

Client preferences: building bridges between therapy and everyday life

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Introduction

One of the major challenges facing the counselling and psychotherapy professional community, at this point in its history, concerns the question of how to reconcile knowledge that is derived from specific theoretical models, and knowledge that is derived from more general, pan-theoretical perspectives. On the one hand, approaches to therapy, such as CBT and psychodynamic, offer coherent, effective and persuasive frameworks for practice. On the other hand, there are also several widely-documented generic concepts, such as the therapeutic alliance, and therapist responsiveness, and practices, such as the use of client feedback and tracking procedures, that are not tied to mainstream theories of therapy in any kind of explicit manner. It is possible to view the existence of these theoretical disjunctions as a problem for the field, as evidence of a state of unresolvable conceptual fragmentation and muddle. However, it is also possible to regard them as creative irritants, as indications of the growing edge of our understanding of how therapy works, and as opportunities to keep thinking in fresh ways about what we are trying to achieve in our practice.

In the present paper, I would like to explore some of the practical and theoretical implications of the concept of *preference*. The concept of client preferences has emerged in recent years as a topic of some significance within the counselling and psychotherapy research literature. Over the last 20 years, groups of researchers in many countries have conducted studies on the extent to which client preferences for different therapy models or procedures might have an impact on the ultimate helpfulness of the therapy they receive. By now, enough of these studies have been carried out to make it possible to see whether consistent patterns have emerged. Reviews of this literature have been published by myself ([McLeod, 2012, 2013](#)), [Swift and Callahan \(2009\)](#) and [Lindhiem et al. \(2014\)](#). The most comprehensive and systematic reviews that are currently available, from [Swift and Callahan \(2009\)](#) and [Lindhiem et al. \(2014\)](#), provides compelling evidence of the significance of client preferences, derived from more than 30 high-quality studies. Compared to clients who are allocated to therapy without consideration to their preferences, clients who receive a form of therapy that is consistent with their preferences are less likely to drop out of therapy, report stronger alliances with their therapists, and demonstrate better outcomes at the end of therapy. The magnitude of these effects is not

trivial and has important practical implications. For example, adoption of preference-informed therapy services has the potential to reduce costs and waiting lists, by minimising “do not attend” rates and drop-out. In terms of service design and planning, the effect on the outcome of receiving a preferred therapy is greater than that achieved by channeling clients toward interventions that have been designated as empirically validated.

On the basis of the findings of research in client preferences, it would seem reasonable to expect the therapy profession to find ways to assimilate this research knowledge into practice, as a matter of urgency. As far as I can see, there are no signs at all that this is happening. Things go on, much as before. Rather than lament that this state of affairs represents yet another example of the gap between therapy research and practice, I would like to suggest that it represents a situation in which further conceptual and theoretical work needs to be carried out, to enable connections to be made between the results of empirical studies and the world of practice. Therapy is a highly complex activity. Assimilating the concept of client preferences into the models of practice used by therapists is not a straightforward undertaking. The researchers have delivered the idea – now it needs to be unpacked by practitioners, supervisors and trainers.

The following sections of this paper represent an attempt to begin to find a place, or set of places, for the concept of preference within our existing understanding of therapy practice. The most straightforward and obvious way in which client preferences have an effect on therapy is in the area of client engagement and commitment. When the therapy that is offered matches the client’s ideas about what is helpful, he or she is more likely to participate fully. By contrast, when what is offered clashes with or contradicts the client’s ideas, he or she is likely to disengage or even withdraw from therapy. In the discussion below, the link between preference and commitment is assumed. The focus instead, is on other ways in which attention to client preferences can have an impact on the process of therapy. An appreciation of these possibilities requires careful exploration of the meaning of the concept of preference. Following a brief critical conceptual analysis, consideration is given to the ways in which conversations around preferences can contribute to the development of the therapeutic relationship, the construction of a reflective space within therapy, and the process of building bridges between therapy and the everyday life of the client.

