were seen by Alcoholics Anonymous, more than respondents who were seen by marriage counselors, and equal to those respondents who were seen by family doctors, psychiatrists, or social workers. This finding is similar to that reported by Eysenck (1952), in that psychotherapy worked, but not any better than groups that would be considered to not have received psychotherapy. However, Seligman

still concluded that the survey had "provided empirical validation of the effectiveness of psychotherapy" (p. 974).

A number of criticisms have been found with *Consumer Reports* (1995) study on the effectiveness of psychotherapy. Seligman (1995) reported on 7 specific methodological flaws, including: 1) a sampling bias in what type of people read consumer reports and what type of people respond to the surveys given, 2) no control groups were used in the study, 3) self-report data can often be flawed, 4) the survey was not double-blind or single-blind, 5) the outcome measures were likely inadequate, 6) retrospective biases were likely made by the respondents in filling out the questionnaire, and 7) random assignment of patients to treatment was not used. Jacobson and Christensen (1996) taking in mind the above mentioned flaws with the *Consumer Reports* study as well as other methodological issues, suggested that the study be rejected by the field. They conclude:

> What is interesting about examining Eysenck's (1952) study in light of the *CR* (1995) survey is that virtually all of the criticisms leveled at Eysenck's evaluation were more sophisticated from a methodological perspective. ...the field was correct in rejecting Eysenck's evaluation: The control groups and the measures of outcome were inadequate. We don't see any reason to revert to a methodology that was rejected for its methodological inadequacies 20 years ago. (p. 1036)

> …we do believe, with equal conviction that championing surveys such as the *CR* (1995) study actually set the field back and return clinicians to an early stage of scientific discovery at a time when they can ill afford to abandon the lessons they have learned over the past 40 years. (p. 1038)

Matt and Navarro (1997) reviewed the literature examining both effectiveness and efficacy for psychotherapy in a total of 63 meta-analyses dating between 1977 and 1991. Included in this review were more than 3,800 studies and tens of thousands of subjects. From their review Matt and Navarro concluded that psychotherapeutic interventions have

universally positive effects across different classes of interventions, patient populations, settings, outcomes, and research designs. None of the reviewed meta-analyses indicated that psychotherapeutic interventions were ineffective or harmful, however, as expected due to sampling error, some or the individual studies did. Of the 28 meta-analyses that reported an effect size estimate for psychotherapy the mean was 0.67. Further, Matt and Navarro pointed out that although the estimates for the effect of psychotherapy are consistently positive, there may be a number of moderator effects (type of treatment, length of treatment, subject characteristics, setting characteristics, and research design) that play a role in the magnitude of the overall effect.

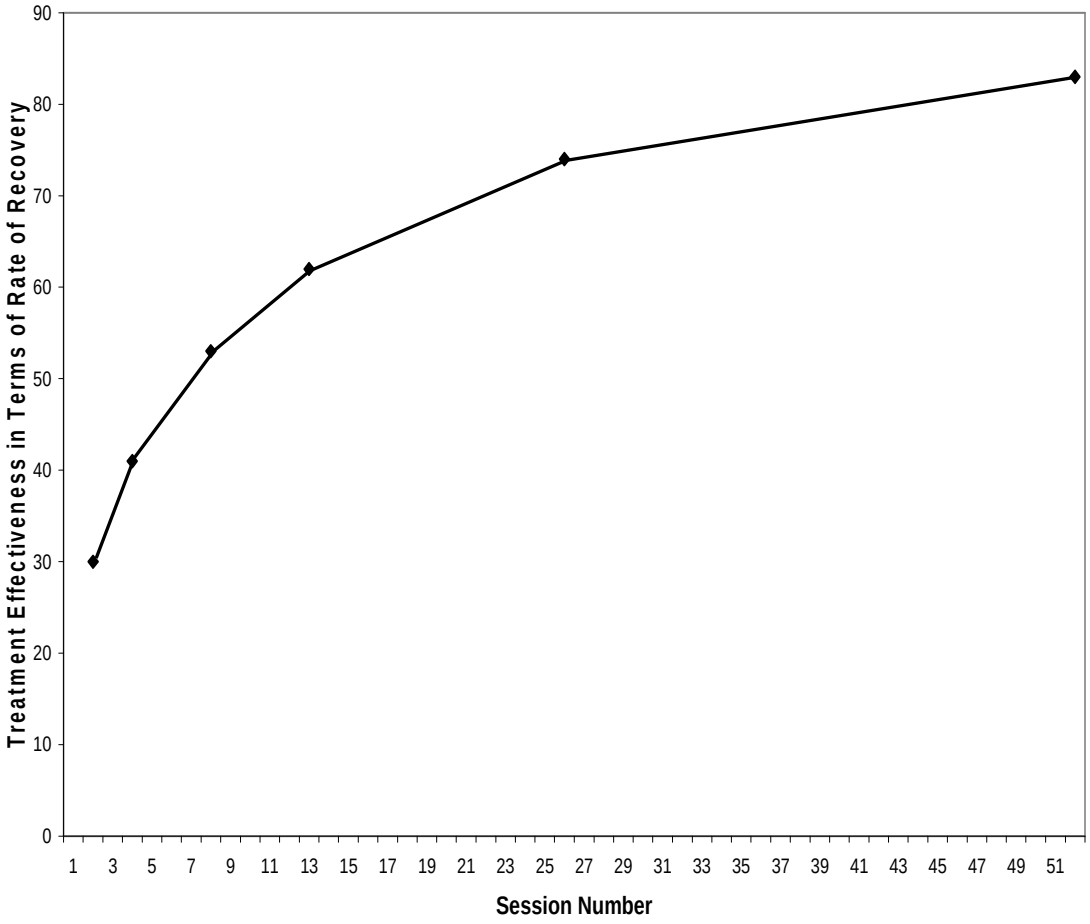
The Role of Dose in the Effect

The studies and meta-analyses mentioned, excluding the *Consumer Reports* (1995) study, have evaluated the effectiveness of psychotherapy through similar methods; comparison to a no treatment or placebo control group. These studies have generally found psychotherapy to be an effective treatment. However, in order to fully understand the effectiveness of psychotherapy it may be important to understand the role that the dose or amount of treatment plays. The dose-effect literature, dating back to the 1980s, looks at the effectiveness of psychotherapy from this perspective.

The dose-effect model was first introduced by Howard, Kopta, Krause, and Orlinsky (1986). In this 1986 meta-analysis, Howard et al. were interested in examining the relationship between the number of sessions of individual psychotherapy received and the percentage of clients who improved. Using probit analysis on outcome data from over 2,400 clients included in 15 different studies, Howard et al. indicated that 10% to 18% of clients improved prior to the first session, 48% to 58% of clients improved after 8

sessions, about 75% of clients by six months (26 sessions), and about 85% of clients were considered improved at the end of one year of treatment (52 sessions). Based on this data, the dose-effect relationship forms a negatively accelerated curve, indicating that with a greater number of sessions there is a greater likelihood of improvement; however, diminishing returns can be expected as the dosage increases. Howard et al.'s dose-effect curve can be viewed in Figure 2.

Figure 2. Howard et al.'s (1986) dose-effect curve.



Note. Adapted from "The dose-effect relationship in psychotherapy," by K. I. Howard, S. M. Kopta, M. S. Krause, and D. E. Orlinsky, 1986, *American Psychologist, 41*, p. 160.

Since the release of Howard et al.'s (1986) seminal article, studies have explored the dose-effect relationship within diagnostic categories and symptom categories, in outpatient populations, using trainee clinicians, using a change criteria of clinical significance as compared to improvement, and using session-by-session survival analysis as compared to pre-post-probit analysis (Barkham et al., 1996; Callahan & Hynan, 2005; Draper, Jennings, Baron, Erdur, & Shankar, 2002; Hansen & Lambert, 2003; Kadera, Lambert, & Andrews, 1996; Kopta, Howard, Lowry, & Beutler, 1994; Lambert, Okiishi, Finch, & Johnson, 1998; Lueger, Lutz, & Howard, 2000). Although different percentages of improved clients have been found, a negatively accelerated dose-effect relationship has been demonstrated across these studies.

In attempting to summarize the results from the previous literature, Hansen, Lambert, and Forman (2002) examined the data from seven studies dating back to the original Howard et al. meta-analysis. They found that a range of between 5 to 104 sessions was required to reach a 50% patient recovery rate. Hansen et al. accredited this large range to the different symptoms measured, the different methods used to study outcome (pre-post-test compared to session-by-session), and the different methods used to analyze the data (probit analysis compared to survival analysis compared to observed percentages). When taking these differences into account, Hansen et al. concluded that between 13 and 18 sessions of therapy are required for 50% of patients to improve, and that clients who continue in treatment after the median number of sessions continue to show improvement.

Conclusions on the Effect

After reviewing the literature on effectiveness, efficacy, and dose-effect, Lambert and Ogles (2004) summarized the current findings on the effect of psychotherapy. They concluded that psychotherapy is effective when compared to no-treatment or placebo treatment control groups, that many clients who participate in treatment make meaningful (clinically significant) improvements, that clients generally maintain their gains over time, and that some evidence supports therapy's effect in practice. Finally, Lambert and Ogles reported that "these findings provide an impressive array of evidence for the efficacy, effectiveness, and utility of psychotherapy if it is given in substantial doses" (p.160).

The Specific versus Common Factors Debate

In summary, the research has consistently found that psychotherapy is an effective treatment method for psychological disorders. However, indicating which factors make psychotherapy effective has been the source of a long standing debate. On one side of the debate are those who support the use of specific factors or empirically supported treatments in clinical practice. This side indicates that the use of specific effective treatments leads to the best outcomes in therapy (APA Division 12 Task Force, 1995; Chambless et al., 1996, 1998). On the other side of the debate are those who support the use of common factors or techniques that are common to all forms of therapy. These factors include things such as the therapist's ability to show empathy and warmth and the client's expectations for improvement. Supporters on this side indicate that the best outcome in therapy is found through the use of these common factors (Luborsky et al., 1975; Wamplod, 2006).

Specific Factors

The question as to whether the use of specific effective treatments leads to the best outcomes in therapy has received particular attention since the release of the 1995 report by the American Psychological Association Division 12's Task Force on the Promotion and Dissemination of Psychological Procedures (Chambless et al., 1995). This task force believed that in order for clinical psychology to survive in competition with biological psychiatry, a new emphasis needed to be placed on recognizing psychotherapies with proven efficacy. They proposed that psychological treatments be placed in one of three categories (well established treatments, probably efficacious treatments, and experimental treatments) based on the treatments level of empirical support.

According to the task force, in order for a treatment to be "well established" it needed to meet the following criteria: 1) have at least two good group design studies demonstrating its efficacy, or 2) have a large series of single case design studies demonstrating efficacy. Under the first criteria the two good group design studies needed to be conducted by different investigators and show that the treatment is superior to pill, psychological placebo, or to another treatment, or show that the treatment is equivalent to an already established treatment. Under the second criteria the single case design studies must have used good experimental designs and compared the intervention to another treatment. Further, in order for a treatment to be considered "well-established" the studies supporting it must be conducted with treatment manuals and have clearly specified client sample characteristics. In order for a treatment to be considered "probably efficacious" it needed to fit the following criteria: 1) have two studies show that the treatment is more effective than a waiting-list control group, or 2) have one study that demonstrates

effectiveness according to the “well-established” criteria or two studies conducted by the same investigator that meet the criteria, or 3) have two good studies that demonstrate effectiveness but are still flawed by a lack of homogeneity of the client sample, or 4) have a small series of single case designs that meet the criteria for a “well-established” treatment. All other psychological treatments that did not meet the criteria to be categorized as “well-established” or “probably efficacious” were considered to be “experimental treatments”.

After defining the criteria for empirically supported treatments the Division 12 task force provided a number of recommendations in the areas of research, training, and practice for clinical psychology. Specifically, for research this task force recommended that studies continue to evaluate the effectiveness of treatments, however, to do so using the high quality of design as described in their given criteria. It was also recommended that a complete list of treatments that fit the criteria be composed and that this list be updated as new research studies are conducted. In the area of training the task force recommended that all APA accredited doctoral programs and internship sites teach and provided experience in the use of these empirically supported treatments. Further, all approved workshops teaching psychological treatments for continuing education credits must specify whether the techniques fit the criteria outlined above. Finally, in the area of practice the task force recommended that clinicians, mental health centers, third party payers, HMOs, and national institutes be made aware of and use/provide funding for the empirically supported treatments.

The release of the Division 12 Task Force report has had a tremendous impact on the field of clinical psychology. Many researchers and practitioners agree that a

psychological treatment should be empirically supported before it is used in practice or taught to trainee clinicians. Chambless and Crits-Christoph (2006) argue that:

> …treatment decisions should be made, whenever possible, on the basis of the results of empirical research that tests what treatment works for what problems experienced by clients with what important characteristics that might moderate the treatment outcome… Thus, in the face of evidence that Treatment A works, it is not sufficient for the practitioner who prefers Treatment B to rest on the fact that no one has shown that Treatment B is ineffective. Treatment A remains the ethical choice until the success of Treatment B is documented… (p., 192)

In a recent Division 12 *Presidential Column* (2007) Marsha M. Linehan discussed the advances that our field has made due to the current focus on evidence and empirically supported treatments. In talking about the use of evidence in practice she says:

> The question is, what would you want tried first: a treatment with evidence that it works (and does not harm) or one applied by an experienced clinician but without any data that it works? What would you want your therapist to know: treatments with scientific data that they work? That is our central question. (p., 4)

Others have recognized the value of the Division 12 report on making the public as well as agencies aware of the usefulness of psychological interventions as a treatment for mental disorders (Beutler, Moleiro, & Talebi, 2002; Chambless & Crits-Christoph, 2006; Lambert & Ogles, 2004)

A number of criticisms have been raised since the release of Division 12's Task Force on the Promotion and Dissemination of Psychological Procedures report (Chambless et al., 1995) and the list of empirically supported treatments. Some of the major criticisms are concerning the task force's failure to recognize the literature that indicates that all studied psychotherapies are equally effective, their emphasis on the use of manualized treatments, the emphasis on efficacy as shown by randomized controlled

trials as compared to effectiveness, and their ignoring of common factors that may explain more of the effect in therapy.

Several objections have been brought up in regards to empirically supported treatments due to a failure to find differences in the literature between psychotherapies. Many of the major reviews and meta-analyses analyzing the effectiveness of psychotherapy have also compared the effectiveness of the different treatment methods and have found little differences. Luborsky et al. (1975) used the box score method to review comparative studies dating back to the 1950s with regards to this question. Of 11 studies that compared outcome results of different treatments, only 4 found differences between the percentage of clients improved; however, most of these studies were deemed to be of poor quality. Five studies had been conducted comparing client-centered therapy to other traditional therapies. Of these 5 studies, 4 of them found the therapies to be equal and only one found that the traditional therapies were superior. In 19 studies that compared behavior therapy to psychotherapy, 13 studies found the two to be equivalent and only 6 studies found behavior therapy to be superior. However, Luborsky et al. again point out the poor quality of the 6 studies that found behavior therapy superior to psychotherapy. Luborsky et al. concluded that "comparative studies of different forms of psychotherapy found insignificant differences in proportions of patients who improved by the end of psychotherapy" (p., 1003). Due to the failure to find differences, Luborsky et al. reached the conclusion asserted by Rosenzweig in 1936 that the "dodo bird verdict" that "everybody has won and all must have prizes" (p., 1003) is probably the most accurate description of psychotherapy.

Smith and Glass (1977) in their meta-analytic review of the effect of psychotherapy across 375 studies also analyzed the effect of the differing therapies. In all Smith and Glass compared 10 different treatment types. The effect sizes for each of these treatments can be found in Table 5. When categorizing these treatment types into behavioral and non-behavioral categories a small difference was found with the behavioral treatments showing an average effect size of 0.83 and the non-behavioral treatments showing an average effect size of 0.59. However, Smith and Glass indicate that the small difference may be due to the methodology differences in the studies. When including only studies where a behavioral and non-behavioral treatment were simultaneously compared (N = 119 effect sizes) there is only a 0.07 difference between the two groups. Smith and Glass further compared psychodynamic treatments to systematic desensitization and behavioral modification. When comparing outcomes for the typical phobic client using regression equations little effect size differences were found (psychodynamic = 0.92, systematic desensitization = 1.05, and behavioral modification = 1.12). Again when comparing outcomes for the typical neurotic client using regression equations, little effect size differences were found (psychodynamic = 0.64, systematic desensitization = 0.52, and behavioral modification = 0.85). In view of these results Smith and Glass concluded that there are negligible differences in the effects produced by different types of therapy.

Table 5.

Smith and Glass' (1977) therapy type effects.

Type of therapy	M effect size	Treated percentile status compared to control group
Psychodynamic	0.59	72%
Adlerian	0.71	76%
Eclectic	0.48	68%
Transactional analysis	0.58	72%
Rational-emotive	0.77	78%
Gestalt	0.26	60%
Client-centered	0.63	74%
Systematic desensitization	0.91	82%
Implosion	0.64	74%
Behavior modification	0.76	78%

Note. Adapted from "Meta-analysis of psychotherapy outcome studies," by M. L. Smith and G. V. Glass, 1977, *American Psychologist, 32,* p. 756. Copyright 1977 by the American Psychological Association.

More recently Wampold et al. (1997) conducted a meta-analysis testing the "dodo bird verdict" whether or not differences exist between the different psychotherapies. Included in Wampold et al.'s meta-analysis were only 1) studies that directly compared two or more therapies and 2) studies that examined the effectiveness of "bona fide" treatments. In this meta-analysis "bona fide" treatments were defined as "those delivered by trained therapists and were based on psychological principles, were offered to the psychotherapy community as viable, or contained specified components" (p., 205). Also unique to the meta-analysis, Wampold et al. did not classify treatments into general category types. Among the studies conducted between 1970 and 1995, 277 effect sizes were calculated. These effect sizes were then randomly assigned a positive or negative sign. It was thought that if there were differences between the therapies then the effect sizes after random assignment of a sign would equal zero but would produce thick tails in a distribution due to the large effects. On the other hand it was thought that if there were not differences between the therapies then the effect sizes after random assignment of sign would equal zero and would be normally distributed. See Figure 3 for Wampold et al.'s visual explanation of this comparison.

Figure 3. Wampold et al.'s (1997) dodo bird hypothesis (p., 206).

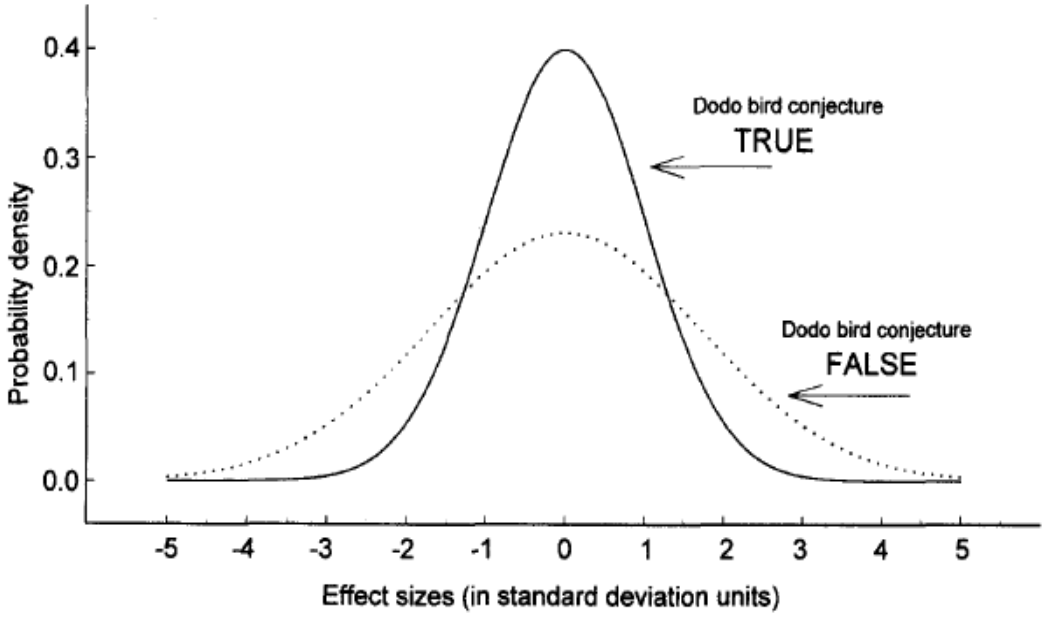


Figure 1. A distribution of effect sizes (with signs determined randomly) when the Dodo bird conjecture is true and when it is false.

