An Exploration of Activity and Therapist Preferences and Their Predictors in German-Speaking Samples

DISSERTATION

zur Erlangung des akademischen Grades

Doctor philosophiae

(Dr. phil.)

im Fach Psychologie

eingereicht bei der Humanwissenschaftlichen Fakultät der

Universität Potsdam

von

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2023

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Datum der Disputation: 01.09.2023

Published online on the
Publication Server of the University of Potsdam:
https://doi.org/10.25932/publishup-60753
https://nbn-resolving.org/urn:nbn:de:kobv:517-opus4-607534

Acknowledgements

Ich möchte meine tiefe Dankbarkeit meinen beiden Betreuer:innen Florian Weck und Franziska Kühne ausdrücken, die mich gefördert und mir damit zahlreiche Wege in der Wissenschaft und der Ausbildung zum Psychotherapeuten eröffnet haben. Sie standen mir im gesamten Promotionsprozess mit Geduld, Rat, Vertrauen und konstruktivem Feedback zur Seite. Ohne ihre umfassende Betreuung wäre diese Arbeit nicht möglich gewesen. Zudem möchte ich meinen wissenschaftlichen Kolleginnen Ulrike Maaß, Destina Ay-Bryson, und Alexandra Schöttler für ihre Unterstützung, die vielen entlastenden Gespräche zur Motivationssteigerung und die großartige Zusammenarbeit einen großen Dank aussprechen. Darüber hinaus danke ich auch den nicht-wissenschaftlichen Kolleg:innen Ewa Gartenschläger, Arne Klopfleisch und Maik Schellhase für ihre administrative Unterstützung sowie die lustigen Gespräche und Pausen, die Leichtigkeit in jeden Arbeitstag brachten. Weiterer Dank gebührt Guido Hesselmann und Claudia Meißner als Mentor:innen, die in mir die Begeisterung am wissenschaftlichen und therapeutischen Arbeiten geweckt haben.

Ein riesiger Dank gilt meinen Eltern Grit Heinze und Heiner Frohn für ihre bedingungslose Liebe und moralische, emotionale und auch finanzielle Unterstützung in jeder Lebensphase. Sie haben mir gelehrt, offen auf neue Themen oder Ansichten anderer Personen einzugehen sowie mit Ehrgeiz und Durchhaltevermögen meine Ziele zu verfolgen. Weiterer großer Dank an meinen Bruder Jan Freymann als eines meiner größten Vorbilder, der mich immer wieder zu neuen Bestleistungen motiviert und mir zusammen mit seiner Ehefrau und der Lektorin dieser Arbeit, Elisabeth Freymann, in allen Lebensbereichen mit Rat zur Seite steht.

Abschließend gebührt weiterer großer Dank allen meinen Freunden, die mich über viele Jahre vor und während der Promotion begleitet haben und immer für mich da waren, ob bei gemeinsamen Unternehmungen und Reisen, aufmunternden Gesprächen in schwierigeren Phasen oder spaßigen Runden zum Abschalten vom alltäglichen Arbeiten.

Abstract

According to current definitions of evidence-based practice, patients' preferences play an important role for the psychotherapeutic process and outcomes. However, whereas a significant body of research investigated preferences regarding specific treatments, research on preferred activities or therapist characteristics is rare, investigated heterogeneous aspects with inconclusive results, lacked validated assessment tools, and neglected relevant preferences, their predictors as well as the perspective of mental health professionals. Therefore, the three studies of this dissertation aimed to address the most fundamental drawbacks in current preference research by providing a validated questionnaire, focus efforts on activity and therapist preferences and add preferences of psychotherapy trainees. To this end, *Paper I* reports the translation and validation of the 18-item Cooper-Norcross Inventory of Preference (C-NIP) in a broad, heterogeneous sample of N = 969 laypeople, resulting in good to acceptable reliabilities and first evidence of validity. However, the original factor structure was not replicated. *Paper II* assesses activity preferences of psychotherapists in training using the C-NIP and compares them with the initial laypeople sample. There were significant differences between both samples, with trainees preferring a more patient-directed, emotionally intense and confrontational approach than laypeople. CBT trainees preferred a more therapist-directed, present-focused, challenging and less emotional intense approach than psychodynamic or -analytic trainees. *Paper III* explores therapist preferences and tests predictors for specific preference choices. For most characteristics, more than half of the participants did not have specific preferences. Results pointed towards congruency effects (i.e., preference for similar characteristics), especially for members of marginalized groups. The dissertation provides both researchers and practitioners with a validated questionnaire, shows potentially obstructive differences between patients and therapists and underlines the importance of therapist characteristics for marginalized groups, thereby laying the foundation for future applications and implementations in research and practice.