A critical conceptual analysis of “preference”

The research on client preferences is mainly organised around studies in which clients are asked to make choices between different forms of therapy or are invited to complete questionnaires that ask them about which types of therapy activity (e.g., exploring feelings, working on behaviour change) they believe would be most useful for them. In research terms, the concept of preference is ‘operationalised’ as a cognitive process that involves responding to different pre-determined options. A key aspect of the essential meaning of preference, in these studies, refers to an implied action tendency – client preferences are activities and behaviours that the person would be willing to do. However, a preference is different from an actual commitment to do something or the

actual behaviour of taking that action. Expressing a preference is also somewhat nuanced: the person is not saying that he or she would only do that thing, or will refuse all other options. These are some of the meanings that I draw on when I use the concept of “preference”.

This kind of conceptual analysis makes it possible to see why it is not necessarily a straightforward matter to integrate preferences into therapy practice. From the point of view of the therapist, there is a lot happening when a client expresses a preference. In order to arrive at a fuller understanding of what is involved in expressing a preference, it can be useful to consider the meaning of other concepts, adjacent to and connected with the concept of preference, that have been used within the therapy research literature. There are quite a few alternative concepts that can be found within ‘preference territory’: beliefs, attitudes, expectations, choice, credibility of treatment models, insider knowledge, theory of change, theory of cure, multiple intelligence, and learning style. If this cluster of concepts is going to have an impact on therapy practice, it will be necessary for someone to sort out how they all fit together, and what they all mean. For example, the idea of ‘expectation’ has received quite a lot of attention within the research literature. It seems clear that there is an overlap between expectations and preferences. Both of them refer to the person’s ideas of what might happen. However, the concept of expectation taps into what the person anticipates or believes will happen, whereas preferences refer to what the person wants to happen. On the other hand, one particular aspect of expectations, the area of outcome expectations, has been shown to have an important role in shaping action – clients who positively expect therapy to help tend to do better than those whose expectations are lower (Greenberg, Constantino, & Bruce, 2006).

A valuable conceptual comparison can be made between preference and other ideas such as ‘theory of change’ (Duncan & Miller, 2000), ‘insider knowledge’ (White & Epston, 1990) and “theory of cure” (Philips, Wennberg, & Werbart, 2007). ‘Preference’ implies some kind of micro choice-point. For example; ‘I would prefer to have a therapist who challenges me, rather than one who is merely supportive’. By contrast, ideas such as theory of change, insider knowledge and theory of cure refer to structured and organised sets of ideas that have been built up over time. From the point of view of a therapist, it may be important to know whether a preference is merely a micro-choice (‘my last therapist was too nice to me, and that did not help’) or in fact reflects a deeper level of understanding (‘I have learned that I get into difficulty in my life when I intellectualised and avoid difficult issues, and that is why I want you to be more willing to challenge me’).

Another way of making sense of the concept of preference is to consider how its meaning draws on various cultural discourses. The most obvious cultural referent for the concept of preference is the discourse around consumerism and the person as consumer. A consumer is someone who has preferences for different types of product and service. Commercial companies make substantial investments in shaping consumer choices. Often, this is accomplished by implying links between micro-choices (e.g., choice of hair shampoo) and lifestyle options. There can be quite a lot of resistance, and even anger, among therapists, in relation to the importation of consumerist practices into the world of

therapy. Basically, consumers are being manipulated by multinational companies. The earth's resources are wasted on trivial choices. In addition, from the perspective of many therapists, people who are caught up in being 'consumers' lose sight of what is really important in life.

However, the cultural meaning of being a consumer, and expressing preferences, is also associated with ideas about standing up for rights, and resisting the control of corporate enterprises. There are consumer movements that act collectively to demand high standards of service, or to secure fair wages for workers. The concept of preference may, for some clients and therapists, evoke these meanings. Within this same discursive arena, the same ideas are used by governments and health care organisations to signal a move to a position where the rights and choices of service users are given some weight. For some individuals, this positioning may be viewed as genuine, while for others it may be regarded as empty rhetoric, or worse.