Note. From "A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, 'all must have prizes'," by B. E. Wampold et al., 1997, *Psychological Bulletin, 122,* p. 206. Copyright 1997 by the American Psychological Association.

Wampold et al. (1997) did find that when the 277 effect sizes were randomly assigned a sign the aggregated effect size was near zero (d = 0.0021). Further when testing for the homogeneity of these effects around zero, chi square analysis lead to a failure to reject the null hypothesis (p = .94), indicating that homogeneity was observed. Further, Wampold et al. calculated the average effect when all 277 effect sizes were assigned a positive sign. This was thought to provide an upper bound estimate of the type of therapy. The resulting upper bound estimate effect size was d = 0.19. Finally Wampold et al. also compared effect sizes for treatments across publication years (if true difference exist between treatments but were obscured due to methodological problems seen in studies of the past, differences in effect sizes would be seen here) and between treatments determined to be similar and treatments determined to be dissimilar (if true differences exist between treatments, similar treatments would show smaller effects when compared to each other). Both of these analyses produced results indicating no differences. Wampold et al. concluded that the "dodo bird verdict" was supported in their meta-analysis and that there is no difference in outcomes between the different psychological treatments.

Another major criticism with empirically supported treatments is the emphasis on the use of treatment manuals. The task force's criteria indicates that in order for a treatment to be considered "well established" a treatment manual must be used in studies considering its effectiveness. It was originally thought that treatment manuals were beneficial because they could be used to describe a specific intervention in enough detail so that a researcher could use the manual to test that intervention or so that a clinician could use the manual to guide their practice in delivering that intervention (Addis &

Cardemil, 2006). However, a number of criticisms concerning the use of treatment manuals have been raised.

One major criticism with the use of treatment manuals is that they put undue emphasis on a small part (the technique) in the process of psychotherapy (Duncan & Miller, 2006; Lambert & Ogles, 2004; Silverman, 1996; Wampold, 2001). Wampold (2001) suggested that only 1% of therapeutic change can be attributed to the specific technique. Manuals focus on this specific factor that contributes so little to the outcome while ignoring other factors such as therapist variables and client variables. In illustration of this point Aaron T. Beck, whose work contributed to the popularization of manuals (Lambert & Ogles, 2004), has been quoted saying: "You can't do cognitive therapy from a manual any more than you can do surgery from a manual." (Duncan & Miller, 2006).

Additionally, some argue that the use of treatment manuals does not produce improved outcomes in therapy (Duncan & Miller, 2006; Lambert & Ogles, 2004). Testing this hypothesis Bein et al. (2000) examined the effect of training 16 therapists in a manualized Time-Limited Dynamic Psychotherapy. In this study each of the 16 therapists treated 2 clients using their traditional treatment, then received one year of training in the manualized treatment, and then treated 2 clients using the manualized treatment. In this well referenced Vanderbilt II project, Bein et al. found that there were no differences in outcome between the clients that were treated prior to training with the traditional treatment and the clients that were treated after training in the manualized treatment. A failure to find improved outcome with the use of treatment manuals has been repeatedly found in the literature (Shadish, Matt, Navarro, & Phillips, 2000).

Further research on treatment manuals has actually found negative effects associated with their use (Beutler et al., 2004; Duncan & Miller, 2006). In a review of the literature on the negative effects of treatment manuals Addis, Wade, and Hatgis (1999) reported that, when surveyed, clinicians believe that manuals have a negative impact on the therapeutic relationship. Other negative effects pointed out by Addis et al. included manuals failure to address the individual needs of clients and the resulting restriction in the innovation of clinicians. The Vanderbilt II project, mentioned earlier, also studied the negative effects of training clinicians in the use of a manual. Henry, Strupp, Butler, Schacht, & Binder (1993) found that after training in the use of a manual, therapists were judged to be less optimistic, less supportive of clients' confidence, spend less time evaluating clients' feelings, to be less warm, to be more authoritarian, and to express more negative attitudes.

The Division 12 Task Force on the Promotion and Dissemination of Psychological Procedures report (1995) on "empirically supported treatments" has also been criticized due to its emphasis on the use of randomized controlled trials in studying the efficacy of treatments. Randomized controlled trials seek to examine the effectiveness of therapy or a particular treatment through strict control of variables that may effect client change, but are not related to the treatment of interest. While this strict control may increase the internal validity of randomized control trials, the external validity of such trials is often called into question. Many argue that the results of randomized controlled trials do not carry over or apply to clinical practice. Opponents of randomized controlled trials indicate that the subjects do not represent actual clients and that the process in controlled trials does not represent the process in actual practice.

With regards to how well subjects from randomized clinical trials represent actual clients a number of differences between the two populations have been pointed out. One area in which these two populations may be different is in the reason for seeking services. While those in the clinic setting often actively seek services, participants in randomized control trials may be enticed to participate in a treatment by an advertisement or in some cases by some type of reward (i.e., money or extra credit). A second area of difference between the two populations is in the presenting problems. Randomized controlled trials seek control by often excluding participants with a medical condition, sub-clinical levels of pathology, severe pathology, or a comorbid diagnosis. However, it has been reported that actual clients often show one or more of these excluding characteristics. Westen and Morrison (2001) indicated that exclusion rates for randomized controlled trials for depression were 68%, for panic disorder 64%, and for generalized anxiety disorder 68%. Stirman, DeRubeis, Crits-Christoph, and Brody (2003) examined the issue of exclusion discrepancy by comparing charts on 347 actual clients to the literature on randomized controlled trials. They found that 67% of those clients were judged not to be eligible for participation in a single randomized controlled trial study due to not meeting the above mentioned exclusion criteria.

It has been argued that in addition to participant characteristics in randomized controlled trials lacking external validity the process of treatment in these trials does not represent what actually happens in clinical practice. Hansen, Lambert, and Forman (2002) compared outcome data on over 6,000 clients seen across six different outpatient sites across the nation to outcomes reported in the literature of 28 randomized controlled trials. The average number of sessions a participant attended in the randomized controlled

trials was 12.7 and the rate of recovery based on the criteria of clinically significant change (Jacobson & Truax, 1991) in these trials was 57.6% of participants. In contrast, the average number of sessions a client attended was less than 5 and the rate of recovery based on the criteria of clinically significant change was only 20% of clients. Hansen et al. concluded that the results of randomized controlled trials may not represent outcomes as observed in clinical practice.

After reviewing the literature on empirically supported treatments, therapy manuals, and treatment protocols, Lambert and Ogles (2004) report that more research is needed to determine whether training therapists in the use of these specific factors has any real effects on therapy outcome. They also indicate that there is little evidence for the "transportability" of specific empirically supported treatments to the clinical population. Finally, Lambert and Ogles conclude that "little evidence supports the notion that specific techniques make a substantial contribution to the treatment effects. Indeed, a line of research that centers on further specifying common factors may ultimately result in a larger harvest" (p. 176).

C*ommon Factors*

Many of the critics of empirically supported techniques and specific factors indicate that common factors play a much larger role in the effect of psychotherapy. Common factors are the variables that are common to all effective models and schools of psychotherapy and many believe that it is their presence, or the lack thereof, that determines the overall effect of a psychological treatment. Lambert and Ogles (2004) define common factors as "those dimensions of the treatment setting (therapist, therapy, client) that are not specific to any particular treatment" (p., 151). The idea of common

factors and their effect was first introduced by Rosenzweig in 1936. Noting that widely divergent forms of psychotherapy were all equally effective, Rosenzweig indicated that the there must be some principles common to all forms of psychotherapy that are causing the general effectiveness.

Since Rosenzweig's (1936) introduction of common factors many different theories about what constitutes a common factor have been proposed. Many believe that the common factors are associated with or even detailed in the Rogerian necessary and sufficient conditions for therapeutic change. Rogers (1957) indicated that there are six conditions that are both necessary and sufficient to produce or describe change that occurs in psychotherapy; implying that change will not occur in therapy if these conditions are not present and only these conditions need be present in order for change to occur in therapy. He further explains that any time a change does occur in a client it is due to the presence of these conditions and not due to other factors such as differing treatment techniques or theories.

The first of Rogers (1957) conditions is that two persons must be in psychological contact. This condition simply indicates that a client and a therapist have some kind of psychological relationship, while the remaining conditions seek to describe that relationship. The second condition applies to the client, who must be in a state of incongruence, being vulnerable or anxious. This incongruence on the part of the clients represents a discrepancy between their actual self and the way they view the world and their ideal self or the way that they would like to be. As compared to the client, the third condition indicates that the therapist must be in a state of congruence. This state of congruence by the therapist represents the necessity of the therapist to be him or her true

self, genuine and integrated. There can be no deception of feelings or actions on the part of the therapist. This is only required of the therapist in session as part of the relationship with the client. Fourth of the conditions, the therapist must experience unconditional positive regard for the client. Unconditional positive regard implies complete acceptance of the client without any form of judging or valuing the clients' beliefs, thoughts, emotions, or behaviors. The therapist must further experience an empathic understanding of the client. Rogers describes this empathy as sensing the client's world as if it is your own. Not only is it necessary for the therapist to feel this empathy, but it also must be communicated to the client. Communicating this empathy as well as the experienced unconditional positive regard is the last of Rogers' six necessary and sufficient conditions. Rogers reports that the varying degrees of effectiveness in therapy are due to the varying levels of presence of these conditions.

Although many accept that Rogers' necessary and sufficient conditions describe the common factors in psychotherapy, other definitions of the common factors have also been widely recognized. Frank (1976) was one of the first to summarize the proposed common factors into a cohesive model. This model, as described by Weinberger (1995), indicates that across all forms of psychotherapy individuals first seek treatment because they have a sense of demoralization. This demoralization is due to the fact that they are experiencing stress or anxiety over a specific problem. The purpose of psychotherapy is then to help reduce the stress or anxiety by instilling hope which alleviates the demoralization. Frank indicates that all therapies instill this hope by providing a healer, a healing setting, an understanding of the problem, and a set of prescribed methods for overcoming the problem.

Since the release of evidence based practice and empirically supported treatments a number of other models of common factors have been hypothesized. Weinberger (1995) recognized that there existed a large number of proposals of different common factors without scientific evidence supporting one set of factors over another. Weinberger offered a list of five classes of common factors that may or may not be present in different forms of therapy, but are present in psychotherapeutic change in general. These factors included 1) the therapeutic relationship, 2) expectations of therapeutic success, 3) confronting or facing the problem, 4) providing an experience of mastery or cognitive control over the problematic issue, and 5) attributing of the therapeutic success to the client. He further reviewed a large body of research supporting these factors as playing a role in psychotherapeutic change. Weinberger reported that different schools take advantage of these different factors; humanistic and experiential approaches emphasize the relationship, behavioral approaches emphasize confronting the problem, cognitive approaches emphasize mastery or control, and no schools focus on or include expectations or attributions of therapeutic success. Although widely cited, Weinberger did indicate that his five common factors are only illustrative and not exhaustive and that more empirical research needs to be conducted in this area.

Lambert and Ogles (2004) and Lambert and Bergin (1994) have described a more detailed list of common factors. This list of common factors is split into three categories: support factors, learning factors, and action factors. According to Lambert and Ogles support factors provide a client with an increased sense of safety and a decreased sense of tension and anxiety. The support factors are followed developmentally in the therapeutic process by learning factors which lead to changes in the way clients understand their

problems. After the occurrence of support and learning factors the client acts differently in an attempt to master and overcome the problems. A complete summary of the common factors separated into the three categories as provided by Lambert and Ogles is given in Table 6.

Table 6.

Lambert and Ogles (2004) sequential listing of common factors.

Support Factors	Learning Factors	Action Factors
Catharsis	Advice	Behavioral regulation
Identification with therapist	Affective experiencing	Cognitive mastery
Mitigation of isolation	Assimilating problematic experiences	Encouragement of facing fears
Positive relationship	Cognitive learning	Taking risks
Reassurance	Corrective emotional experience	Mastery efforts
Release of tension	Feedback	Modeling
Structure	Insight	Practice
Therapeutic alliance	Rationale	Reality testing
Therapist/client active participation	Exploration of internal frame of reference	Success experience
Therapist expertness	Changing expectations of personal effectiveness	Working through
Therapist warmth, respect, empathy, acceptance, genuineness		
Trust		

Note. From *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (p. 173), by M. J. Lambert, 2004, New York: John Wiley & Sons, Inc. Copyright 2004 John Wiley & Sons, Inc.

Regardless of the definition or specificity of the number and type of common factors that exist, there is ample evidence that these factors play a role in the effectiveness of psychotherapy. This literature identifies a number of different areas that lend support to the common factors theory: no differences are observed between treatments and therapies that are theoretically different, clients often respond to treatment before the active ingredients have been provided, placebo shows some level of effectiveness as a form of treatment, component analysis show specific factors do not add to the effect, and studies show common factors to play a large role in outcome.

Earlier parts of this paper discuss the literature demonstrating the general effectiveness of psychotherapy (Lambert & Ogles, 2004; Lipsey & Wilson, 1993; Luborsky et al., 1975; Shapiro & Shapiro, 1982; Smith & Glass, 1977; Westen & Morrison, 2001) and the finding that one therapy does not differ from another in effectiveness (Luborsky et al., 1975; Smith & Glass, 1977; Wampold, 1997). Proponents of the effect of common factors therefore conclude that if therapy is effective and no specific therapy is more or less effective than another, there must be common factors to all therapies that make them, in general, effective treatments.

Another consistent finding in the literature that provides evidence in favor of common factors is the fact that clients often improve early on in treatment before the active specific ingredients have been used. This early improvement ties closely to Howard, Lueger, Maling, and Martinovich's (1993) phase model of psychotherapy. According to this model clients make changes during psychotherapy through three specific phases: remoralization, remediation, and rehabilitation. Remoralization represents an improvement in the sense of well-being which precedes improvements in

symptom reduction and life functioning. Howard et al. as well as others (Callahan, Swift, & Hynan, 2006; Mintz, Mintz, Arruda, & Hwang, 1992) have shown that improvements in remoralization usually occur early on in the course of therapy by around 4-5 sessions before the active ingredients of any specific theory or treatment have been provided.

Ilardi and Craighead (1994) reviewed this idea of early improvement across 8 studies of cognitive-behavioral treatment for depression. In this review Ilardi and Craighead analyzed client improvement across sessions in over 500 clients. They found that a large percent of the changes that occur in cognitive therapy happen during the first four weeks of treatment. Further they note that this change happens before the specific techniques of cognitive-behavioral therapy have been applied. Instead, Ilardi and Craighead point to common factors that are present in these early sessions as causing the early change that occurs in clients. They indicate that the factors of discussing a treatment rational and assigning homework may be most strongly linked to improvement by helping the client overcome feelings of hopelessness. Similar findings have been argued across other treatments and disorders (Wilson, 1998).

Not only do clients show improvements before specific ingredients have been used, but they often show improvements or gains without the use of specific ingredients at all; a phenomenon known as the placebo effect. A placebo as defined in medical terms is a treatment that is pharmacologically inert, but may have an effect due to the consumer of the placebo's expectations. In psychotherapy a placebo has been defined as the common factors, or factors that are not unique to the specific psychological treatment. Evidence of the placebo effect is seen throughout the literature examining the effectiveness of psychotherapy. As mentioned earlier, some critics of Eysenck's (1952)

controversial review indicate that his control groups were actually receiving placebo or common factors treatments (Rosenweig, 1953).

Grissom (1996) specifically conducted a meta-analysis of over 45 previously conducted meta-analyses to examine the placebo effect in psychotherapy. Grissom found that four types of comparisons were made in the previous studies: therapy vs. control, therapy vs. placebo, placebo vs. control, and therapy vs. therapy. Pertinent to the placebo effect, it was found that therapy when compared to control showed an effect size of 0.75. However, when therapy was compared to a placebo the effect size was lower at 0.58. This decrease in effect size indicates that the placebo treatment had some kind of effect. Further, when the placebo group was compared to a control group, the effect size of the placebo treatment was 0.44, again indicating that placebo treatment has an effect in psychotherapy. Based on these results it is thought that the placebo treatments show an effect because they capitalize on the use of the common factors.

Stevens, Hynan, and Allen (2000) conducted a similar meta-analysis looking at the placebo effect across 80 studies by comparing common factors to no treatment, specific factors to no treatment, and complete treatment to no treatment. In this meta-analysis it was found that the complete treatment calculated effect size was 0.28, specific factors calculated effect size was 0.19, and the common factors effect size was 0.11. Stevens et al. noted that the calculated effect sizes were similarly divided between the three categories; however, they were smaller than what has previously been found in the literature. They report that the lower effect sizes, especially in the area of common factors, may be due to their calculating weighted effect sizes instead of un-weighted effect sizes, and their analyzing a more restricted study base.

Studies using component analysis show common factors to be superior contributors to improvement when compared to specific factors. Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) tested the effect of 1 variable that was unique to cognitive therapy and 2 variables that were common to other forms of therapy in the treatment of 30 clients who received cognitive therapy for depression. In this study cases received ratings on the three factors (therapeutic alliance, emotional involvement, and focus on the impact of distorted cognitions on depressive symptoms) as well as three outcome ratings (BDI, HDRS, and GAS) at post-treatment. When controlling for pre-treatment severity of symptoms and type of treatment, the two common factors correlated highly with outcome while the specific cognitive factor did not. Castonguay et al. concluded that common factors were responsible for the change as a result of the application of cognitive therapy in their clients.

Ahn and Wampold (2001) further utilized component and dismantling analysis to compare common and specific factors of therapy. Ahn and Wampold conducted a meta-analysis on 27 component studies published between 1990 and 1999. They hypothesized that if specific ingredients contributed significantly to the effect of psychotherapy, then complete treatments would show a large effect when compared to treatments that were missing a critical specific ingredient. On the other hand, if specific ingredients did not contribute significantly to the effect of psychotherapy, then the complete treatments would show an effect close to zero when compared to treatments that were missing the critical component. A visual illustration of this hypothesis can be viewed in Figure 4.

Figure 4. Ahn and Wampold's (2001) hypothesis of the effect in component analysis.

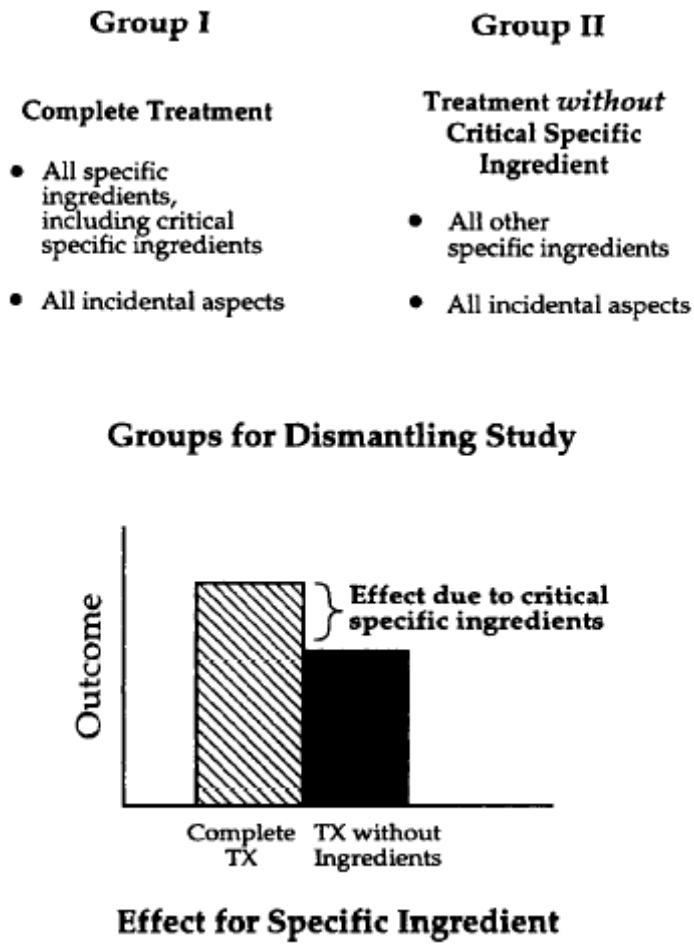


Figure 1. Dismantling study illustrated. Tx = treatment.

Note. From "Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy," by H. Ahn and B. E. Wampold, 2001, *Journal of Counseling Psychology, 48*, p. 252. Copyright 2001 by the American Psychological Association.

Ahn and Wampold (2001) found the effect size of the complete treatments to be *d* = -0.20. According to Ahn and Wampold, the negative value indicates that the treatment conditions with fewer components outperformed the treatment conditions with more components. However, this effect size is considered to be small (Cohen, 1988) and did not differ significantly from zero. It was therefore found that component studies provided no evidence that specific ingredients are responsible for the beneficial effect of psychotherapy. Based on these findings, Ahn and Wampold concluded that the benefits of treatments are probably due to factors that are common to all treatments.

Finally, a number of reviews report that common factors explain a large amount of variability in the effectiveness of psychotherapy. Messer and Wampold (2002) argued that the previously found effect sizes for the specific factors (*d* = 0.20) are an upper estimate or even an overestimate of the true differences between pairs of treatments. They believe that this overestimate is due to the previous effect sizes being based on absolute values which do not take into account sampling error, and the use of non-therapeutic or non-"bona-fide" treatments being used by researchers as control groups. Even given that 0.20 is an overestimate of the true effect of specific factors, Messer and Wampold indicate that this effect is still small and insignificant explaining at most 1% of the variance in psychotherapeutic change. Instead, it is pointed out that a number of common factors play a larger role: the therapist-client alliance shows an effect size of *d* = 0.54, indicating that this factor explains 7% of the variance in psychotherapy outcome; therapist and research allegiance may explain 70% of the variance; and the therapist characteristics may explain 6-9%. These estimates are similar to those found by other reviews (Lambert & Ogles, 2004; Wampold, 2001).

One major criticism that has been raised against the supporters of common factors is that they over-emphasize a common thing. Chambless and Crits-Christoph (2006) have recently argued this point. They agree that the common factors play a role in psychotherapy outcome; however, they also believe that the specific factors play an additional role. Chambless and Crits-Christoph indicate that understanding and applying common factors in psychotherapy is important. However, because the common factors do not explain 100% of the variance in treatment outcome, it is also important to understand and apply specific factors when treating mental disorders.

Implications of the Debate

The outcome of the debate between the relative importance of specific and common factors in the effectiveness of psychotherapy outcome has many important implications for the field of clinical psychology. Many of these implications were pointed out by the Division 12 Task Force on Promotion and Dissemination of Psychological Procedures (Chambless et al., 1995) when they made recommendations for action based on empirically supported treatments. If one of these sets of factors (specific or common) show to contribute more to the outcome of therapy than the other, then that set of factors should also be emphasized more in the field through a number of actions, including but not limited to: accredited graduate programs should teach those factors didactically and provide clinical training in the use of those factors; accredited internships should likewise focus a fair amount of training on those factors; workshops and seminars should be provided for continuing education training in those factors; clinicians should focus on using those factors in their practice, especially when evaluating their cases; and

researchers should focus their scientific efforts on understanding those factors in greater detail, as well as many other implications.

Client Preferences

Although a large amount of research has examined the issue comparing specific and common factors and how they relate to the overall effectiveness of psychotherapy, little or no research has been conducted examining client preferences on the debate. It is possible that clients may show a preference for the use of specific factors, or show a preference for the use of common factors in their treatment. Numerous studies have indicated that clients do indeed indicate preferences toward the treatment they receive, both in the medical field and in the mental health field setting (Aita et al., 2005; Ertly & McNamara, 2000; Riedel-Heller, Matschinger, & Angermeyer, 2005). However, clinicians in both settings do not always consult their clients concerning these preferences (Benbassat, 1998; Charles, et. al, 1997; Ford, 2006; Shiloh, 2006). This is in error due to the fact that client preferences play a role in the process and outcome of the treatment that is provided (Devine & Fernald, 1973; Mendonca & Brahm, 1983; Rokke et al., 1999; Swift & Callahan, 2009). It thus follows that it is important to understand clients' preferences concerning the use of specific factors or common factors in therapy.

The research indicates that clients do have preferences toward the treatment that they receive. A recent study examining treatment preferences was conducted by Riedel-Heller, Matschinger, and Angermeyer (2005). In this study a face-to-face interview was administered to over 5,000 German participants. The interview examined attitudes toward different types of treatments by presenting participants with a vignette for one of two disorders (schizophrenia or depression) and then asking respondents to make a first and

second choice with regards to a preferred treatment provider and a preferred treatment. In terms of a preferred treatment provider participants were asked to choose between a confidant, psychiatrist, psychotherapist, family physician, self-help group, priest, community nurse/district or community public health department, non-medical practitioner, and cure at a spa. In terms of a preferred treatment option participants were asked to choose between psychotherapy, natural remedies, acupuncture, relaxation, psychotropic drugs, meditation/yoga, and ECT.

Riedel-Heller et al. (2005) found that the majority of interviewees recommended seeking treatment from a health professional, specifically endorsing mental health professionals most often for both disorders. Further, psychotherapy was rated as the most often recommended type of treatment by participants for both disorders. Table 7 reports Riedel-Heller et al.'s results in terms of the percentage of participants to indicate a given treatment preference. Riedel-Heller et al. further used a logistical regression model to examine factors associated with the expressed preferences. It was found that for these participants age, gender, education level, definition of mental illness, and perceived causes of the illness all played a role in the expressed preferences.

Table 7.

Riedel-Heller et al.'s (2005) observed treatment preferences.

Depression		Schizophrenia	
% of participants	First choice	% of participants	First Choice
Treatment provider			
22.4%	Psychotherapist	34.6%	Psychiatrist
21.2%	Psychiatrist	24.7%	Psychotherapist
20.1%	Family physician	17.4%	Family physician
16.8%	Confidant	8.9%	Confidant
11.2%	Self-help group	8.5%	Self-help group
Treatment type			
53.7%	Psychotherapy	64.7%	Psychotherapy
18.3%	Relaxation	14.7%	Psychotropic drugs
10.6%	Natural remedies	10.8%	Relaxation
10.6%	Psychotropic drugs	5.1%	Natural remedies
3.8%	Meditation/Yoga	2.0%	Meditation/Yoga

Note. Adapted from "Mental disorders – Who and what might help?," by S. G. Riedel-Heller, H. Matschinger, and M. C. Angermeyer, 2005, *Social Psychology and Psychiatric Epidemiology, 40,* 167-174. Copyright by Springer Science + Business Media.

A number of other surveys/interviews of the general public have indicated that preferences for type of treatment do exist. Churchill et al. (2000) surveyed 895 adult patients seeking medical treatment at one of 20 general practice sites. In this survey participants were asked to rank four treatment options (trying to pull themselves together, seeing a psychiatrist, taking tablets, and seeing a counselor/therapist) by preference given the scenario that they were seeking services for depression. Among participants, 50.8% favored seeing a counselor/therapist, while only 15.3% favored a drug treatment. Priest, Vize, Roberts, Roberts, and Tylee (1996) surveyed over 2000 participants across the United Kingdom with regards to treatment preferences for depression. Similar results were found; 85% of participants believed that counseling was an effective treatment for depression, 91% thought that people suffering from depression should be offered counseling, only 46% felt that anti-depressants were an effective treatment, and 68% of the participants thought that antidepressants were addictive.

Others have also found that actual clients in a mental health field have specific preferences with regards to the treatment they receive. Gum et al. (2006) conducted a study in which depressed adults were given an option of the type of treatment they received (medication or counseling). Of the 1,602 participating clients 57% preferred counseling over medication. More drastic results were found by Bedi et al. (2000), who reported that among 220 clients who were given an option, almost two-thirds of them preferred counseling as compared to antidepressants. Devine and Fernald (1973) found that preferences were expressed by clients in the treatment of choice (systematic desensitization, encounter, rational-emotive, or modeling-behavior rehearsal) for a snake phobia. Renjilian et al. (2001) found preferences of treatment (individual or group)

among clients who were seeking treatment for obesity. Additional studies have found that sex differences, belief differences, and cultural differences may affect the preferences that clients have regarding mental health treatments (Propst, Ostrom, Watkins, Dean & Mashburn, 1992; Schwartz & Rubel, 2005; Wong, Kim, Zane, Kim, & Huang, 2003).

An interesting study conducted by Wanigaratne and Barker (1995) examined treatment preferences among 5 different styles of therapy. In this study 25 clients at a psychiatric day hospital were asked to watch five four-minute videos of role-played counseling sessions and then answer questions concerning the credibility and preference for each of the portrayed therapy types. The five therapy styles presented in the video were psychodynamic, humanistic, cognitive-behavioral, focusing on external contributors to the problems, and the therapist playing the role of a friend. Wanigaratne and Barker found that participants preferred the cognitive-behavioral treatment most often when asked if they would feel comfortable receiving a similar style of therapy, if they thought the therapist's approach would be helpful, and if they would like their current therapist to use a similar style of therapy. The psychodynamic approach was the second most preferred treatment type, followed by focusing on the external contributors, the humanistic style, and the therapist playing the role of a friend, which showed no statistical difference. Wanigaratne and Barker further found that the perceived credibility of the treatment was highly correlated (r = .83) with the stated preference. Also, in examining the factors that may have contributed to the clients' treatment preferences, it was found that symptom severity (as measured by the SCL-90) was correlated with a preference for the psychodynamic style, sex only played a role in preferences for the

therapist playing the role of a friend style, and age showed no statistically significant associations.

Of particular interest to this study is the role that treatment efficacy information plays in client preferences. Kazdin (1981) had college students listen to a case description and indicate a preference for which treatment the case should receive. Participants were given the option of 4 treatments, 2 of which were described as having a strong effect in terms of the rapidity, magnitude, and durability of the changes while the other 2 were described as having a weak effect. Kazdin reported that the efficacy information did have an effect on the participants' perceptions of the strength of the treatments, but did not have an influence on the participants' ratings of acceptability of treatment. On the other hand, the presence of adverse side effects did influence the acceptability of treatment ratings.

In a follow-up study Kazdin (1984) asked a clinical population of parents and children who were seeking treatments for deviant child behaviors to rate possible treatment options. In this study 40 parents and 40 children (1984) were provided with a treatment description of a child who was seeking services for problems similar to the complaints of the participating clients as well as a description of four different treatment options which were randomly described as producing either strong or weak effects. Kazdin found that parents and children differed in preferences for type of treatment, with children preferring medication most often and parents preferring time-out most often. It was further found that the described efficacy of the treatment resulted in greater ratings of acceptability for both parents and children, with treatments described as producing strong

effects being rated as more acceptable. These results further replicate the finding that preferences for treatments do exist.

Defining Evidence Based Practice in Psychology

In recent years it has been recognized (by researchers, practitioners, and organizations) that clients and patients have preferences with regards to the treatment that is provided; and a number of organizations have stressed the importance of understanding these preferences in the delivery of health care. Concerned that the health system in the United States was not providing consistent high-quality medical care to all people, the Institute of Medicine's committee on Quality Health Care in America in 2001 released a report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, indicating how the health care system could be reinvented to improve the delivery of care to the public. In this report the Institute of Medicine indicated six core needs for health care. According to the report, health care needs to be safe, effective, patient-centered, timely, efficient, and equitable. In describing patient-centered care the report emphasizes the importance of providing care that is "respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (p. 3). Further, when outlining ten rules for their redesign of the health care system, the Institute of Medicine indicates that care should be customized according to patient's needs and values, and that the patient is the source of control in decision making.

In general the committee on the Quality of Health Care in America stressed the importance of practice in health care fitting a new definition of evidence-based. According to the report, earlier definitions of evidence-based practice emphasized the

correct use of current evidence in making decisions about the care of patients. However, it was felt by the committee that these prior definitions failed to incorporate other factors, such as clinical expertise and patient values, in the decision making process. As a result the committee and the Institute of Medicine adopted a new definition of evidence based practice adapted from Sackett et al. (2000). This definition is as follows:

> Evidence-based practice is the integration of best research evidence with clinical expertise and patient values. *Best research evidence* refers to clinically relevant research, often from the basic health and medical sciences, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination); the power of prognostic markers; and the efficacy and safety of therapeutic, rehabilitative, and preventative regimens. *Clinical expertise* means the ability to use clinical skills and past experience to rapidly identify each patient's unique health state and diagnosis, individual risks and benefits of potential interventions, and personal values and expectations. *Patient values* refers to the unique preferences, concerns, and expectations that each patient brings to a clinical encounter and that must be integrated into clinical decisions if they are to serve the patient (p., 147).

Of particular interest to this paper is the inclusion of patient values to the definition. According to the definition health care should not just be based on scientific research or clinical expertise, but should also be based on the values, preferences, concerns, and expectations of the patient.

In 2005 the American Psychological Association adopted a policy statement on evidence-based practice in psychology that was based on the Institute of Medicine's 2001 definition. The APA defined evidence-based practice in psychology as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA policy statement, 2005; APA Presidential Task Force on Evidence-Based Practice, 2006). This APA policy further emphasizes the importance of considering personal preferences, values, and preferences related to the treatment,

including goals and treatment expectations, of the patient. The statement further states that it should be a central goal to maximize patient choice and clinical decisions should be made in collaboration with the patient. According to the APA policy, mental health care should also not just be based on scientific research or clinical expertise, but should also include the values, preferences, concerns, and expectations of the patient.

Decision-Making and Client Preferences

As a result of the research that indicates that clients/patients do have preferences with regards to treatment, and the recent emphasis on the importance of taking these preferences into account, different models have been proposed about how to involve the client in the decision-making process. Shared decision-making is one popular model aimed at involving both parties in the treatment decision-making process. This model as defined by Charles, Gafni, and Whelan (1997, 1999) includes four parts:

1. At a minimum, both the physician and patient are involved in the treatment decision-making process.
2. Both the physician and patient share information with each other.
3. Both the physician and the patient take steps to participate in the decision-making process by expressing treatment preferences.
4. A treatment decision is made and both the physician and patient agree on the treatment to implement.

Ford et al. (2003) provided a similar but slightly different definition of shared decision making by pointing out four key elements to the model: provision of clear information, questions from the patient, willingness to share decisions, and agreement between patient and doctor about the problem and the plan of action. Charles et al. (1997) further suggested that the shared decision-making model should be used when "several treatment options exist with different possible outcomes and substantial uncertainty,

when there is no clear-cut right or wrong answer, and when treatments vary in their impact on the patient's physical and psychological wellbeing" (p. 682).

The shared decision-making model should be distinguished from other common decision-making models including the paternalistic model and the informed choice model. In the paternalistic model, as described by Parsons (1951), the health care provider is seen as an authoritative figure that uses his or her knowledge and skills to decide what is best for the patient. The health care provider, as the expert, provides the appropriate diagnosis and treatment for the patient without considering the patient's preferences when making decisions. In the paternalistic model the patient plays a passive role, with only the duty to try to get well and comply with the health care provider's orders.

If the paternalistic model is seen as one extreme giving all of the decision-making power to the health care provider, the informed choice model can be seen as the other extreme giving all of the decision-making power to the patient. In this model, as described by Hurley, Birch, and Eyles (1992), the health care provider possesses the technical knowledge of the illness and available treatments and it is the health care provider's duty to pass this knowledge on to the patient. The patient then possesses the available scientific knowledge and knowledge about his or her own preferences, and is thus able to make the decisions about the care and treatment.

The shared-decision model can be placed in the middle between both extremes. This model emphasizes a simultaneous interaction between the health care provider and the patient at all stages of the decision-making process (Charles, Whelan, & Gafni, 1999) with both parties having an investment in the treatment decision (Ford, Schofield, &

Hope, 2003). The health care provider's investment is due to his or her concern over the patient; the patient's investment is due to his or her having to live with the consequences of the decision. In this model the patients and health care providers have different, but equally valuable, perspectives and roles (Makoul & Clayman, 2006) and while health care providers share scientific information about the illness and possible treatments, the patients share information about how the illness affects them personally as well as their own preferences for treatment. When coming up with a decision in this model it is important that both parties negotiate to find the ideal treatment to implement (Charles, Whelan, Gafni, Willan, & Farrell, 2003).

Arguments and evidence from the medical setting support the use of the shared-decision model as compared to other decision-making models. One argument in support of the shared-decision model is that patients have the right to be involved in the decision-making process. Ford et al., (2003) in a survey of health care providers and the general public, found that most people felt that it was a right of the patients to be involved in the decision-making process. Ford et al. further point out that it is important to remember that because the outcome of the treatment decision will mainly have an effect on the patient, they should be integrally involved in the treatment decision-making process.

In addition to the argument that patient involvement is an ethical right, shared decision-making has been supported by studies concerning patient preferences about wanting to be involved. In 2006 Ford, Schofield, and Hope conducted a study observing 212 doctor-patient consultations in the Oxfordshire area that included a survey of the patient's desired level of involvement. They found that patients desire to have their preferences taken into account and want to be involved in the decision-making process.

Further, this study found that patients are often dissatisfied with their level of involvement in the decision-making process. Levinson, Kao, Kuby, and Thisted (2002) conducted a survey of 2,765 U.S. adults in order to assess public preferences for participation in decision-making. In this study 96% of the participants wanted to be offered choices and to be asked for their opinions with concern for treatment. In Benbassat, Pilpel, and Tidhar's (1998) review of 18 studies concerning patient preferences about level of involvement in the decision-making process they found that the proportion of patients who preferred an active role in the decision-making process as compared to a passive role varies from as high as 81% to as low as 22%. Even studies performed with cancer patients and patients with other serious illnesses further support the idea that patients want to be involved in the decision-making process (Benbassat et al., 1989; Hack et al., 1994).

Although shared decision-making may be considered a right of the patients, patients generally want to participate in the decision-making process, and it leads to improved treatment satisfaction and improved treatment outcomes, this model is generally not used in actual practice. Ford (2006) conducted a study in which they observed 212 consultations to determine who was making the decisions. In these 212 consultations 471 decisions were made. Of these decisions 53% of them were made by the doctor alone, 24% were made by the doctor after considering the patients opinion, 12% were shared, 5% were made by the patient after considering the doctors opinion, and 6% were made by the patient alone. When looking specifically at decisions concerning medical treatments (N = 133) 76% were doctor led, 13% were patient led, and only 11%

were shared between the doctor and patient. It is evident that currently client preferences are not taken into account as they should be in the decision-making process.

The Effects of Matching Preferences

A number of studies have examined the effect that matching clients to a preferred treatment has on therapy outcome. One early study to examine the effects of providing a client with a preferred treatment was conducted by Devine and Fernald (1973). In this study the outcome of therapy was compared in 64 clients receiving treatment for snake phobia: 16 clients were given a preferred treatment, 16 clients were given a non-preferred treatment, and 16 clients were not given a choice of treatment. Ratings by therapists found that clients who were given their preferred treatment showed less resistance and more involvement. Further, Devine and Fernald reported that those clients who were given their preferred treatment showed significantly more improvements than those clients who were given a non-preferred treatment and those clients who were randomly assigned to a treatment option, regardless of the type of treatment. Table 8 shows the mean post-therapy scores for the different groups.

Table 8.

Devine and Fernald's (1973) results comparing treatment preference and outcome.

		Assigned therapy	
Type of therapy	Preferred	Random	Non-preferred
Systematic desensitization	*M* = 23 (*N* = 4)	*M* = 20.88 (*N* = 4)	*M* = 17.25 (*N* = 4)
Encounter	*M* = 31.38 (*N* = 4)	*M* = 18.5 (*N* = 4)	*M* = 15 (*N* = 4)
Rational emotive	*M* = 36.5 (*N* = 4)	*M* = 30.63 (*N* = 4)	*M* = 39.5 (*N* = 4)
Modeling-behavior rehearsal	*M* = 41.5 (*N* = 4)	*M* = 17.25 (*N* = 4)	*M* = 32.25 (*N* = 4)
Total	*M* = 33.09 (*N* =16)	*M* = 21.81 (*N* =16)	*M* = 18.59 (*N* = 16)

Note. The table shows rankings on the post-therapy measures of fear of snakes. High ranks indicate much improvement. From "Outcome effects of receiving a preferred, randomly assigned, or nonpreferred therapy," by D. A. Devine and P. S. Fernald, 1973, *Journal of Consulting and Clinical Psychology, 41,* p. 106. Copyright 1973 by the American Psychological Association.