Finally, the meaning of 'preference' can be viewed through the lens of psychotherapy theory. Some therapists would be uncomfortable with any assumption that a statement of preference can ever be quite what it seems. Some therapists might wish to argue that there is always an implicit or unconscious aspect to human awareness and decision-making. Other therapists might suggest that different parts of the self might express contrasting preferences. There is an undoubted truth in these positions. For example, it is easy to identify situations in therapy in which a client was not able to articulate a positive or negative preference around a therapy activity, until that activity actually took place. For instance, a client might not know that group therapy felt oppressive, until they had been in a group for a few weeks. A client might not know that dream work was wonderful, until they tried it. Where were these preferences, before the event?

The discussion in this section does not claim to offer a comprehensive conceptual analysis of the idea of client preferences. The intention, instead, is to make it clear that there is important conceptual work to be done. One of the practical implications that flows from analysis of the concept of preference, is that it is important to be careful around the use of language when referring to this issue. A substantial amount of research and practical work has been carried out within the field of medicine, into the ways in which doctors can engage in shared decision-making that takes account of the health beliefs and preferences of patients. A comprehensive and accessible review of this literature can be found in [Mulley, Trimble and Elwyn \(2012\)](#). Within this body of work, patient preferences are typically examined in relation to concepts such as 'decisions' or 'options'. What has been found is that, though technically correct, these terms act as barriers. Their meaning is not readily familiar to patients. These concepts implicitly assume that patients are willing to take active roles in decision making, whereas patients are often unaware that decisions are required, or have taken place, never mind feel that they could or should have participated in them ([Entwistle & Watt, 2006](#)). Some medical researchers have sought to develop ways of talking about preferences that more directly connect with

the reality of the patient. For example, one of the key questions in a scale developed by [Elwyn et al. \(2013, p.104\)](#) is: 'How much effort was made to include what matters most to you in choosing what to do next?'

Preference in relationship

At its heart, counselling and psychotherapy is a relationship. Everything that happens in therapy takes place in the context of a relationship between the client and the therapist. As a result, an adequate understanding of the role of client preferences in therapy needs to incorporate a relational perspective.

One of the conclusions that has been strongly supported by research is that the therapeutic alliance acts as a powerful mediator between preference and outcome: clients who feel that their therapist is responsive to them, and 'talking their language', report higher alliance levels at an early stage in therapy, which in turn forms the basis for later productive therapeutic work ([Elkin et al., 1999](#); [Iacoviello et al., 2007](#); [Kwan, Dimidjian & Rizvi, 2010](#)). However, unpacking the complexities of the relational dimension of client preferences has not been a particularly central issue within the research that has been carried out. As a contribution to stimulating further discussion in this area, I would like to suggest that it may be valuable to consider four key relational aspects of client preferences: relational style, collaboration and therapist transparency.

Most research into client preferences has been based on either asking the person which treatment approach they would favour (e.g., psychodynamic versus CBT), or has invited them to rate their preference for items in a list of therapeutic elements or activities. In respect of the latter type of study, one of the preference scales that has been shown to have predictive value, in terms of outcome, is the *Psychotherapy Preferences and Experiences Questionnaire* (PEX-P1) ([Berg, Sandahl, & Clinton, 2008](#)). This 25-item scale includes statements that reflect change processes/activities, such as 'learning to forget painful memories' and 'learning practical solutions to concrete problems'. However, it also includes items that refer to the client's ideas about the kind of therapeutic relationship that he or she would prefer, for example 'getting active support' and 'working with an active, initiative-taking therapist'. Other client preference and expectations scales include similar items (e.g., [Bowen and Cooper, 2012](#)). The implication here is that people who seek therapy have ideas about the relationship style that they believe would be most helpful for them, and that effective therapists are able, at least to some extent, to adjust their way of being with their clients in order to acknowledge these needs.