Mendonca and Brahm (1983) also studied the effect of providing clients a preferred treatment by comparing the treatment outcome for overweight children of 7 clients who were led to believe they had chosen the treatment they received to 8 clients who were just assigned to a treatment. Although some clients believed that they had chosen the treatment they received, all clients received the exact same treatment program, which consisted of 8 weekly sessions. At pre-treatment Mendonca and Brahm found that the children in the choice group were significantly more motivated for treatment. At post-treatment the researchers further found that participants in the choice group had lost significantly more pounds and had experienced significantly greater reductions on the weight index measure as compared to those participants who received no choice.

Rokke and Lall (1992) investigated the effects of preference and choice of treatment on pain tolerance. In this study 71 undergraduate students were told of 4 different pain management techniques and were asked to indicate which of the four techniques they would prefer. Half of the subjects were then taught and used their preferred pain management technique as they kept their hand in 0 to 1° C water, while the other half of the subjects were randomly assigned to a pain management technique. Rokke and Lall found that although the four strategies did not differ from each other in effectiveness, those participants who were given a choice of treatments tolerated the cold water for a significantly longer period of time (M = 118.9 sec) than subjects who were not given a choice (M = 89.4). Further Rokke and Lall compared subjects in the no-choice condition who were randomly assigned to their preferred pain management technique to those subjects in the no-choice condition who had been assigned to a non-preferred technique. It was found that the no-choice preferred technique condition

showed significantly higher tolerance times, indicating that both choice and preference play a role in the outcome.

Rokke, Tomhave, and Jocic (1999) examined the role of choice in treatment outcome for 40 older adults with depression. These adults were randomly assigned to either a waiting-list control condition, to a condition in which the target of the treatment was assigned, or to a condition in which the target of the treatment was chosen. Overall, it was observed that clients who received one of the treatment conditions showed greater improvements (with regards to the Beck Depression Inventory, Geriatric Depression Scale, and the Hamilton Rating Scale for Depression) than those clients who were placed in the waiting-list control condition. Of those clients who received the treatment and completed therapy, Rokke et al. (1999) found no difference between the choice and no-choice groups on overall treatment outcome. However, it was found that significantly more clients who were assigned to the no-choice condition dropped out of therapy prematurely (59%), indicating that client choice may have an effect on outcome by preventing clients from dropping out of therapy early.

Bedi et al. (2000) has also looked at the effect of client preference in treating depression. This study compared 220 clients who received the treatment that was preferred (antidepressants or counseling) to 103 clients who were randomly assigned a treatment. Inconsistent with previous findings, after 8 weeks of treatment the two groups showed no significant differences. However, a major flaw in this study was that all of the clients actually received the treatment that was preferred due to the fact that the 103 clients who were randomly assigned had chosen random assignment as their preferred

treatment type. Taking this flaw into account it is still probable that treatment preferences play a role in effectiveness of psychotherapy.

In a recent meta-analytic review Swift and Callahan (2009) examined the preference effect for 26 studies that compared clients who received a preferred treatment to clients who received a non-preferred treatment. Swift and Callahan found a small, but significant, outcome effect (r = .15, $CI._{95}$: .09 to .21) in favor of clients who received their preferred treatment. The corresponding binomial effect indicated that matched clients had a 58% chance of showing greater improvement in treatment outcomes. Further analysis of premature termination indicated that clients who received their preferred treatment were also about half as likely to drop-out when compared to other clients. Swift and Callahan did find that study design was a moderating variable such that partially randomized preference trials may underestimate the treatment preference effect.

Given the fact that clients do show preferences concerning the treatment they receive and that these preferences play a role in outcome regarding the efficacy of the treatment, it would thus be important to understand client preferences with regards to the use of specific versus common factors in psychotherapy. As in other areas of client preference (Fairhurst, 1996; Mendonca & Brahm, 1983; Rokke et al., 1999; Wong et al., 2003), understanding and implementation with regards to specific and common factor preferences may possibly lead to better treatment decision-making, increased client satisfaction, greater treatment follow through, and improved general outcome.

Measuring Preferences Using a Delay-Discounting Model

A delay-discounting model may be one way to examine preferences with regards to the use of specific or common factors in treatment. Delay-discounting has been used

to refer to an individual's preference between two rewards: a smaller immediate reward and a larger delayed reward. In this type of model, a larger delayed reward may be subjectively appraised as less valuable than a smaller immediate reward due to the passage of time (Wileyto, Audrain-McGovern, Epstein, & Lerman, 2004). For example, individuals may prefer $50 today (smaller immediate reward) as compared to $100 one year from now (larger delayed reward). The measurement of discounting typically involves finding the point at which subjects view the smaller immediate reward as equal to the larger delayed reward; often called the 'indifference point'. In the before mentioned example individuals may prefer the smaller immediate reward; however, if the larger delayed reward were increased to $150 one year from now, individuals may then prefer the later reward. An exact indifference point is found by systematically manipulating the value of the rewards until the individual shows a switch in preference for the delayed reward over the other.

While delay-discounting procedures have long been used in economics to improve marketing strategies and psychology as a measure of impulsivity, in recent years researchers in the medical field have begun to use these procedures to examine decision-making concerning health and treatment options. Researchers in the medical field have used delay-discounting to examine both preventative behaviors that require an upfront cost to achieve a long-term benefit, and destructive behaviors that produce an upfront reward at a long-term cost (e.g., Chapman et al., 2001; Heil et al., 2006; Ohmur et al., 2005; Ortendahl & Fries, 2005). Researchers in the medical field have also used delay-discounting to examine patient preferences and decision-making with regard to treatment options (e.g., Chapman et al., 1999; Hayman et al., 1996). An example of a delay-

discounting instrument used to examine decision making concerning treatment options might ask participants to choose between a treatment that lasts one week and alleviates 25% of the symptoms and a treatment that lasts one year and alleviates 100% of the symptoms.

Delay-discounting procedures may also have application in the mental health field in examining client preferences and decision-making with regard to psychological treatment options. Swift and Callahan (2008) have used this model to compare treatments that differ in effectiveness (in terms of rate of recovery) across differing amounts of time (number of requisite sessions of therapy). This type of question may also be used to assess participants' preferences with regards to the use of specific versus common factors in the treatment process. An example of this type of measure comparing one common factor to a specific factor can be found in Appendix A. By systematically altering the effectiveness (specific factor) for two treatments, one that is provided with a greater level of a given common factor and one that is provided with a lesser level of that factor, values can be found that illustrate the relative importance that participants give to these factors.

Hypotheses

Given the literature the following hypotheses were proposed:

1. Participants will indicate a difference in preference between treatments that emphasize specific factors and treatments that emphasize common factors.
2. Participants will place greater value on those common factors that the literature reports are more closely tied to outcome.
3. The most recent list of empirically supported treatments (Chambless et al., 1998)

cites comparative studies for most of the treatments on the list. In many of these studies the empirically supported treatment shows an outcome of participant improvement/recovery that is greater than a comparison treatment. Although significant, the difference between these two treatments is often not large. Therefore, participants are predicted to show a larger difference in their expressed preferences between treatments that are high or low in a given common factor as compared to the differences seen between treatments in the majority of the empirically supported treatment comparative trials.

CHAPTER III

METHODOLOGY

Participants were successive adult clients seeking services from a university-based psychology department training clinic. This clinic provides services for both a student and community based population. All participants were treated in accordance with the American Psychological Association's "Ethical Principles of Psychologists and Code of Conduct" (APA, 2002) and the study was conducted with approval from the University's Institutional Review Board.

Materials

All adult clients at the clinic were given the option to complete a survey addressing treatment preferences prior to an initial intake session. The survey was composed of four parts (informed consent, demographic information, four delay-discounting sections, and other measures used to answer further research questions) and took about 15 minutes to complete. The survey as given is available in Appendix B.

Demographic Information

Demographic information was gathered in order to identify and characterize the sample on the variables of gender, age, ethnicity, years of education, socio-economic status, current enrollment as a student, marital status, and having received previous therapy services.

Delay-discounting Instrument

The four delay-discounting sections were used in order to assess client treatment

preferences and values with regards to specific and common factors. Each instrument compared two treatments: one that was relatively high in effectiveness (specific factor), but low in a given common factor; and one that had altering levels of effectiveness and was high in the given common factor. The treatment that was relatively high in effectiveness was always described as having a 70% recovery rate. This 70% recovery rate was based off of Hansen, Lambert, and Forman's (2002) finding that in randomly controlled trials, an average of 67.2% of clients/participants show reliable improvement. The common factors that were used were derived from Lambert and Ogles' (2004) list of support factors. That list has been provided in Table 6, and an explanatory list of how they were conceptually used in this study can be found in Table 9.

Table 9.

Lambert and Ogles (2004) support factors conceptually grouped.

Support factors	Grouped factors
Catharsis	CAP
Identification with therapist	TR
Mitigation of isolation	TR
Positive relationship	TR
Reassurance	TIS
Release of tension	CAP
Structure	CAP
Therapeutic alliance	TR
Therapist/client active participation	TIS/CAP
Therapist expertness	TE
Therapist warmth, respect, empathy, acceptance, genuineness	TIS
Trust	TIS

Note. CAP = client active participation, TR = therapeutic relationship, TIS = therapist interpersonal style, TE = therapist expertness. The information in column 1 are from *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (p. 173), by M. J. Lambert, 2004, New York: John Wiley & Sons, Inc. Copyright 2004 John Wiley & Sons, Inc.

These factors all fall under the support category, the use of which Lambert and Ogles (2004) described as having an effect by "increasing in the client a sense of trust, security, and safety, along with decreases in tension, threat, and anxiety" (p., 173), which precede and lead to other changes that occur in psychotherapy. These factors include the therapeutic relationship (identification with therapist; mitigation of isolation; therapeutic alliance; and a positive relationship), therapist interpersonal style (reassurance; therapist active participation; therapist warmth, respect, empathy, acceptance, genuineness; and trust), therapist expertness, and client active participation (catharsis, structure, release of tension, client active participation). Lambert and Ogles explain that these factors have been derived from the empirical research and have been correlated with outcome in research studies of psychotherapy. An example of a choice that was given for each category is provided below.

Therapeutic Relationship. Would you prefer a treatment that is on average 70% effective and is delivered by a therapist who you can not relate to, or a treatment that is on average 50% effective and is delivered by a therapist who you can develop a good, positive relationship with?

Therapist Interpersonal Style. Would you prefer a treatment that is on average 70% effective and is delivered by a therapist that is described as cold, distant, and judgmental, or a treatment that is on average 50% effective and is delivered by a therapist that is described as warm, empathetic, and accepting?

Therapist Expertness. Would you prefer a treatment that is on average 70% effective and is delivered by a therapist that has very few years of schooling and clinical experience, or a treatment that is on average 50% effective and is delivered by a therapist

who has completed many years of schooling and clinical experience?

Client Active Participation. Would you prefer a treatment that is on average 70% effective and is delivered by a therapist who does all of the talking, or a treatment that is on average 50% effective and is delivered by a therapist who listens and allows you to do more of the talking?

Finding the Indifference Point. In each of the four delay-discounting choice scenarios, participants made a series of choices comparing the specific treatment that is high in effectiveness and low in a common factor to the alternative treatment that has altering effectiveness values and is high in the given common factor. Presumably, if the effectiveness of the altering treatment is too low, participants will prefer the highly effective treatment. However, as the effectiveness of the altering treatment increases, participants will make a switch in preference to the altering treatment that is high in the given common factor. The point at which the switch in preference is made is the participant's indifference point. This indifference point represents the minimum effectiveness that a common factors treatment must have in order to be seen as preferable to a treatment that is high in effectiveness, but low in a given common factor.

Other Measures

Outcome Questionnaire 45.2. The self-report Outcome Questionnaire 45.2 (OQ-45.2: Lambert et al., 1996; Lambert, Okiishi, Finch, & Johnson, 1998) was used to measure participant symptom distress. On the OQ45.2 clients respond to items with categorical ratings ranging from *never* to *almost always* to describe their experiences each week. A total score (ranging from 0 to 180) is generated along with 3 sub-scores representing different conceptual, symptomatic domains: subjective distress (e.g.,

symptoms of depression, anxiety, etc.), interpersonal functioning (e.g., relationships with others), and social role performance (e.g., school and/or work performances). The OQ-45.2 manual reports that the clinical range is indicated by scores above a cut-off score of 63 for the total, and domain scores on or above 36, 14, and 12 for symptom distress, interpersonal functioning, and social role performance, respectively.

According to the OQ-45.2 administration manual, there are no significant differences between male and female samples. The manual also reports a test–retest reliability of .87 for the total and .78 to .82 for the domains, an internal consistency of .93 for the total and .70 to .92 for the domains, and high concurrent validity [.78-.88 correlation of total score with the General Severity Index of the SCL-90-R (Derogatis, 1977), .82-.92 symptom distress domain score with the General Severity Index of the SCL-90-R, .49-.64 interpersonal functioning domain score with the Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureno, & Vallasenor, 1988) and Social Adjustment Scale (Wiessman & Bothwell, 1976), and .53-.73 correlation of social role performance domain score with the IIP and SAS]. On the OQ-45.2 no significant differences according to ethnicity have been identified (Nebeker, Lambert, & Huefner; 1995). An examination of specificity and sensitivity to change during treatment found the OQ-45.2 to perform adequately (Vermeersch, Lambert, & Burlingame, 2000).

Procedure

This study was conducted with approval from the University's Institutional Review Board. From July 2007 to October 2008, all successive adult clients presenting for therapy services at the Psychological Services Center were given the opportunity to participate in this survey prior to the intake session. The survey was given to the client by

the intake therapist who described it as a survey used for research purposes. It was mentioned that participation and the responses on the survey would not affect the treatment that was to be received. A written short introduction to this survey (which included a brief description of the nature of the study, the approximated length in time required to complete the study, and the qualifications for participation) was first presented along with information concerning informed consent. Participants were ensured of confidentiality if they choose to participate. This confidentiality included that completed surveys were not linked to any identifying information and that the responses submitted were stored by a controlled access server. Upon providing informed consent participants were able to turn directly to the survey where they were given further instructions. Upon completion of the survey, participants submitted their results to the intake therapist who was instructed not view the participants' responses. Participants were allowed to withdraw from the study at anytime by either informing the intake therapist that they did not desire to participate or by not completing the survey.

CHAPTER IV

FINDINGS

Participant Demographics

Participants were 66 adult clients who presented for an intake appointment at the university-based psychology department clinic. The average age of participants in this sample was 28.58, ranging from 18 to 65 years with a median age of 24.5 and a modal age of 21. The majority of participants endorsed being female (63.6%) and of Caucasian ethnicity (78.8%). Other ethnicities represented in this sample included African American (6.1%), Hispanic American (1.5%), Native American (10.6%), and Bi/Multi-Racial American (3%). In terms of marital status, 54.5% of the sample endorsed being single, while 24.2% endorsed being married, 6.1% endorsed being separated, and 15.2% endorsed being divorced at the time of participation. A slight majority of participants were current college students (59.1%), while 11.1% had not graduated from high school, 16.7% had graduated from high school only, 9.1% had graduated from college, and 3% of participants had obtained a graduate or higher level degree. Of those participants who reported a value (N = 42), the average yearly income was $19,798. After intake each client was assigned a diagnosis by their intake therapist. The primary diagnoses given to these clients included mood disorder (56.1%), anxiety disorder (27.3%), adjustment disorder (12.1%), and other (4.5%). In terms of distress levels, the average OQ45.2 score of this sample at intake was 73.9 (SD = 24.88), which falls in the clinical range and is similar to the average of clinical samples according the OQ45.2 manual. Sixteen of the

clients scored in the normal range (< 63) on the OQ45.2 at intake. Additionally, 59.1% of participants had previously received therapy.

An additional 19 adult clients presented at the clinic for a therapy intake appointment without completing the survey. It is unknown whether these clients were not given the opportunity to participate by their intake therapist or whether these clients refused participation. The clients did not participate had a mean age of 29.79 (SD = 11.06), and were primarily female (63.2%), of Caucasian ethnicity (83.3%), single (57.9%), and endorsed being non-students (68.4%). Analyses comparing these non-participants to the participants indicated no significant differences for the demographic variables of age [$t(82) = 0.43$, $p = .67$], gender [$\chi^2(1, N = 84) = 0.00$, $p = 1.00$], ethnicity [$\chi^2(4, N = 83) = 0.97$, $p = .92$], marital status [$\chi^2(3, N = 84) = 3.17$, $p = .37$], and students status [$\chi^2(1, N = 84) = 2.53$, $p = .11$].

Preliminary Analyses

Client preferences were calculated by averaging individual indifference points across participants for each of the four common factors domains: therapist interpersonal style, therapeutic relationship, client active participation, and therapist expertness. Each of the four average indifference points were then subtracted from the default value (70%) in order to determine the value that clients gave to each of the included common factors.

In terms of the therapist interpersonal style, clients on average preferred a 21.46% (*SD* = 18.14) or higher effective treatment delivered by a therapist described as warm, empathetic, and accepting, compared to a 70% effective treatment delivered by a therapist described as cold, distant, and judgmental. This indicates that clients were willing to receive a treatment that was 48.54% less effective in order to ensure that they

received a therapist who is warm, empathetic, and accepting. Of particular note, 62.3% of the sample indicated that they would prefer a warm, empathetic, and accepting therapist even when the treatment was at the lowest possible effectiveness level (10%).

In terms of the therapeutic relationship, clients on average preferred a 31.86% (*SD* = 20.31) or higher effective treatment delivered by a therapist they could develop a good, positive relationship with, compared to a 70% effective treatment delivered by a therapist they could not relate to. This indicates that clients were willing to receive a treatment that was 38.14% less effective in order to ensure that they received a therapist who they could develop a relationship with. Additionally, 34.5% of the sample indicated that they would prefer to develop a relationship with the therapist even when the treatment was at the lowest possible effectiveness level (10%).

In terms of client active participation, clients on average preferred a 35.29% (*SD* = 21.01) or higher effective treatment delivered by a therapist who listens and allows the client to do more of the talking, compared to a 70% effective treatment delivered by a therapist who does all of the talking. This indicates that clients were willing to receive a treatment that was 34.71% less effective in order to ensure that they would do more of the talking in session. Furthermore, 30.8% of the sample indicated that they would prefer the therapist to listen while they do more of the talking even when the treatment was at the lowest possible effectiveness level (10%).

Last, in terms of therapist expertness, clients on average preferred a 44.23% (*SD* = 20.94) or higher effective treatment delivered by a therapist that has completed many years of schooling and clinical experience, compared to a 70% effective treatment delivered by a therapist that has very few years of schooling and clinical experience. This

indicates that clients were willing to receive a treatment that was 25.77% less effective in order to ensure that their therapist was high in expertise. Interestingly, 34.6% of the sample indicated that they would prefer the 70% effective treatment and therapist with few years of experience unless the therapist with more years of schooling and clinical experience was paired with a treatment of 65% or higher effectiveness level.

The indifference points across the four delay-discounting scenarios were averaged for each participant and then averaged across the entire sample. Clients on average preferred a 32.8% (*SD* = 15.05) or higher effective treatment that was relatively high in one of the common factors, compared to a 70% effective treatment that was relatively lower in one of the common factors. This indicates that on average clients were willing to receive treatments that were 37.2% less effective in order to ensure a higher level of the included common factors.

Analyses for Hypothesis One

We were first interested in examining whether participants on average discounted at a significant level. In other words, were participants willing to sacrifice a statistically significant amount of effectiveness (compared to the 70% comparison value) in order to ensure presence of the common factors. In order to determine whether the observed preferences were statistically significant, five one-sample *t*-tests were conducted comparing the preferred indifference points from each of the scenarios to the default value of 70%. Results of these *t*-tests can be found in Table 10. All comparisons were found to be statistically significant with large effect sizes.

Table 10.

Comparison of Preference Indifference Points to the Default Treatment Value of 70% Effectiveness.

Preference domain (*N*)	*M* diff. (C.I. 95%)	*SD*	*t* value	*d* effect
Therapist interpersonal style (53)	48.54 (43.54 to 53.54)	18.12	19.48*	2.68
Therapeutic relationship (55)	38.14 (32.65 to 43.63)	20.31	13.93*	1.88
Client active participation (52)	34.72 (28.86 to 40.56)	21.01	11.91*	1.65
Therapist expertness (52)	25.77 (19.94 to 31.60)	20.94	8.87*	1.23
Common factors average (55)	37.20 (33.14 to 41.27)	15.05	18.34*	2.47

* $p < .001$

Analyses for Hypothesis Two

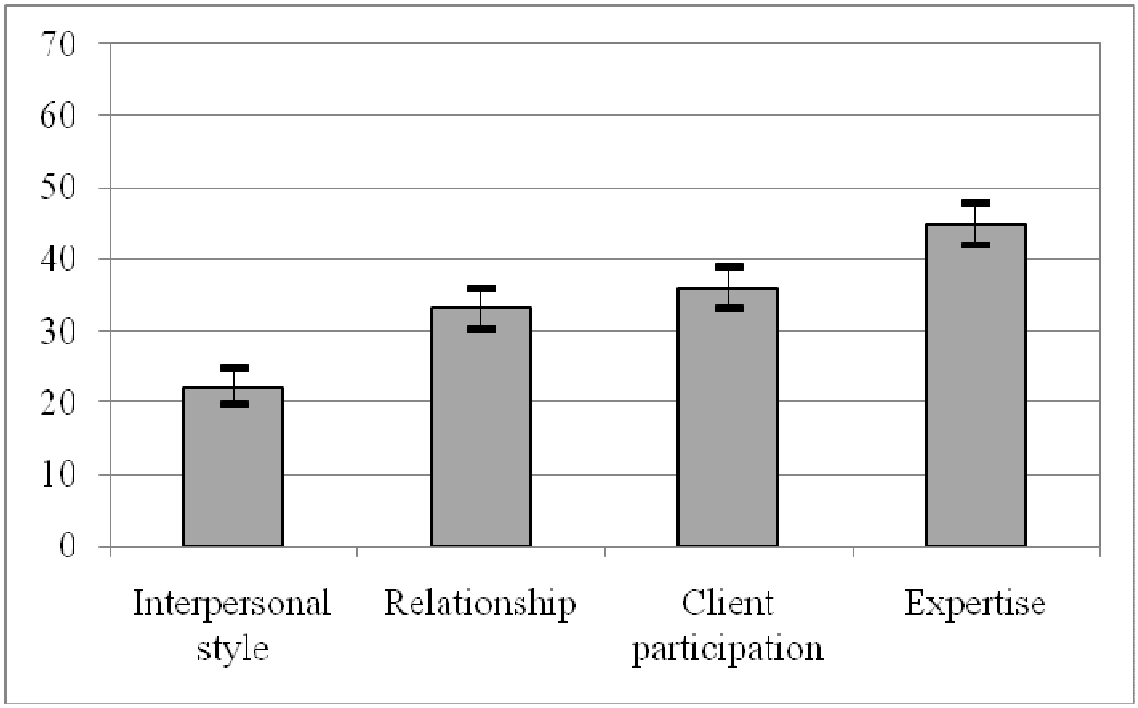
A one-factor within-subjects ANOVA was used to compare client preference points (indifference points) for each of the four common factor scenarios. Evidence of a violation of the sphericity assumption was not present ($W = .90$, $p = .42$). The difference in indifference points between the four scenarios was significant [$F(3, 147) = 17.91$, $p < .001$, $\eta_p^2 = .268$], indicating that 26.8% of the variability in indifference points was accounted for by the scenario condition. Post-hoc pair-wise comparisons with a Bonferroni adjustment were used to compare each of the scenario conditions to each other (see Table 11 for summary of results). In summary, clients indicated a greater preference (lowest indifference point) for the therapist interpersonal style, followed by the therapeutic relationship and client active participation (no significant difference was observed between these two conditions), and followed last by preferences for therapist expertise (see Figure 5).

Table 11.

Pair-wise Comparisons of Differences for the Four Discounting Scenarios.

Comparison	*M* diff (C.I. 95%)	*p* value
Interpersonal style vs. relationship	10.9 (3.12 to 18.68)	.002
Interpersonal style vs. client participation	13.85 (5.21 to 22.49)	< .001
Interpersonal style vs. expertise	22.75 (12.74 to 32.76)	< .001
Relationship vs. client participation	2.95 (-4.98 to 10.88)	1.00
Relationship vs. expertise	11.85 (3.16 to 20.54)	.003
Client participation vs. expertise	8.9 (0.4 to 17.4)	.035

Figure 5. Mean Indifference Points (with Standard Error Bars) for each of the Delay-discounting Scenarios.



Analyses for Hypothesis Three

In comparative trials one treatment can be found to be superior to another when it results in a significantly higher client recovery rate. In examining the comparative trials listed by Chambless et al. (1998), on average the "empirically supported treatments" (N = 46) were found to have resulted in a recovery rate that was higher than their compared treatments (N = 65) by M = 20.98% (SD = 15.91). The preference values (70 – $Mean_{\text{indifference point}}$) for the average total score and each of the delay-discounting scenarios were compared to the average difference between treatments (M = 20.98). The results of these one-sample t-test comparisons can be found in Table 12. In summary, the total average preference value and three of the preference domains (therapist interpersonal style, therapeutic relationship, and client active participation) were found to be significantly different from the test value (20.98) with observed medium to large effects. These results indicate that for these domains clients on average would prefer an inferior treatment compared to an "empirically supported treatment" if that treatment was delivered with a higher level of the given common factor.

The average total preference value was 37.2%, indicating that these clients would be willing to receive a treatment that was less effective by 37.2% to ensure that the treatment was provided with a higher presence of certain treatment factors. In examining the list of "empirically supported treatments", only 9 of the 65 comparisons found differences in recovery rates higher than this percent. If comparing the comparative trials to the value placed on therapists' expression of acceptance, warmth, and empathy (M = 48.54), only 5 of the 65 comparisons found differences in recovery rates higher than this percent.

Table 12.

Comparison of Preference Values to Differences in Recovery Rates from Comparative Trials (20.98%).

Preference domain (*N*)	*M* diff. (*C.I. 95%*)	*t* value	*d* effect
Therapist interpersonal style (53)	27.56 (22.57 to 32.56)	11.06**	1.52
Therapeutic relationship (55)	17.16 (11.67 to 22.65)	6.27**	0.85
Client active participation (52)	13.73 (7.88 to 19.58)	4.71**	0.65
Therapist expertness (52)	4.79 (-1.04 to 10.62)	1.65*	0.23
Common factors average (55)	16.22 (12.16 to 20.29)	8.00**	1.08

* $p = .11$

** $p < .001$

Secondary Analyses

Removal of Dichotomous Decision Makers. In each of the scenarios a number of participants failed to identify a point at which their preferences switched from one treatment to the other. An example of how this looks can be found in Figure 6. While this may be interpreted as expressing a strong preference for one treatment option, it is also possible that these participants were actually only making a dichotomous decision ignoring the altering effectiveness weights. To correct for this, all participants who were identified as possibly making dichotomous decisions were removed and average preference values for each of the scenarios were re-calculated. For the therapist interpersonal style scenario, 33 participants were removed from the analyses. The average indifference point for the remaining participants was M = 36.03 (SD = 14.77), representing a preference value of 33.97%. For the therapeutic relationship scenario, 19 participants were removed from the analyses. The average indifference point for the remaining participants was M = 38.19 (SD = 12.44), representing a preference value of 31.81%. For the client active participation scenario, 16 participants were removed from the analyses. The average indifference point for the remaining participants was M = 40.71 (SD = 11.28), representing a preference value of 29.29%. For the therapist expertise scenario, 18 participants were removed from the analyses. The average indifference point for the remaining participants was M = 40.00 (SD = 13.11), representing a preference value of 30%. With these values removed for each of the scenarios, the new total common factors average indifference point was calculated to be M = 38.09 (SD = 10.65), representing a preference value of 31.91%.

Figure 6. Example of a Dichotomous Decision-Maker Using the Therapist Interpersonal Style Scenario.

Would you prefer a **treatment** that is on average **70% effective** (on average 70% of clients recover by the end of the treatment) and is delivered by a therapist that is described as **cold, distant, and judgmental**, or a **treatment** that that has differing levels of effectiveness and is delivered by a therapist that is described as **warm, empathetic, and accepting**?

→	☐ 70% cold, distant, judgmental	☑ 10% warm, empathetic, accepting
→	☐ 70% cold, distant, judgmental	☑ 20% warm, empathetic, accepting
→	☐ 70% cold, distant, judgmental	☑ 30% warm, empathetic, accepting
→	☐ 70% cold, distant, judgmental	☑ 40% warm, empathetic, accepting
→	☐ 70% cold, distant, judgmental	☑ 50% warm, empathetic, accepting
→	☐ 70% cold, distant, judgmental	☑ 60% warm, empathetic, accepting
→	☐ 70% cold, distant, judgmental	☑ 70% warm, empathetic, accepting
→	☐ 70% cold, distant, judgmental	☑ 70% warm, empathetic, accepting
→	☐ 70% cold, distant, judgmental	☑ 60% warm, empathetic, accepting
→	☐ 70% cold, distant, judgmental	☑ 50% warm, empathetic, accepting
→	☐ 70% cold, distant, judgmental	☑ 40% warm, empathetic, accepting
→	☐ 70% cold, distant, judgmental	☑ 30% warm, empathetic, accepting
→	☐ 70% cold, distant, judgmental	☑ 20% warm, empathetic, accepting
→	☐ 70% cold, distant, judgmental	☑ 10% warm, empathetic, accepting

Note: This scenario represents a dichotomous decision maker because one set of choices was endorsed regardless of the effectiveness value.

The resulting indifference points with the smaller samples were compared to the indifference points previously found when including the entire sample. Thus the sample of participants with dichotomous decision-makers removed was compared to the complete sample (in this case our population of interest). Five *z*-tests were run for each of the scenarios and the total to determine if removing these participants had a significant effect on the results. The results of these *z*-tests can be found in Table 13. In summary, removing the dichotomous decision-makers resulted in significantly higher indifference points for the therapist interpersonal style scenario and the total average score. On the other hand, removing the dichotomous decision-makers did not significantly affect the average indifference points for the therapeutic relationship, client active participation, or therapist expertise scenarios. It should be noted however, that different individuals were removed from each of the scenarios, indicating that relatively few participants ($N = 9$) were making dichotomous decisions across the board. For example, some participants made dichotomous decisions for the therapist interpersonal style scenario indicating that they would prefer a warm, empathetic, accepting therapist no matter how low the effectiveness of the treatment; however, these same participants expressed lower preference values for the other scenarios. This may indicate that participants were not necessarily just making dichotomous decisions but that they were weighing certain scenarios at a greater (or less) level.

Table 13.

Comparisons of the Smaller Sample (Dichotomous Decision-Makers Removed) to the Complete Sample.

Preference domain	Complete *M* (*SD*)	Sample *M* (*N*)	*z* value	*d* effect
TIS	21.46 (18.14)	36.03 (20)	3.37**	0.82
TR	31.86 (20.31)	38.19 (36)	1.62	0.31
CAP	35.29 (21.01)	40.71 (34)	1.26	0.26
TE	44.23 (20.94)	40.00 (36)	1.03	0.20
Average	32.80 (15.05)	38.09 (47)	2.33*	0.35

Note. CAP = client active participation, TE = therapist expertness, TIS = therapist interpersonal style, TR = therapeutic relationship.

* $p < .05$

** $p < .001$

Grouping Preference Types. Participants in this study may have expressed preference patterns across the four domains that were more or less similar to the patterns expressed by other participants. For example, a group of participants may have expressed relatively low indifference points across all domains, another group may have expressed relatively high indifference points across all domains, another group may have expressed low indifference points for therapist interpersonal style and therapeutic relationship while expressing high indifference points for client active participation and therapist expertise, etc. Cluster analysis was used to test the hypothesis that participants could be grouped according to their expressed pattern of preferences.

In order to determine the number of clusters that were present, a hierarchical cluster analysis was first run in SPSS with cases being clustered by their expressed indifference points on the four discounting scenarios. In this analysis Ward's method was used for the linkage method to create the clusters, with similarity determined through squared Euclidean distances. Due to missing data, only 50 participants were included in the analysis. In examining the agglomeration schedule (see Figure 7 and graph of stages and coefficients in Figure 8) and the dendrogram (see Figure 9), it was determined that four clusters of clients best fit the data.

Figure 7. Agglomeration schedule results from hierarchical cluster analysis.

Stage	Cluster Combined		Coefficients	Stage Cluster First Appears		Next Stage
	Cluster 1	Cluster 2		Cluster 1	Cluster 2	
1	22	36	.000	0	0	2
2	16	22	.000	0	1	4
3	19	21	.000	0	0	4
4	16	19	.000	2	3	5
5	16	18	.000	4	0	22
6	1	24	.028	0	0	21
7	4	42	.057	0	0	24
8	6	7	.087	0	0	19
9	20	27	.199	0	0	27
10	48	50	.315	0	0	33
11	10	38	.462	0	0	26
12	29	30	.690	0	0	30
13	14	33	.924	0	0	39
14	11	25	1.184	0	0	26
15	2	39	1.446	0	0	38
16	3	49	1.713	0	0	27
17	23	41	1.983	0	0	34
18	28	47	2.295	0	0	28
19	6	32	2.643	8	0	29
20	5	15	3.020	0	0	37
21	1	44	3.409	6	0	33
22	9	16	3.844	0	5	24
23	12	13	4.405	0	0	31
24	4	9	4.983	7	22	48
25	31	45	5.564	0	0	42
26	10	11	6.218	11	14	32
27	3	20	6.876	16	9	34
28	17	28	7.581	0	18	41
29	6	35	8.323	19	0	45
30	29	34	9.187	12	0	35
31	12	37	10.143	23	0	36
32	10	46	11.193	26	0	37
33	1	48	12.284	21	10	39
34	3	23	13.654	27	17	38
35	29	43	15.043	30	0	41
36	8	12	16.598	0	31	43
37	5	10	18.425	20	32	44
38	2	3	20.314	15	34	46
39	1	14	22.722	33	13	42
40	26	40	27.115	0	0	44
41	17	29	31.552	28	35	46
42	1	31	36.919	39	25	43
43	1	8	43.025	42	36	45
44	5	26	51.129	37	40	49
45	1	6	60.099	43	29	47
46	2	17	72.767	38	41	47
47	1	2	90.098	45	46	48
48	1	4	135.448	47	24	49
49	1	5	196.000	48	44	0

*Figure 8.*Scree Plot Based on the Agglomeration Schedule with Participants Being Clustered by Expressed Indifference Points.

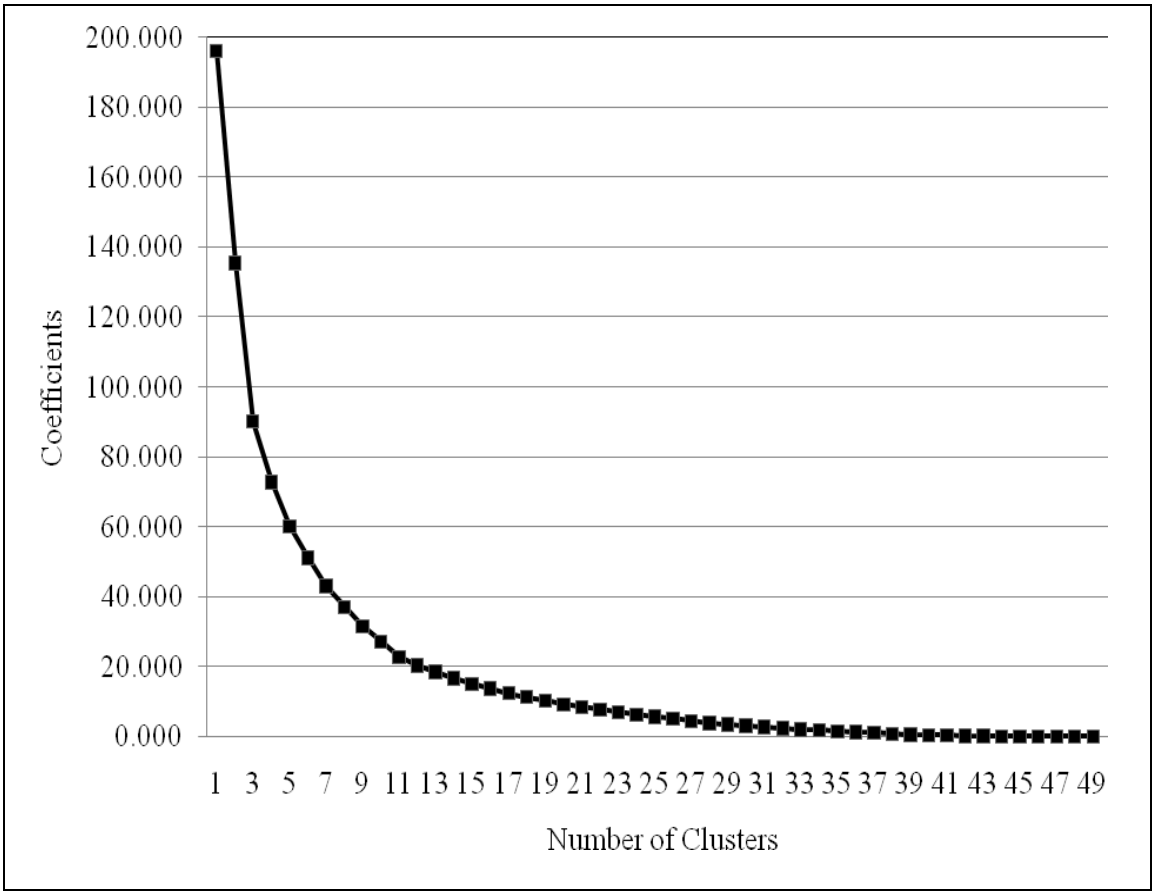
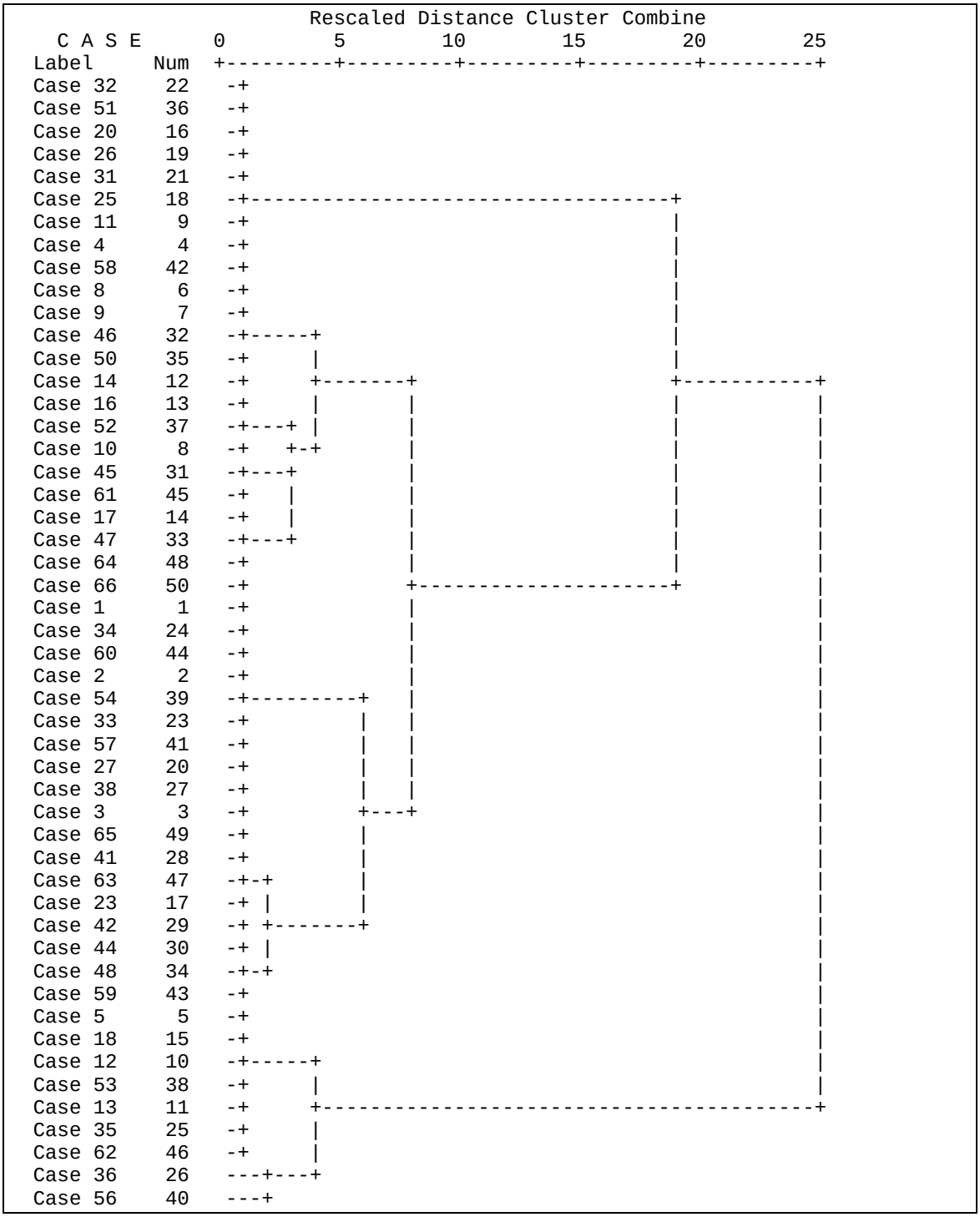


*Figure 9.*Dendogram with Participants Being Clustered by Expressed Indifference Points.