Attention to client preferences can form an important element in the process of building a collaborative relationship. Curiosity about what the client believes might be more (or less) helpful in therapy, has the effect of positioning the client as resourceful and active within the client-therapist relationship. It also conveys respect for the client. It introduces the client to the idea that the responsibility for what happens is shared between both participants in therapy. These relational characteristics would be widely regarded by therapists as desirable. It is worth noting that engaging in conversations around

preferences goes beyond merely telling the client that therapy is a joint endeavour. Instead, these conversations provide a practical demonstration of what working together can mean in practice.

Attention to client preferences also leads to an appreciation of the role of therapist transparency. Client preferences do not, and can never, exist in relation to a limitless set of possibilities. Client preferences always exist in relation to therapist preferences, understood in terms of the theory and way of working of the actual, embodied therapist with whom a client is interacting. At a relational level, statements of preference (on either side) always lead to some form of negotiation. If a client is asked about his or her preferences, without any opportunity to know what is on offer, then he or she is straight away at a disadvantage. In this scenario, the client needs to guess what it is that their therapist might be willing to offer. This is probably not a helpful position for a client to be in, particularly at the start of therapy when their priority is to deal with pressing worries and bad feelings. It therefore seems likely that the expression and exploration of client preferences is facilitated by therapist transparency around what they are able to offer. There are many ways in which a therapist can convey this kind of information to a client. Therapist personal statements on their websites, or in leaflets provided to clients, are necessarily brief, but can at least anchor what is on offer in some general principles, or can be used to direct the client to where they can read more about the therapist's approach. Therapist explanations of what they have to offer can also be embedded in the on-going process of therapy, particularly in early sessions (Oddli & Rønnestad, 2012).

Theory and research on therapist transparency and self-disclosure has been mainly concerned with issues around sharing of biographical information and immediate thoughts and feelings triggered by client behaviour. The client preference literature introduces an added emphasis: the act of sharing information about how one works, and what one has to offer, which represents a significant aspect of therapist transparency.

These relational aspects of responsiveness to client preferences – relationship style, collaboration and therapist transparency/self-disclosure – need to be seen as merely some start points. A massive amount of research on the therapeutic alliance, has demonstrated that therapist 'alignment' with the client is necessary for good outcome.

Much of the research on this topic has drawn on Bordin's (1979) conceptualisation – a good alliance is built around a strong emotional bond, alongside agreement around the goals and tasks of therapy. Incorporating a client preference perspective into this conceptualisation introduces some further possibilities. It may be that a strong client-therapist alliance depends on arriving at a workable shared understanding of what an alliance should look like. It may also be that a strong alliance requires the therapist to meta-communicate around what is on offer, and show willingness to shift their way of being in the direction of the client's preferred relational style. In this context, it is of interest that one of the main characteristics of therapists who achieve the best results, is that they possess highly developed interpersonal skills that allow them to respond to client feedback in a non-defensive manner (Anderson et al., 2009).

Conversations around preferences create reflective spaces

There seems little doubt that there are many ways in which psychotherapy can help people. When clients are asked about what has been helpful for them, they describe a wide range of events – there is no evidence that the value of therapy can be reduced to a single change process (Timulak, 2007). Nevertheless, the possibility for reflection afforded by talking to a neutral stranger for an hour, would appear to be a near-universal element within all forms of therapy. People seek therapy because they are troubled, in the sense of being caught up in recurring cycle of painful emotions, unsatisfying interactions with others, bad habits, and self-undermining thoughts. Seeing a therapist opens up a space in which it is possible to stand back, or stand aside, from these cycles, and begin to develop a broader perspective on what is happening. In this context, a conversation around client preferences can be seen as a particular type of reflective space. Any invitation to consider preferences can be regarded as an invitation to engage in personal reflection. Preference conversations can be regarded as a form of personal reflection that possesses certain distinctive characteristics. If a therapist invites a client to reflect on the meaning of some aspect of their behaviour, or on the sequence of events that lead up to something that happened in their life, the assumption is that there will probably be a single ‘correct’ or coherent account that can be given (‘I realise now that I felt really angry when...’). By contrast, talking about preferences implies that there are many potentially ‘correct’ responses. In addition, the person can scan as much of their past experience as they like, in formulating their response. These characteristics of preference conversations allow for a way of talking that can be tentative, playful and creative. Another significant aspect of preference conversations is that they are hope-supporting. Implicit in any invitation to talk about preferences is the idea that there is something that, in the end, will have the potential to be helpful.

A further therapeutically useful feature of preference conversations is that they are two-sided. When a therapist invites a client to reflect on how they feel, the client is mainly on their own with this task. By contrast, a preference conversation involves reflecting together: the client reports on his or her reflection on what might be helpful, while the therapist responds with their own reflections on how these suggestions might fit into the process of therapy. Preference conversations, as forms of reflection, can also be facilitated or scaffolded by the use of ‘conversational tools’ such as brief client feedback scales (Sundet, 2009, 2012).

Conversations around client preferences fit readily into early sessions of therapy, and represent an invitation to reflection that is potentially more accessible to clients than other types of reflection that are used in therapy. Attention to preferences may therefore comprise an effective means of establishing an active and meaningful role for reflection within the on-going process of therapy. Initiating this kind of conversational topic can also function as a test of a client’s readiness to engage in reflection. Any therapist who has an interest in client preferences will have encountered some clients who find it hard to specify any of their own ideas about what might be helpful. Given the multiple points of entry into such a conversation, and the lightness with which a discussion can be pursued, it is likely that a client who is not ready to reflect on how they think that therapy might help, will not be someone who engages reflectively with other topics either.

Research into client and therapist experience of moments in therapy when preferences are talked about, and the conversational strategies that are brought into action, has the potential to provide a more nuanced understanding of this process, and to make a valuable contribution to training and practice.

Client preferences as a point of contact with everyday life

A central theme that emerges when clients talk about their ideas of what might be helpful for them, refers to the extent to which therapy preferences are grounded in the person's experience of everyday life. Sometimes this link is determined by practical circumstances. A client may prefer a short-term problem-focused approach to therapy because they cannot afford the time or money to engage in long-term exploration of the childhood origins of their problems. A different client may steer clear of emotion-focused or experiential exercises because they need to go back to work after a therapy session and do not want to get so upset that colleagues will ask them where they have been. In other situations, clients are aware of what has worked for them in the past, or has not worked. In a study of client preferences for counselling for alcohol problems, [Walls \(2014\)](#) found that all of the individuals who were interviewed could draw on long experience of struggling to overcome addiction, as a source of understanding of the type of therapy relationship that was helpful for them, and the types of therapy activities that they believed would be most useful. The question of how therapy relates to everyday life has been explored in studies by [Dreier \(1998, 2000, 2008\)](#) and [Mackrill \(2008\)](#). These researchers were able to show that all of the clients they observed or interviewed had acquired ideas and coping strategies through the course of their lives, and assessed the value of therapy in terms of the degree to which it was consistent with, or allowed further elaboration of, their everyday practices. [Cooper and McLeod \(2011\)](#) have suggested that there exist a wide range of cultural resources, such as reading, art, music, spirituality, outdoor pursuits, pets, and much else, that have been shown to have positive impacts on well-being. When clients are encouraged to talk about these resources, it becomes possible to use these activities to supplement the work that is done in the therapy room. With many clients, the primary function of a relationship with a therapist may be to support initiatives within everyday life settings.

In studies by [Walls \(2014\)](#) and [Vollmer et al. \(2009\)](#), extended interviews, outside of actual therapy sessions, were used to enable client exploration of therapy preferences. In that situation, individuals with no special knowledge or training in therapy were able to talk in a detailed and coherent way about what they thought would be helpful for them in their therapy. These findings support the view that everyday life experience represents a source of therapeutic understanding that may not always be sufficiently integrated into the therapy process.