A K-means cluster analysis was next run in order to determine the pattern of responses for each cluster and in order to determine cluster membership for each participant. Based on the results from the hierarchical cluster analysis, the number of clusters was specified as four. The final cluster centers for each of the four clusters on each of the discounting scenarios can be viewed in Table 14. Cluster centers could range from 10 to 65 (lower values indicate greater preference for the common factor) and are based on the average preference indifference point of the members of the cluster. Cluster one was composed of clients who expressed relatively low indifference points across all domains, and could thus be identified as those who place little value on treatment effectiveness compared to other factors. Cluster two was composed of clients who expressed relatively low indifference points for the therapist interpersonal style domain with higher indifference points for the remaining domains, and could thus be identified as those who desire an empathetic, warm, and accepting therapist above all else. Cluster three was composed of clients who expressed relatively high indifference points across all four domains, and could thus be identified as those who place the greatest value on treatment effectiveness compared to other therapy factors. Finally, cluster four was composed of clients who expressed lower indifference points for the therapist interpersonal style and the therapeutic relationship domains with higher indifference points across the remaining two domains. These clients could be identified as those who desire most to develop a therapeutic relationship with a warm, empathetic, and accepting therapist and care less about what else happens in therapy.

Table 14.

Cluster Centers across the Four Discounting Scenarios.

	Cluster			
Domain	1 (*N* = 14)	2 (*N* =19)	3 (*N* = 8)	4 (*N* = 9)
Therapist interpersonal style	11	16	55	22
Therapeutic relationship	14	45	60	13
Client active participation	11	38	58	49
Therapist expertise	25	53	54	49

Note: The range of possible cluster centers is from 10 to 65. These centers are based on the average indifference point expressed for each scenario by members of the cluster. Lower values correspond to greater preference placed on the given common factor.

A multinomial logistical regression analysis was then used to determine whether client demographic and other therapy related variables could predict cluster membership. The predictor variables included client age, gender, ethnicity (majority vs. minority status), education (no college vs. some college or higher), previous therapy (yes vs. no), primary diagnosis (mood disorder, anxiety disorder, adjustment disorder, or other) and intake scores on the OQ45.2. Mixed results were found in support of the final model including all predictor variables. In support of the model fitting the data significantly better than the intercept only model, deviance chi-square test was found to be non-significant [χ^2 (114) = 92.69, p = .93]. However, the model was not supported by the model chi-square test [χ^2 (27) = 35.39, p < .13]. The model accurately predicated cluster membership for 52.1% of the participants (46.2% for cluster one, 77.8% for cluster two, 37.5% for cluster three, and 22.2% for cluster four).

The likelihood ratio test for each of the predictor variables in the model was next examined. This test compares the full model to a model in which a given predictor has been dropped with a non-significant value indicating that the predictor could be dropped from the model without having a significant effect. In summary, among the predictors only education (measured as no college vs. at least some college) was found to be significant [χ^2 (3) = 13.51, p = .004]. No odds ratio comparisons with any of the predictors were significant when predicting cluster membership with cluster four as comparison.

CHAPTER V

DISCUSSION

The purpose of this study was to examine the value that clients place on their preferences for certain therapy factors. A delay-discounting model was used to allow participants to systematically compare treatments that differed in effectiveness levels and presence of one of four common factor domains: therapist interpersonal style, therapeutic relationship, client active participation, and therapist expertise. On average clients were willing to receive a treatment that was 48.54% less effective in order to ensure that they received a therapist who was warm, empathetic, and accepting, a treatment that was 38.14% less effective in order to ensure that they received a therapist who they could develop a relationship with, a treatment that was 34.71% less effective in order to ensure that they would do more of the talking in session, and a treatment that was 25.77% less effective in order to ensure that their therapist was high in expertise. The preference values from each of the domains were found to be significantly different from zero, thus indicating that clients on average expressed meaningful or actual preferences for these therapy factors.

The existence of these preference values could be taken to suggest a number of different things. It is possible that the preference values may indicate that clients seeking therapy services are less interested in outcomes than they are in therapy processes. In other words, clients may not view recovery as the only goal of therapy. For example, the client who desires to receive a 10% effective treatment delivered by an empathetic

therapist over a 70% effective treatment delivered by a therapist who lacks empathy may be indicating that to him/her getting better or recovering from symptoms is relatively unimportant compared to just having someone to listen and show empathy. On the other hand, it is possible that the preference values may indicate that clients hold their own ideas about what factors will help them as an individual recover. If this were the case, the results indicate that clients are still viewing recovery as the end goal of therapy, but they hold different views about how that goal is going to be achieved. For example, the client who desires to receive a 10% effective treatment and do all of the talking over a 70% effective treatment with a therapist who does all of the talking may be indicating that for her/him to recover it is necessary to talk. This client may feel that even if a treatment is effective with every other client, if that treatment does not allow her/him to do more of the talking, it is not going to help her/him recover. Either way, the fact that clients were found to give a meaningful value to their preferences indicates that for these clients the "empirical support" of a treatment may be less important than other therapy factors.

In addition to finding that the preference values were meaningful (significantly different from zero), the preference values from each of the domains were also found to be significantly different from each other, with the exception of the therapeutic relationship and client active participation. Specifically, clients expressed the highest preference values for the therapist interpersonal style, followed by the therapeutic relationship and client active participation, and followed last by therapist expertise.

Interestingly, the differences in preference values placed on each of the domains matches closely with the research examining the relationship between these variables and treatment outcomes. Each of these domains have been identified as valuable support

factors in therapy that lead to initial changes in a sense of safety, hope, and well-being and in turn lead to improved treatment outcomes (Beutler et al., 2004; Clarkin & Levy, 2004; Lambert & Ogles, 2004). In terms of therapist interpersonal style, Beutler et al. (2004) concluded that in addition to playing a role in the development of the therapeutic relationship, these variables have been found to have a strong correlation with treatment outcome, estimated at around $r = .50$. In terms of the therapeutic relationship, Beutler et al. and Lambert and Ogles both have concluded that it has consistently been found among the stronger predictors of therapeutic change with a correlation with outcome estimated at $r = .22$. The research examining the effect of therapist expertise on treatment outcome has produced more mixed results, and Beutler et al. estimate the effect to be $r = .07$. In terms of client active participation, the results are not as clear, given that the summarized research has not examined client participation in the same way as described in the study (client does more of the talking vs. therapist does more of the talking). For example, Beutler et al. concluded that outcomes show a trend toward being more favorable for therapists who are more direct; however, a therapist can be very direct and say only one sentence during the session. Clarkin and Levy's review concluded that client willingness and ability to become actively involved in therapy consistently predicts outcomes; however, again a client may be highly involved and still do relatively little talking during session.

According the their expressed preferences, participants were found to cluster into one of four groups, including those who placed little value on treatment effectiveness compared to other factors (cluster one), those who desired an empathetic, warm, and accepting therapist above all else (cluster two), those who placed the greatest value on

treatment effectiveness compared to other therapy factors (cluster three), and those who desired most to develop a therapeutic relationship with a warm, empathetic, and accepting therapist and care less about what else happens in therapy (cluster four). Group membership was found to be predicted by education (with higher education participants being more likely to be found in cluster one over cluster two), and to a lesser extent OQ45.2 scores at intake (with higher scorers being slightly more likely to be found in cluster two over cluster one).

Finally the values that the clients gave to their preferences for the common factors included in this study was found to be greater than the average differences found between treatments tested in comparative trials. Further, only 9 of the 65 treatment comparisons resulted in recovery rate differences that were greater than the average preference value across the four domains. Clinical psychologists may often make treatment decisions based solely on the "empirical support" of a treatment; however, the results of this study indicate that decisions based on "empirical support" may not always match with client preferences.

Clinical Implications

Knowledge of client preferences for therapy and the value that they place on those preferences has a number of implications for clinical practice. First it was found that client preferences for treatment were not always based on the effectiveness of treatments. Instead, clients were found to significantly weigh their preferences for treatment effectiveness against preferences for other common factors that can be found in therapy. It is important that clinical psychologists not ignore these preferences for therapy, particularly when making treatment decisions. It has recently been found that clients who

receive their preferred treatment, regardless of what that treatment is, are less likely to prematurely terminate from treatment and are more likely to show improved treatment outcomes compared to clients who receive a non-preferred treatment (Swift & Callahan, 2009). It would thus be erroneous for clinicians to base treatment decisions solely on empirical support without accounting for client preferences.

A shared decision-making model may be one way to include both client preferences and the best available research when making treatment decisions. A shared decision-making approach has been defined as including (1) involvement of two parties, (2) sharing of information, (3) a discussion of preferences, and (4) an agreement between parties as to which treatment is to be implemented (Charles et al., 1997; Ford et al., 2003; Makoul & Clayman, 2005). This model emphasizes a simultaneous interaction between the health care provider and the patient at all stages of the decision making process with both parties having an investment in the treatment decision: The health care provider's investment is due to his or her concern over the patient, the patient's investment is due to his or her having to live with the consequences of the decision. In this model the patients and health care providers have different, but equally valuable, perspectives and roles: while health care providers share scientific information about the illness and possible treatments, the patients share information about how the illness affects them personally and their own preferences for treatment.

This study also has application to the training setting. Training in clinical psychology often focuses more heavily on teaching trainees how to implement empirically supported treatments. However, this study found that clients do not always give preference for variables related to the treatment's effectiveness. Thus, training future

psychologist how to utilize common factor variables in therapy as well as how to identify and include client preferences in therapy would also be important. Integrating all components of evidence-based practice in the training of future clinical psychologists has been argued as important in developing broad competencies (Swift, Callahan, & Collins, under review).

Limitations of the Study

A number of limitations with the current study should be noted. First, this study was conducted in a university-based psychology department training clinic. Analysis of participant demographics indicated that a little over half (59%) of the clients were currently enrolled college students and the vast majority of the participants were of Caucasian ethnicity (79%). It is possible that the preferences found from these clients may not always generalize to clients seen in other settings. For example, Zane, Hall, Sue, Young, and Nunez (2004) have concluded that Asian Americans tend to indicate preferences for more direct treatments, thus the scenario asking about client active participation could produce different results with this population. Another limitation found in this population may be the nature and severity of the presenting problems. It has been argued that clients seen in a university-based clinic do not present with disorders or symptomology that completely generalizes to all other populations. Although preliminary analysis of intake scores on the OQ-45.2 found scores for this population that fell within the clinical range, other settings may include a greater number of clients presenting with severe mental illnesses. Clients with greater severity of impairment may also hold different preferences for treatment, perhaps placing greater importance on treatment effectiveness compared to clients from the population that was used in this study.

Additionally, clients used in this study presented at a training clinic and thus knew that they would be receiving treatment from a trainee. Particularly for the therapist expertise scenario, this may have resulted in less value being placed on therapist experience; thus partially explaining why this scenario resulted in significantly lower preference values compared to the other scenarios. Further research is needed to examine client preferences in different settings.

A second limitation in this study relates to the scenarios that were used to assess client preferences. In this study only four of possibly dozens of common factors were assessed. The four common factors that were chosen were taken to represent the list of support factors listed by Lambert and Ogles (2004), but others could have easily been chosen. Further, this study described the therapeutic relationship as being able to develop a "good, positive relationship" with the therapist; the therapist interpersonal style as "warmth, empathy, and acceptance"; client active participation as the client "doing more of the talking"; and therapist expertise as the therapist having "many years of schooling and experience". The four common factor domains could have easily been described using different terms that may have led to different results. For example, client active participation may have been better described in terms of effort placed into therapy rather than amount of talking.

In addition, the scenarios describe treatment effectiveness in terms of recovery rate. Although this method was used in order to facilitate comparison to the "empirically supported treatments" literature, other descriptions of treatment effectiveness could have been used. Individual clients may not be as concerned with the general performance of a treatment (average recovery rate) as they are with the level of improvement that they

could expect in terms of symptom alleviation or decreases in distress. Further, not all clients view themselves as "sick" or "disordered" and in need of recovery. Instead they may just want to talk about problems without a goal of recovery in mind. For these clients the comparison values may not have been as meaningful.

A third limitation can be found in the dichotomous nature of the questions that were presented to the participants. In this study clients were asked to choose between two treatments, one with a common factor present and one without. This was done in order to find the value that clients placed on the given factor. However, actual therapy, therapist, or treatments are usually presented with varying degrees of the common factors present. For example, one therapist may be very good at showing empathy, another therapist just average at showing empathy, another therapist horrible at showing empathy, and so on. This study only compared the two ends assuming a linear relationship for all values in-between. However, clients may be willing to receive a slightly less effective treatment when the comparison therapist shows moderate empathy and a completely less effective treatment when the comparison therapist shows no empathy. Additionally, clients would likely prefer a treatment that is both high in common factors and high in effectiveness, a scenario that could be present in the actual practice of psychotherapy. However, the scenarios used in this study required clients to compare one against another in order to assign values to the expressed preferences. Further research is needed with different scenarios allowing clients to express preferences while taking these factors into account.

Future Directions

Given the results, implications, and limitations of this study further research is needed using the delay-discounting method to assess client preferences. As mentioned

previously, research is needed in order to examine whether the results found in this study generalize to other client populations and settings. It would also be valuable to assess preferences for the numerous other variables (common factors as well as variables such as variations in the settings of therapy, variations the treatment techniques that are used, variations in therapist demographics, etc.) that have been found to impact treatment outcomes. For example, clients could be asked if they prefer a cognitive-behavioral treatment for their depressive symptoms that has been found to have a 50%, 60%, 70% recovery rate or a pharmacotherapy treatment for their depressive symptoms that has been found to have a 50%, 60%, 70% recovery rate. Additionally, these procedures could easily be adapted to simultaneously compare preferences for multiple variables at a time. Clients could be asked if they would prefer a treatment that is high in empathy and low in directiveness and shows a 30%, 50%, 70%, etc. recovery rate, or a treatment that is low in empathy and high in directiveness and shows a 30%, 50%, 70% etc. recovery rate. Delay-discounting procedures could be applied to assign values and weights to the innumerable different areas in which clients could express preferences for therapy.

Other methods may also be useful in providing a better understanding of client preferences for treatment. For example, person-centered techniques such as the Q-sort could be used to allow clients to express their preferences in more detail. These methods could also be used to identify certain profiles of clients based on expressed preferences.

Conclusions

The purpose of this study was to assess client preferences for common factors in therapy in comparison to the specific factors or treatment effectiveness. By using a delay-discounting method clients were allowed to not only express preferences, but also

identify values and weights corresponding to their preferences. The participating clients were on average found to be willing to sacrifice a significant amount of treatment effectiveness in order to ensure that therapy was delivered with the various common factors present. This more in-depth understanding of client preferences for therapy may help therapists in better providing clients with individually-tailored treatments, thus leading to improved treatment outcomes.

REFERENCES

Addis, M. E., & Cardemil, E. V. (2006). Does manualization improve therapy outcomes?. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 131-160). Washington, DC: American Psychological Association.

Addis, M. E., Wade, W. A., & Hatgis, C. (1999). Barriers to dissemination of evidence-based practices: Addressing practitioners' concerns about manual-based psychotherapies. *Clinical Psychology: Science and Practice, 6,* 430-441.

Ahn, H., & Wampold, B. E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *Journal of Counseling Psychology, 48,* 251-257.

Aita, V., McIlvain, H., Backer, E., McVea, K., & Crabtree, B. (2005). Patient-centered care and communication in primary care practice: What is involved?. *Patient Education and Counseling, 58,* 296-304.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57,* 1060-1073.

Andrews, G., & Harvey, R. (1981). Does psychotherapy benefit neurotic patients? A reanalysis of the Smith, Glass, and Miller data. *Archives of General Psychiatry, 38,* 1203-1208.

American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61,* 271-285.

Asarnow, J. R., Jaycox, L. H., & Tompson, M. C. (2001). Depression in youth: Psychosocial interventions. *Journal of Clinical Child Psychology, 30,* 33-47.

Barkham, M., Rees, A., Stiles, W. B., Shapiro, D. A., Hardy, G. E., & Reynolds, S. (1996). Dose-effect relations in time-limited psychotherapy for depression. *Journal of Consulting and Clinical Psychology, 64,* 927-935.

Bedi, N., Chilvers, C., Churchill, R., Dewey, M., Duggan, C., Fielding, K., et al. (2000). Assessing effectiveness of treatment of depression in primary care: Partially randomized preference trial. *British Journal of Psyciatry, 177,* 312-318.

Bein, E., Anderson, T., Strupp, H. H., Henry, W. P., Schacht, T. E., Binder, J. L., et al. (2000). The effects of training in Time-Limited Dynamic Psychotherapy: Changes in therapeutic outcome. *Psychotherapy Research, 10,* 119-132.

Benbassat, J., Pilpel, D., & Tidhar, M. (1998). Patients' preferences for participation in clinical decision making: A review of published surveys. *Behavioral Medicine, 24,* 81-88.

Bergin, A. E. (1963). The effects of psychotherapy: Negative results revisited. *Journal of Counseling Psychology, 10,* 244-250.

Beutler, L. E., Moleiro, C., & Talebi, H. (2002). How practitioners can systematically use empirical evidence in treatment selection. *Journal of Clinical Psychology, 58,* 1199-1212.

Beutler, L. E. (2004). The empirically supported treatments movement: A scientist-practitioner's response. *Science and Practice, 11,* 225-229.

Bradley, M. C., & Mandell, D. (2005). Oppositional defiant disorder: A systematic review of evidence of intervention effectiveness. *Experimental Criminology, 1,* 343-365.

Callahan, J. L., & Hynan, M. T. (2005). Models of psychotherapy outcome: Are they applicable in training clinics?. *Psychological Services, 2,* 65-69.

Callahan, J. L., Swift, J. K., & Hynan, M. T. (2006). Test of the phase model of psychotherapy in a training clinic. *Psychological Service, 3,* 129-136.

Cartwright, D. S. (1955). Effectiveness of psychotherapy: A critique of the spontaneous remission argument. *Journal of Counseling Psychology, 2,* 290-296.

Cartwright-Hatton, S., Roberts, C., Chitsabesan, P., Fothergill, C., & Harrington, R. (2004). Systematic review of the efficacy of cognitive behavior therapies for childhood and adolescent anxiety disorders. *British Journal of Clinical Psychology, 43,* 421-436.

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64,* 497-504.

Chambless, D. L., Baker, M. J., Baucom, D. H., Beutler, L., Calhoun, K. S., Crits-Christoph, P., et al. (1998). Update on empirically validated therapies, II. *The Clinical Psychologist, 51,* 3-16.

Chambless, D. L., & Crits-Christoph, P. (2006). What should be validated?. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in*

mental health: Debate and dialogue on the fundamental questions (pp. 131-160). Washington, DC: American Psychological Association.

Chambless, D. L., Sanderson, W. C., Shoham, V., Bennett Johnson, S., Pope, K. S., Crits-Cristoph, P., et al. (1996). An update on empirically validated therapies. *The Clinical Psychologist, 49,* 5-18.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66,* 7-18.