Conclusions

The aim of this paper has been to reflect on the practical meaning of the concept of client preference, with regard to the process of counselling and psychotherapy. It is possible to see that attending to preferences has the potential to open up therapeutically valuable

areas of conversation and dialogue between client and therapist. It is not sufficient to regard client preferences as merely tickets or vouchers that the client can cash in. Instead, it is more appropriate to conceptualise preferences in action language terms (Schafer, 1976), as an indicator of what a client sees himself or herself as willing or ready to *do*. From that perspective, *preferring* or *mattering* can be viewed as a higher order construct that refers to a bundle of practices that have the potential to be enacted: *doing homework tasks, expressing emotions, making sense of a puzzling personal reaction*. Developing an understanding of what the client regards as meaningful and helpful action is a crucial aspect of therapy. No matter the problem with which they are struggling, most people do as much as they can to resolve the issue by drawing on their own resources, before they consider turning to therapy. The common starting point for much of therapy is the client's sense of being stuck. In this context, conversations around preferences can be viewed as a way of identifying plausible actions that might be taken to become unstuck. The impact of preferences-talk does not lie solely in being able to find the central change activity that *will* be key to helping the client moving on (although this is welcome when it occurs). Talking about preferences is more a matter of being able to hold a conversation around things that *could* help. As a conversational strategy, therefore, some of its power lies in encouraging small but meaningful shifts from a stance of 'nothing can help' to 'there are some actions that might, just, help'.

Researchers have played a central role in documenting the significance of attending to client preferences, in relation to various types of therapy outcome. The present paper can be regarded as representing an attempt to carry forward some of the work of looking at what these research findings might imply, within the arena of therapy practice. Ideally, research and practice should spark off each other in a cyclical manner. Taking account of the meaning that a construct might have for practitioners, should make it possible for researchers to articulate more focused research questions and conceptually richer theoretical models. The ideas explored within the present paper suggest at least two directions for further research. One direction would be to avoid any tendency to impose closure on how 'preferences' are defined and measured. Up to now, client preferences have been operationalised in terms of preferences for specific models of therapy, or preferences for specific therapy activities and interventions. It seems clear that client preferences stretch somewhat beyond these domains. For example, clients express preferences for different types of relational style, ways of thinking (Pearson, 2011) and scheduling arrangements (Carey, 2005, 2007).

A further direction that might be taken by researchers with an interest in client preferences, would be to look in more detail at what happens when preferences are discussed in therapy, and the decisions and actions that follow from such conversations. The suggestion was made in earlier sections of this paper, that such moments or episodes in therapy may be potentially helpful and significant for clients, in a number of ways. There are several methodological approaches that might be applied to the task of exploring this hypothesis in greater depth.

A final point that is certain is that clients have a lot more to teach us about the meaning and functioning of client preferences in the context of counselling and psychotherapy. Recently, I was involved in two studies, as yet unpublished, that used qualitative interviews to explore different aspects of the client's experience of preference-holding and choice-making within therapy (Bowie, 2014; Walls, 2014). One of the striking findings to emerge from both of these studies was the extent to which the client talked about, and possessed an awareness of, their own *negative* preferences for what might happen in therapy. Yes, the clients who were interviewed had ideas about what they were looking for from a therapist, and activities that might be more or less helpful for them. But, at the same time, they also had a sense of what would not be possible for them to accept, or might lead them to quit therapy. As far as I am aware, the concept of negative preferences has not been considered in the preferences research that has been carried out so far – the assumption has been that beneficial outcomes arise from being in receipt of good things, rather than being (at least partially) the result of not being exposed to bad things. As with the topic of positive preferences, the issue of negative preferences has similar potential to open up therapeutically valuable conversations.

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