Chapman, G. B., Brewer, N. T., Coups, E. J., Brownlee, S., Leventhal, H., & Leventhal, E. A. (2001). Value for the future and preventive health behavior. *Journal of Experimental Psychology: Applied, 7,* 235-250.

Chapman, G. B., Nelson, R., Hier, D. B. (1999). Familiarity and time preferences: Decision making about treatments for migraine headaches and Crohn's disease. *Journal of Experimental Psychology: Applied, 5,* 17-34.

Charles, C., Gafni, A., & Whelan, T. (1997). Shared decision-making in the medical encounter: What does it mean? (Or it takes at least two to tango). *Social Science & Medicine, 44,* 681-692.

Charles, C., Gafni, A., & Whelan, T. (1999). Decision-making in the physician-patient encounter: Revisiting the shared treatment decision-making model. *Social Science & Medicine, 49,* 651-661.

Charles, C. A., Whelan, T., Gafni, A., Willan, A., & Farrell, S. (2003). Shared treatment decision making: What does it mean to physicians?. *Journal of Clinical Oncology, 21,* 932-936.

Charles, C., Whelan, T., & Gafni, A. (1999). What do we mean by partnership in making decisions about treatment?. *British Medical Journal, 319,* 780-782.

Churchill, R., Khaira, M., Gretton, V., Chilvers, C., Dewey, M., Duggan, C., et al. (2000). Treating depression in general practice: Factors affecting patients' treatment preferences. *British Journal of General Practice, 50,* 905-906.

Consumer Reports. (1995, November). Mental health: Does therapy help? pp. 734-739.

Dekker, J., Molenaar, P. J., Kool, S., Van Aalst, G., Peen, J., & de Jonghe, F. (2005). Dose-effect relations in time-limited combined psycho-pharmacological treatment for depression. *Psychological Medicine, 35*, 47-58.

Derogatis, L. R. (1977). *The SCL-90 manual I: Scoring, administration and procedures for the SCL-90*. Baltimore: Clinical Psychometric Research.

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

Draper, M. R., Jennings, J., Baron, A., Erdur, O., & Shankar, L. (2002). Time-limited counseling outcome in a nationwide college counseling center sample. *Journal of College Counseling, 5*, 26-38.

Duncan, B. L., & Miller, S. D. (2006). Does manualization improve therapy outcomes?. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 131-160). Washington, DC: American Psychological Association.

Eddy, K. T., Dutra, L., Bradley, R., & Westen, D. (2004). A multidimensional meta-analysis of psychotherapy and pharmacotherapy for obsessive-compulsive disorder. *Clinical Psychology Review, 24,* 1011-1030.

Ertl, M. A., & McNamara, J. R. (2000). Predicting potential client treatment preferences. *Psychotherapy, 37,* 219-227.

Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology, 16,* 319-324.

Eysenck, H. J. (1978). An exercise in mega-silliness. *American Psychologist, 33,* 517.

Fairhurst, S. K. (1996). Promoting change in families: Treatment matching in residential treatment centers. *Residential Treatment for Children & Youth, 14,* 21-32.

Ford, S., Schofield, T., & Hope, T. (2003). What are the ingredients for a successful evidence-based patient choice consultation?: A qualitative study. *Social Science & Medicine, 56,* 589-602.

Ford, S., Schofield, T., & Hope, T. (2006). Observing decision-making in the general practice consultation: Who makes which decisions?. *Health Expectations: An International Journal of Public Participation in Health Care & Health Policy, 9,* 130-137.

Frank, J. D. (1976). Psychotherapy and the sense of mastery. In R. L. Spitzer & D. F. Klein (Eds.), *Evaluation of psychotherapies: Behavioral therapies, drug therapies, and their interactions* (pp. 47-56). Baltimore, MD: Johns Hopkins University Press.

Gallo, P. S. (1978). Meta-analysis: A mixed meta-phor?. *American Psychologist, 33,* 515-517.

Garfield, S. L. (1994). Research on client variables in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change (4th ed.).* (pp. 190-228) New York: John Wiley & Sons.

Glass, G. V., & Smith, M. L. (1978). 'An exercise in mega-silliness': Reply. *American Psychologist, 33,* 517-519.

Glass, G. V., & Smith, M. L. (1980). Ask not for whom the bell tolls. *American Psychologist, 35,* 223.

Grissom, R. J. (1996). The magical number .7 ± .2: Meta-analysis of the probability of superior outcome in comparisons involving therapy, placebo, and control. *Journal of Consulting and Clinical Psychology, 64,* 973-982.

Gum, A. M., Arean, P. A., Hunkeler, E., Tank, L., Katon, W., Hitchcock, P., et al. (2006). Depression treatment preferences in older primary care patients. *The Gerontologist, 46,* 14-22.

Hack, T. F., Degner, L. F., & Dyck, D. G. (1994). Relationship between preferences for decisional control and illness information among women with breast cancer: A quantitative and qualitative analysis. *Social Science & Medicine, 39,* 279-289.

Hansen, N. B., & Lambert, M. J. (2003). An evaluation of the dose-response relationship in naturalistic treatment settings using survival analysis. *Mental Health Services Research, 5,* 1-12.

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9,* 329-343.

Hayman, J., Weeks, J., & Mauch, P. (1996). Economic analyses in health care: An introduction to the methodology with an emphasis on radiation therapy. *International Journal of Radiation Oncology, Biology, Physics, 35,* 827-841.

Heil, S. H., Johnson, M. W., Higgins, S. T., & Bickel, W. K. (2006). Delay-discounting in currently using and currently abstinent cocaine-dependent outpatients and non-drug-using matched controls. *Addictive Behaviors, 31,* 1290-1294.

Henry, W. P., Strupp, H. H., Butler, S. F., Schacht, T. E., & Binder, J. L. (1993). Effects of training in time-limited dynamic psychotherapy: Changes in therapist behavior. *Journal of Consulting and Clinical Psychology, 61,* 434-440.

Hope, T. (1996). *Evidence based patient choice.* London: King's Fund.

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., & Ureato, G. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56,* 885-892.

Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist, 41,* 159-164.

Howard, K. I., Lueger, R. J., Maling, M. S., & Martinovich, Z. (1993). A phase model of psychotherapy outcome: Causal mediation of change. *Journal of Consulting and Clinical Psychology, 61,* 678-685.

Hunsley, J., & Lee, C. M. (2007). Research-informed benchmarks for psychological treatments: Efficacy studies, effectiveness studies, and beyond. *Professional Psychology: Research and Practice, 38,* 21-33.

Hurley, J., Birch, S., & Eyles, J. (1992). Information, efficiency and decentralization within health care systems. *CHEPA Working Paper,* 92-121.

Ilardi, S. S., & Craighead, W. E. (1994). The role of nonspecific factors in cognitive-behavior therapy for depression. *Clinical Psychology: Science and Practice, 1,* 138-156.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century.* Washington, DC: Institute of Medicine.

Jacobson, N. S., & Christensen, A. (1996). Studying the effectiveness of psychotherapy: How well can clinical trials do the job?. *American Psychologist, 51,* 1031-1039.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59,* 12-19.

Kadera, S. W., Lambert, M. J., & Andrews, A. A. (1996). How much therapy is really enough? A session-by-session analysis of the psychotherapy dose-effect relationship. *Journal of Psychotherapy Practice & Research, 5,* 132-151.

Kalat, J. W. (1980). A misuse of statistics: Reply to Rimland. *American Psychologist, 35,* 223-224.

Kazdin, A. E. (1981). Acceptability of child treatment techniques: The influence of treatment efficacy and adverse side effects. *Behavior Therapy, 12,* 493-506.

Kazdin, A. E. (1984). Acceptability of aversive procedures and medication as treatment alternatives for deviant child behavior. *Journal of Abnormal Child Psychology, 12,* 289-301.

Kopta, S. M., Howard, K. I., Lowry, J. L., & Beutler, L. E. (1994). Patterns of symptomatic recovery in psychotherapy. *Journal of Consulting and Clinical Psychology, 62,* 1009-1016.

Lambert, M. J., Burlingame, G. M., Umphress, V. J., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., et al. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy, 3,* 249-258.

Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin, & S. L. Garfield (Eds.), *Handbook of Psychotherapy and Behavior Change (4th ed.),* (pp. 143-189). Oxford, England: John Wiley & Sons.

Lambert, M. J., Hansen, N. B., & Finch, A. E. (2001). Patient-focused research: Using patient outcome data to enhance treatment effects. *Journal of Consulting and Clinical Psychology, 69,* 159-172.

Lambert, M. J., Hansen, N. B., Umpress, V., Lunnen, K., Okiishi, J., & Burlingame, G. M. (1996). *Administration and scoring manual for the OQ-45.2*. Stevenson, MD: American Professional Credentialing Services LLC.

Lambert, M. J., Lunnen, K., Umphress, V. (1994). *Administration and scoring manual for the Outcome Questionnaire (OQ-45.1).* Salt Lake City, UT: IHC Center for Behavioral Healthcare Efficacy.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Eds.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change (5th ed.),* (pp. 139-193). New York: John Wiley & Sons.

Lambert, M. J., Okiishi, J. C., Finch, A. E., & Johnson, L. D. (1998). Outcome assessment: From conceptualization to implementation. *Professional Psychology: Research and Practice, 29,* 63-70.

Landis, C. (1937). A statistical evaluation of psychotherapeutic methods. In L. E. Hinsie (Ed.), *Concepts and Problems of Psychotherapy,* (chapter 5). New York: Columbia University Press.

Landman, J. T., & Dawes, R. M. (1982). Psychotherapy outcome: Smith and Glass' conclusions stand up under scrutiny. *American Psychologist, 37,* 504-516.

Levinson, W., Kao, A., Kuby, A., & Thisted, R. A. (2005). Not all patients want to participate in decision making: A national study of public preferences. *Journal of General International Medicine, 20,* 531-535.

Linehan, M. M. (2007). In defense of science and controlled clinical trials. *The Clinical Psychologist, 60,* 1-4.

Lipsey, M. W., & Wilson, D. B. (1993). The efficacy of psychological, educations, and behavioral treatment: Confirmation from meta-analysis. *American Psychologist, 48,* 1181-1209.

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,* 995-1008.

Lueger, R. J., Lutz, W., & Howard, K. I. (2000). The prediction and observed course of psychotherapy for anxiety and mood disorders. *Journal of Nervous and Mental Disease, 188,* 127-134.

Makoul, G., & Clayman, M. L. (2006). An integrative model of shared decision making in medical encounters. *Patient Education and Counseling, 60,* 301-312.

Matt, G. E., & Navarro, A. M. (1997). What meta-analyses have and have not taught us about psychotherapy effects: A review and future directions. *Clinical Psychology Review, 17,* 1-32.

Meares, R., Stevenson, J., & D'Angelo, R. (2002). Eysenck's challenge to psychotherapy: A view of the effects 50 years on. *Australian and New Zealand Journal of Psychiatry, 36,* 812-815.

Meltzoff, J., & Kornreich, M. (1970). *Research in psychotherapy.* New York: Atherton.

Mendonca, P. J., & Brehm, S. S. (1983). Effects of choice on behavioral treatment of overweight children. *Journal of Social and Clinical Psychology, 1,* 343-358.

Messer, S. B., & Wampold, B. E. (2002). Let's face facts: Common factors are more potent than specific therapy ingredients. *Clinical Psychology: Science and Practice, 9,* 21-25.

Mintz, J., Mintz, L. I., Arruda, M. J., & Hwang, S. S. (1992). Treatments of depression and the functional capacity to work. *Archives of General Psychiatry, 49,* 761-768.

Nebeker, R. S., Lambert, M. J., & Huefner, J. C. (1995). Ethnic differences on the Outcome Questionnaire. *Psychological Reports, 77*(3), 875-879.

Ohmura, Y., Takahashi, T., & Kitamura, N. (2005). Discounting delayed and probabilistic monetary gains and losses by smokers of cigarettes. *Psychopharmacology, 182,* 508-515.

Ortendahl, M., & Fries, J. F. (2005). Framing health messages based on anomalies in time preference. *Medical Science Monitor: International Medical Journal of Experimental And Clinical Research, 11,* RA253-256.

Parsons, T. (1951). Illness and the role of the physician: A sociological perspective. *American Journal of Orthopsychiatry, 21,* 452-460.

Presby, S. (1978). Overly broad categories obscure important differences between therapies. *American Psychologist, 33,* 514-515.

Priest, R. G., Vize, C., Roberts, A., Roberts, M., & Tylee, A. (1996). Lay people's attitudes to treatment of depression: Results of opinion poll for Defeat Depression Campaign just before its launch. *British Medical Journal, 313,* 858-859.

Propst, L. R., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology, 60,* 94-103.

Renjilian, D. A., Perri, M. G., Nezu, A. M., McKelvey, W. F., Shermer, R. L., & Anton, S. D. (2001). Individual versus group therapy for obesity: Effects of matching participants to their treatment preferences. *Journal of Consulting and Clinical Psychology, 69,* 717-721.

Riedel-Heller, S. G., Matschinger, H., & Angermeyer, M. C. (2005). Mental disorders—Who and what might help? Help-seeking and treatment preferences of the lay public. *Social Psychiatry and Psychiatric Epidemiology, 40,* 167-174.

Rimland, B. (1979). Death knell for psychotherapy?. *American Psycholgist, 33,* 192.

Rodebaugh, T. L., Holaway, R. M., & Heimber, R. G. (2004). The treatment of social anxiety disorder. *Clinical Psychology Review, 24,* 883-908.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95-103.

Rokke, P. D., & Lall, R. (1992). The role of choice in enhancing tolerance to acute pain. *Cognitive Therapy and Research, 16,* 53-65.

Rokke, P. D., Tomhave, J. A., Jocic, Z. (1999). The role of client choice and target selection in self-management therapy for depression in older adults. *Psychology and Aging, 14,* 155-169.

Rosenthal, D., & Frank, J. D. (1956). Psychotherapy and the placebo effect. *Psychological Bulletin, 53,* 294-302.

Rosenzweig, S. (1953). Idiodynamics and tradition. *Psychological Review, 60,* 209-210.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry, 6,* 412-415.

Sackett, D. L., Straus, S. E., Richardson, W. S., Rosenberg, W., & Haynes, R. B. (2000). *Evidence based medicine: How to practice and teach EBM (2nd ed.).* London: Churchill Livingstone.

Schwartz, S. H., & Rubel, T. (2005). Sex differences in value priorities: Cross-cultural and multimethod studies. *Journal of Personality and Social Psychology, 89,* 1010-1028.

Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The Consumer Reports study. *American Psychologist, 50,* 965-974.

Shadish, W. R., Navarro, A. M., Matt, G. E., & Phillips, G. (2000). The effects of psychological therapies under clinically representative conditions: A meta-analysis. *Psychological Bulletin, 126,* 512-529.

Shapiro, D. A., & Shapiro, D. (1982). Meta-analysis of comparative therapy outcome studies: A replication and refinement. *Psychological Bulletin, 92,* 581-604.

Sheldrick, R. C., Kendall, P. C., & Heimberg, R. G. (2001). The clinical significance of treatments: A comparison of three treatments for conduct disordered children. *Clinical Psychology: Science and Practice, 9,* 418-430.

Shiloh, S., Gerad, L., & Goldman, B. (2006). Patients' information needs and decision-making processes: What can be learned from genetic counselees?. *Health Psychology, 25,* 211-219.

Silverman, W. H. (1996). Cookbooks, manuals, and paint-by-numbers: Psychotherapy in the 90's. *Psychotherapy: Theory, Research, Practice, Training, 33,* 207-215.

Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32,* 752-760.

Stevens, S. E., Hynan, M. T., & Allen, M. (2000). A meta-analysis of common factor and specific treatment effects across the outcome domains of the phase model of psychotherapy. *Clinical Psychology: Science and Practice, 7,* 273-290.

Stirman, S. W., DeRubeis, R. J., Crits-Christoph, P., & Brody, P. E. (2003). Are samples in randomized controlled trials of psychotherapy representative of community outpatients? A new methodology and initial findings. *Journal of Consulting and Clinical Psychology, 71,* 963-972.

Strupp, H. H. (1963). The outcome problem in psychotherapy revisited. *Psychotherapy: Theory, Research & Practice, 1,* 1-13.

Swift, J. K., & Callahan, J. L. (2008). A delay-discounting measure of great expectations and the effectiveness of psychotherapy. *Professional Psychology: Research and Practice, 39,* 581-588.

Swift, J. K., & Callahan, J. L. (2009). The impact of client treatment preferences on outcome: A meta-analysis. *Journal of Clinical Psychology, 65,* 368-381.

Swift, J.K., Callahan, J.L., & Collins, F. (Under Review). Integrating all components in the training of evidence-based practice in psychology.

Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically validated psychological treatments: Report and recommendations. *The Clinical Psychologist, 48,* 3-23.

Vermeersch, D. A., Lambert, M. J., & Burlingame, G. M. (2000). Outcome questionnaire: Item sensitivity to change. *Journal of Personality Assessment, 74,* 242-261.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Erlbaum.

Wampold, B. E. (2006). What should be validated?. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 131-160). Washington, DC: American Psychological Association.

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,* 203-215.

Wanigaratne, S., & Barker, C. (1995). Clients' preferences for styles of therapy. *British Journal of Clinical Psychology, 34,* 215-222.

Weinberger, J. (1995). Common factors aren't so common: The common factors dilemma. *Clinical Psychology: Science and Practice, 2,* 45-69.

Weissman, M. M., & Bothwell, S. (1976). Assessment of social adjustment by patient self-report. *Archives of General Psychiatry, 33,* 1111-1115.

Weisz, J. R., & Weiss, B. (1989). Assessing the effects of clinic-based psychotherapy with children and adolescents. *Journal of Consulting and Clinical Psychology, 57,* 741-746.

Weisz, J. R., Weiss, B., Alicke, M. D., & Klotz, M. L. (1987). Effectiveness of psychotherapy with children and adolescents: A meta-analysis for clinicians. *Journal of Consulting and Clinical Psychology, 55,* 542-549.

Weisz, J. R., Weiss, B., & Donenberg, G. R. (1992). The lab versus the clinic: Effects of child and adolescent psychotherapy. *American Psychologist, 47,* 1578-1585.

Weisz, J. R., Weiss, B., Han, S. S., Granger, D. A., & Morton, T. (1995). Effects of psychotherapy with children and adolescents revisited: A meta-analysis of treatment outcome studies. *Psychological Bulletin, 117,* 450-468.

Westen, D., & Morrison, K. (2001). A multidimensional meta-analysis of treatments for depression, panic, and generalized anxiety disorder: An empirical examination of the status of empirically supported therapies. *Journal of Consulting and Clinical Psychology, 69,* 875-899.

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice, 24,* 190-195.

Wileyto, E. P., Audrain-McGovern, J., Epstein, L. H., & Lerman, C. (2004). Using logistic regression to estimate delay-discounting functions. *Behavior Research Methods, Instruments & Computers, 36,* 41-51.

Wilson, G. T. (1998). Manual-based treatment and clinical practice. *Clinical Psychology: Science and Practice, 5,* 363-375.

Wong, E. C., Kim, B. S. K., Zane, N. W. S., Kim, I. J., & Huang, J. S. (2003). Examining culturally based variables associated with ethnicity: Influences on credibility perceptions of empirically supported interventions. *Cultural Diversity & Ethnic Minority Psychology, 9,* 88-96.

APPENDIX A

Delay-discounting model for specific versus common factors preferences.

Imagine that you are currently experiencing a significant amount of distress and you have a choice between two treatment options. The two treatment options differ in terms of observed effectiveness (the average percent of clients who recover when provided the treatment) and the level of another variable often seen to play a role in treatment outcome. You are asked to indicate your preference among these two.

Would you prefer a treatment that is on average 70% effective and is delivered by a therapist that is described as cold and distant, or a treatment that is on average10% effective and is delivered by a therapist that is described as warm and trusting?

- - NEXT CHOICE - -

Would you prefer a treatment that is on average 70% effective and is delivered by a therapist that is described as cold and distant, or a treatment that is on average 20% effective and is delivered by a therapist that is described as warm and trusting?

- - NEXT CHOICE - -

Would you prefer a treatment that is on average 70% effective and is delivered by a therapist that is described as cold and distant, or a treatment that is on average 30% effective and is delivered by a therapist that is described as warm and trusting?

This process is continued until both treatments are of equal effectiveness and then in the opposite direction until the original choice is again provided.

APPENDIX B

The survey as provided to participating clients is provided beginning on the following page.

A Study of Preferences and Expectations for Psychotherapy

Investigators: Joshua Swift, M.S.; Clinical Psychology Graduate Student; Oklahoma State University

Purpose: Joshua Swift, Clinical Psychology Graduate Student, is conducting a research study on the preferences and expectations people have concerning psychotherapy.

Procedures: In this study you will be asked to fill out a survey with a number of questions concerning your preferences and expectations for psychotherapy. Completion of each survey should take approximately 10 minutes.

Risks and Benefits: There are no known risks associated with this project which are greater than those ordinarily encountered in daily life. There are also no known personal benefits that are anticipated as resulting from participation. Your assigned therapist will not see your answers to the survey and your answers will not affect your treatment in any way. However, the information resulting from this study may aid in understanding preferences and expectations that people have in general.

Confidentiality: The records of this study will be kept private. Any written results will discuss group findings and will not include information that will identify you. Research records will be stored securely and only researchers and individuals responsible for research oversight will have access to the records. It is possible that the consent process and data collection will be observed by research oversight staff responsible for safeguarding the rights and wellbeing of people who participate in research.

Contacts: For information regarding this study, please contact Joshua Swift, at (405) 780-7096 or by email at jkswift42@gmail.com or Dr. Jennifer Callahan (research advisor) at (405) 744-3788 or by email at jennifer.callahan@okstate.edu

If you have questions about your rights as a research volunteer, you may contact Dr. Sue C. Jacobs, IRB Chair, 219 Cordell North, Stillwater, OK 74078, 405-744-1676 or irb@okstate.edu.

Participant Rights: Your participation is completely voluntary, and you have the right to withdraw from this study at any time without penalty.

A Study of Preferences and Expectations for Psychotherapy

Directions: Please answer each question in the survey to the best of your ability. Answer each question with regards to how you really feel, not how you may think others would like you to respond. If you find a particular question distressing you may skip it and go on to the next question without penalty. Thank you for your participation.

Demographics: First, please provide some basic demographic information about yourself. You may answer by providing a response in the blank spaces or by checking the appropriate box.

Age: _____ Gender: □ Male □ Female

Ethnicity: □ Caucasian □ African American □ Hispanic □ Native American
□ Asian American □ Bi/Multi-Racial American
□ International residing in the U.S. □ Other: _____

Education: □ No High School □ Some High School □ High School Graduate
□ College Freshman □ College Sophomore □ College Junior □ College Senior
□ College Graduate □ Graduate Level Degree □ Higher (PhD, MD, etc.)

Occupation: _____ Yearly Income: _____

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Remarried

Are you currently a student at OSU? □ Yes □ No

Have you previously received therapy from a mental health professional? □ Yes □ No

PLEASE CONTINUE TO THE NEXT PAGE

Preferences: Many people have different preferences or values with regards to the psychotherapy services that they receive. Please answer the following questions according to your personal preferences. Remember to answer each question according to how you really feel, not how you may think others would like you to respond.

In this section you will be asked to compare two differing treatments. The two treatment options differ in terms of observed effectiveness (the average percent of clients who recover when provided the treatment) and the level of another variable often seen to play a role in treatment outcome. You are asked to indicate your preference among these two treatment options.

The following is an **example** of the type of questions you may be asked using money. Please indicate your preferences by checking the corresponding box. Arrows (→) mark where to indicate your preferences

Would you prefer to receive $10 today or $11 one week from now?

→ ☐ $10 today ☐ $11 one week from now

Would you prefer to receive $10 today or $15 one week from now?

→ ☐ $10 today ☐ $15 one week from now

Would you prefer to receive $10 today or $20 one week from now?

→ ☐ $10 today ☐ $20 one week from now

PLEASE CONTINUE TO THE NEXT PAGE

Again, in this section you will be asked to compare two differing treatments. The two treatment options differ in terms of observed effectiveness (the average percent of clients who recover when provided the treatment) and the level of another variable often seen to play a role in treatment outcome. You are asked to indicate your preference among these two treatment options. There are a total of 4 comparisons. Make sure to read and complete all 4 carefully.

COMPARISON 1

Would you prefer a **treatment** that is on average **70% effective** (on average 70% of clients recover by the end of the treatment) and is delivered by a therapist who you **can not relate to**, or a **treatment** that has differing levels of effectiveness and is delivered by a therapist who you **can develop a good, positive relationship with**?

→	□ 70% can not relate to	□ 10% can develop a good, positive relationship with
→	□ 70% can not relate to	□ 20% can develop a good, positive relationship with
→	□ 70% can not relate to	□ 30% can develop a good, positive relationship with
→	□ 70% can not relate to	□ 40% can develop a good, positive relationship with
→	□ 70% can not relate to	□ 50% can develop a good, positive relationship with
→	□ 70% can not relate to	□ 60% can develop a good, positive relationship with
→	□ 70% can not relate to	□ 70% can develop a good, positive relationship with
→	□ 70% can not relate to	□ 70% can develop a good, positive relationship with
→	□ 70% can not relate to	□ 60% can develop a good, positive relationship with
→	□ 70% can not relate to	□ 50% can develop a good, positive relationship with
→	□ 70% can not relate to	□ 40% can develop a good, positive relationship with
→	□ 70% can not relate to	□ 30% can develop a good, positive relationship with
→	□ 70% can not relate to	□ 20% can develop a good, positive relationship with
→	□ 70% can not relate to	□ 10% can develop a good, positive relationship with

COMPARISON 2

Would you prefer a **treatment** that is on average **70% effective** (on average 70% of clients recover by the end of the treatment) and is delivered by a therapist that is described as **cold, distant, and judgmental**, or a **treatment** that that has differing levels of effectiveness and is delivered by a therapist that is described as **warm, empathetic, and accepting**?

→	□ 70% cold, distant, judgmental	□ 10% warm, empathetic, accepting
→	□ 70% cold, distant, judgmental	□ 20% warm, empathetic, accepting
→	□ 70% cold, distant, judgmental	□ 30% warm, empathetic, accepting
→	□ 70% cold, distant, judgmental	□ 40% warm, empathetic, accepting
→	□ 70% cold, distant, judgmental	□ 50% warm, empathetic, accepting
→	□ 70% cold, distant, judgmental	□ 60% warm, empathetic, accepting
→	□ 70% cold, distant, judgmental	□ 70% warm, empathetic, accepting
→	□ 70% cold, distant, judgmental	□ 70% warm, empathetic, accepting
→	□ 70% cold, distant, judgmental	□ 60% warm, empathetic, accepting
→	□ 70% cold, distant, judgmental	□ 50% warm, empathetic, accepting
→	□ 70% cold, distant, judgmental	□ 40% warm, empathetic, accepting
→	□ 70% cold, distant, judgmental	□ 30% warm, empathetic, accepting
→	□ 70% cold, distant, judgmental	□ 20% warm, empathetic, accepting
→	□ 70% cold, distant, judgmental	□ 10% warm, empathetic, accepting

COMPARISON 3

Would you prefer a **treatment** that is on average **70% effective** (on average 70% of clients recover by the end of the treatment) and is delivered by a therapist that has **very few years of schooling and clinical experience**, or a **treatment** that that has differing levels of effectiveness and is delivered by a therapist who has **completed many years of schooling and clinical experience**?

→	□ 70% few years of experience	□ 10% many years of experience
→	□ 70% few years of experience	□ 20% many years of experience
→	□ 70% few years of experience	□ 30% many years of experience
→	□ 70% few years of experience	□ 40% many years of experience
→	□ 70% few years of experience	□ 50% many years of experience
→	□ 70% few years of experience	□ 60% many years of experience
→	□ 70% few years of experience	□ 70% many years of experience
→	□ 70% few years of experience	□ 70% many years of experience
→	□ 70% few years of experience	□ 60% many years of experience
→	□ 70% few years of experience	□ 50% many years of experience
→	□ 70% few years of experience	□ 40% many years of experience
→	□ 70% few years of experience	□ 30% many years of experience
→	□ 70% few years of experience	□ 20% many years of experience
→	□ 70% few years of experience	□ 10% many years of experience

COMPARISON 4

Would you prefer a **treatment** that is on average **70% effective** (on average 70% of clients recover by the end of the treatment) and is delivered by a therapist who **does all of the talking**, or a **treatment** that that has differing levels of effectiveness and is delivered by a therapist who **listens and allows you to do more of the talking**?

→

□ 70% therapist does all of the talking □ 10% therapist listens, you do most of the talking

→

□ 70% therapist does all of the talking □ 20% therapist listens, you do most of the talking

→

□ 70% therapist does all of the talking □ 30% therapist listens, you do most of the talking

→

□ 70% therapist does all of the talking □ 40% therapist listens, you do most of the talking

→

□ 70% therapist does all of the talking □ 50% therapist listens, you do most of the talking

→

□ 70% therapist does all of the talking □ 60% therapist listens, you do most of the talking

→

□ 70% therapist does all of the talking □ 70% therapist listens, you do most of the talking

→

□ 70% therapist does all of the talking □ 70% therapist listens, you do most of the talking

→

□ 70% therapist does all of the talking □ 60% therapist listens, you do most of the talking

→

□ 70% therapist does all of the talking □ 50% therapist listens, you do most of the talking

→

□ 70% therapist does all of the talking □ 40% therapist listens, you do most of the talking

→

□ 70% therapist does all of the talking □ 30% therapist listens, you do most of the talking

→

□ 70% therapist does all of the talking □ 20% therapist listens, you do most of the talking

→

□ 70% therapist does all of the talking □ 10% therapist listens, you do most of the talking

APPENDIX C

List of comparative studies supporting the empirically supported treatments taken from Chambless et al. (1998).

Treatments with Comparative Studies

Cognitive behavior therapy for panic disorder with and without agoraphobia

1) Barlow et al., 1989
2) Clark et al., 1994

Cognitive behavior therapy for generalized anxiety disorder

1) Butler et al. (1991)
2) Borkovec et al. (1987)

Exposure treatment for agoraphobia

1) Trull et al. (1988)

Exposure/guided mastery for specific phobia

1) Bandura et al. (1969)
2) Ost et al. (1991)

Exposure and response prevention for obsessive-compulsive disorder

1) van Balkom et al. (1994)

Stress inoculation training for coping with stressors

1) Saunders et al. (1996)

Behavior therapy for depression

1) Jacobson et al. (1996)

2) McLean & Hakstaian (1979)

Cognitive therapy for depression

1) Dobson (1989)

Interpersonal therapy for depression

1) DiMascio et al. (1979)

2) Elkin et al. (1989)

Behavior therapy for headache

1) Blanchard et al. (1980)

2) Holroyd & Penzien (1990)

Cognitive-behavior therapy for bulimia

1) Agras et al. (1989)

2) Thackwray et al. (1993)

Multi-component cognitive-behavior therapy for pain associated with rheumatic disease

1) Keefe et al. (1990)

2) Parker et al. (1988)

Multi-component cognitive-behavior therapy with relapse prevention for smoking cessation

1) Hill et al. (1993)

2) Stevens & Hollis (1989)

Behavior modification for enuresis

1) Houts et al. (1994)

Parent training programs for children with oppositional behavior

1) Walter & Gilmore (1973)

2) Wells & Egan (1988)

Behavioral marital therapy

1) Azrin et al. (1980)

2) Jacobson & Follette (1985)

Applied relaxation for panic disorder

1) Ost (1988)

Applied relaxation for generalized anxiety disorder

1) Barlow et al. (1992)

2) Borkovec & Costello (1993)

Cognitive behavior therapy for social phobia

1) Heimberg et al. (1990)

2) Feske & Chambless (1995)

Cognitive therapy for OCD

1) van Oppen et al. (1995)

Couples communication training adjunctive to exposure for agoraphobia

1) Arnow et al. (1985)

EMDR for civilian PTSD

1) Rothbaum (in press)

2) Wilson et al. (1995)

Exposure treatment for PTSD

1) Foa et al. (1991)

2) Keane et al. (1989)

Exposure treatment for social phobia

1) Feske & Chambless (1995)

Stress Inoculation training for PTSD

1) Foa et al. (1991)

Relapse prevention program for obsessive-compulsive disorder

1) Hiss et al. (1994)

Systematic desensitization for animal phobia

1) Kirsch et al. (1983)
2) Ost (1978)

Systematic desensitization for public speaking anxiety

1) Paul (1967)
2) Woy & Efran (1972)

Systematic desensitization for social anxiety

1) Paul & Shannon (1966)

Behavior therapy for cocaine abuse

1) Higgins et al. (1993)

Brief dynamic therapy for opiate dependence

1) Woody et al. (1990)

Cognitive-behavioral relapse prevention therapy for cocaine dependence

1) Carroll et al. (1994)

Cognitive therapy for opiate dependence

1) Woody et al. (1990)

Cognitive-behavior therapy for benzodiazepine withdrawal in panic disorder patients

1) Otto et al. (1993)

2) Spiegel et al. (1994)

Community Reinforcement Approach for alcohol dependence

1) Azrin (1976)

2) Hunt & Azrin (1973)

Cue exposure adjunctive to inpatient treatment for alcohol dependence

1) Drummond & Glautier (1994)

Project CALM for mixed alcohol abuse and dependence (behavioral marital therapy plus disulfiram)

1) O'Farrell et al. (1985)

2) O'Farrell et al. (1992)

Social skills training adjunctive to inpatient treatment for alcohol dependence

1) Eriksen et al (1986)

Brief dynamic therapy

1) Gallagher-Thompson & Steffen (1994)

Cognitive therapy for geriatric patients

1) Scogin & McElreath (1994)

Reminiscence therapy for geriatric patients

1) Arean et al. (1993)

2) Scogin & McElreath (1994)

Self-control therapy

1) Fuchs & Rehm (1977)

2) Rehm et al. (1979)

Social problem-solving therapy

1) Nezu (1986)
2) Nezu & Perri (1989)

Behavior therapy for childhood obesity

1) Epstein et al. (1994)
2) Wheeler & Hess (1976)

Cognitive-behavior therapy for binge eating disorder

1) Telch et al. (1990)
2) Wilfley et al. (1993)

Cognitive-behavior therapy adjunctive to physical therapy for chronic pain

1) Nicholas et al. (1991)

Cognitive-behavior therapy for chronic low back pain

1) Turner & Clancy (1988)

EMG biofeedback for chronic pain

1) Flor & Birbaumer (1993)
2) Newton-John et al. (1995)

Hypnosis as an adjunct to cognitive-behavior therapy for obesity

1) Bolocofsky et al. (1985)

Interpersonal therapy for binge-eating disorder

1) Wilfley et al. (1993)

Interpersonal therapy for bulimia

1) Fairburn et al. (1993)

Multi-component cognitive therapy for irritable bowel syndrome

1) Lunch & Zamble (1989)

2) Payne & Blanchard (1995)

Multi-component cognitive-behavior therapy for pain of sixkle cell disease

1) Gil et al. (1996)

Multi-component cognitive-behavior therapy for chronic pain

1) Turner & Clancy (1988)
2) Turner et al. (1990)

Scheduled, reduced smoking adjunctive to multi-component behavior therapy for smoking cessation

1) Cinciripini et al. (1994)
2) Cinciripini et al (1995)

Thermal biofeedback for Raynaud's syndrome

1) Freedman et al. (1983)

Thermal biofeedback plus autogenic relaxation training for migraine

1) Blanchard et al. (1978)
2) Sargent et al. (1986)

Emotionally focused couples therapy for moderately distressed couples

1) James (1991)
2) Johnson & Greenberg (1985)

Insight-oriented marital therapy

1) Snyder et al. (1989, 1991)

Behavior modification of encopresis

1) O'Brien et al. (1986)

Cognitive-behavior therapy for anxious children (overanxious, separation anxiety, and

avoidant disorders)

1) Kendall (1994)
2) Kendall et al. (1997)

Exposure for simple phobia

1) Menzies & Clarke

Family anxiety management training for anxiety disorders

1) Barrett et al. (1996)

Hurlbert's combined treatment approach for female hypoactive sexual desire

1) Hurlbert et al. (1993)

Masters & Johnson's sex therapy for female orgasmic dysfunction

1) Everaerd & Dekker (1981)

Zimmer's combined sex and marital therapy for female hypoactive sexual desire

1) Zimmer (1987)

Behavior modification for sex offenders

1) Marshall et al. (1991)

Dialectical behavior therapy for borderline personality disorder

1) Linehan et al. (1991)

Family intervention for schizophrenia

1) Falloon et al. (1985)
2) Randolph et al. (1994)

Habit reversal and control techniques

1) Azrin et al. (1980)
2) Azrin et al (1980

Social skills training for improving social adjustment of schizophrenic patients

1) Marder et al. (1996)

Supported employment for severely mentally ill clients

1) Drake et al. (1996)

APPENDIX D

Oklahoma State University Institutional Review Board

Date:	Wednesday, June 27, 2007
IRB Application No	AS0742
Proposal Title:	A study of Client Expectations and Preferences
Reviewed and Processed as:	Expedited

Status Recommended by Reviewer(s): Approved Protocol Expires: 6/26/2008

Principal Investigator(s)

Joshua Swift
215 N. Murray
Stillwater, OK 74078

Jennifer L. Callahan
215 N. Murray
Stillwater, OK 74078

The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

☑ The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be submitted with the appropriate signatures for IRB approval.
2. Submit a request for continuation if the study extends beyond the approval period of one calendar year. This continuation must receive IRB review and approval before the research can continue.
3. Report any adverse events to the IRB Chair promptly. Adverse events are those which are unanticipated and impact the subjects during the course of this research; and
4. Notify the IRB office in writing when your research project is complete.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact Beth McTernan in 219 Cordell North (phone: 405-744-5700, beth.mcternan@okstate.edu).

Sincerely,

Sue C Jacobs

Sue C. Jacobs, Chair
Institutional Review Board

VITA

Joshua Keith Swift

Candidate for the Degree of

Doctorate of Philosophy

Title of Study: CLIENT PREFERENCES AND THE SPECIFIC VERSUS COMMON FACTORS DEBATE

Major Field: Psychology, with an option in Clinical

Biographical:

Education: Graduated with a Bachelor of Science in Psychology from Brigham Young University, Provo, Utah in April, 2005. Received the degree of Master of Science in Psychology from Oklahoma State University, Stillwater, Oklahoma in May, 2007. Completed the requirements for the Doctorate of Philosophy degree with a major in Psychology at Oklahoma State University in December, 2010.

Professional Memberships: American Psychological Association, Society of Clinical Psychology, Division of Psychotherapy, Oklahoma Psychological Association.

Name: Joshua Swift Date of Degree: December, 2010

Institution: Oklahoma State University Location: Stillwater, Oklahoma

Title of Study: CLIENT PREFERENCES AND THE SPECIFIC VERSUS COMMON FACTORS DEBATE

Pages in Study: 156 Candidate for the Degree of Doctor of Philosophy

Major Field: Psychology, with an option in Clinical

Scope and Method of Study: Client preferences for psychological treatments have been found to play an important role in therapy outcomes. The present study was designed to examine client preferences for treatment using a delay-discounting model. In this study adult clients presenting for therapy services were asked to indicate their preferences on four delay-discounting choices concerning treatments with altering levels of effectiveness and another therapy-related variable.

Findings and Conclusions: Data from 66 adult participants indicated that clients would desire a treatment that was 48% less effective in order to ensure that they received a therapist who was warm, empathetic, and accepting; a 38% less effective treatment in order to ensure that they received a therapist with whom they could develop a relationship with; a 34% less effective treatment in order to ensure that they would do more of the talking in session; and a 25% less effective treatment in order to ensure that their therapist was high in expertise. Further, clients were found to cluster into four groups depending on their expressed preferences: those who preferred the common factors over treatment effectiveness, those who preferred treatment effectiveness above any common factor, those who desired most an empathetic therapist, and those who desire most to develop a therapeutic relationship with an empathetic therapist. Given that comparative trials often find small differences in effectiveness levels between treatments and the findings from this study indicating that clients desire less effective treatments if some other therapy-related factor is involved, client preferences should be included in the treatment decision-making process.

ADVISER'S APPROVAL: Jennifer Callahan, Ph.D.