Zusammenfassung

Aktuelle Definitionen von evidenzbasierter Psychotherapie betonen neben Faktoren wie Therapiearten, Interventionen, Therapeut:inneneffekte, Beziehungseffekte und Patient:innenfaktoren die Relevanz von Präferenzen für den Therapieprozess und -erfolg. Während Behandlungspräferenzen bereits in vielen Studien untersucht wurden, gibt es nur wenige heterogene Ergebnisse zu Präferenzen bezüglich des psychotherapeutischen Vorgehens sowie gewünschter Eigenschaften von Psychotherapeut:innen. Zudem fehlen ein validierter Fragebogen, wichtige Präferenzen und deren Prädiktoren sowie die Perspektive der Behandler:innen. Die Dissertation greift daher die größten Lücken der Präferenzforschung im Rahmen von drei Studien zu Aktivitäts- und Therapeut:innenpräferenzen auf.

Paper I stellt die Übersetzung und Validierung des Cooper-Norcross Inventory of Preferences in einer breiten Bevölkerungsstichprobe (N = 969) dar. Obwohl die Originalfaktorstruktur nicht repliziert werden konnte, erfasst die Skala vier Faktoren der Aktivitätspräferenz reliabel und valide. *Paper II* ergänzt eine Stichprobe von N = 466 Psychotherapeut:innen in Ausbildung (PiA) und vergleicht diese mit der ursprünglichen Bevölkerungsstichprobe. PiAs präferierten dabei einen signifikant stärkeren patientengeleiteten, emotional fordernden und konfrontativen Ansatz. PiAs der KVT präferierten im Vergleich zu PiAs der Psychoanalyse oder -dynamik einen therapeutengeleiteten, gegenwärtigen, konfrontativen und weniger emotional fordernden Ansatz. *Paper III* untersuchte Präferenzen hinsichtlich mehrerer Therapeut:inneneigenschaften und deren Prädiktoren. Für die meisten Eigenschaften gaben mehr als die Hälfte der Proband:innen an, keine spezifischen Präferenzen zu haben. Es zeigten sich jedoch Kongruenzeffekte, insbesondere für Personen aus marginalisierten Gruppen. Die Dissertation legt den Grundstein für künftige Anwendungen von Präferenzen für Forschende und Behandelnde, indem ein validierter Fragebogen vorgestellt, potentiell hinderliche Unterschiede zwischen Patient:innen und Therapeut:innen beschrieben und die Relevanz von Therapeut:inneneigenschaften für marginalisierte Gruppen dargestellt wird.

List of Original Papers

Paper I

Heinze, P. E., Weck, F., & Kühne, F. (2022). Assessing patient preferences: Examination of the German Cooper-Norcross Inventory of Preferences. *Frontiers in Psychology*, *12*:795776. https://doi.org/10.3389/fpsyg.2021.795776

Paper II

Heinze, P. E., Weck, F., Hahn, D., & Kühne, F. (2023). Differences in psychotherapy preferences between psychotherapy trainees and laypeople. *Psychotherapy Research*, *33*(3), 374-386. https://doi.org/10.1080/10503307.2022.2098076

Paper III

Heinze, P. E., Weck, F., & Kühne, F. (2023). Preferences for an ideal psychotherapist: What therapist characteristics do laypersons prefer? *Professional Psychology: Research and Practice*, *54*(3), 241-251. https://doi.org/10.1037/pro0000508

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List of Abbreviations

EBP ..... evidence-based practice

CBT ..... cognitive-behavioral therapy

PD ..... psychodynamic therapy

PA ..... psychoanalysis

ST ..... systemic therapy

APA ..... American Psychological Association

PTSD ..... posttraumatic stress disorder

PPAS ..... Preference for Psychotherapy Approaches Scale

TAP ..... Treatment Acceptability and Preference Measure

CPF ..... Counseling Preference Form

TPEX ..... Treatment Preferences and Experiences Questionnaire

PEX ..... Psychotherapy Preferences and Experiences Questionnaire

PCCI ..... Preference for College Counseling Inventory

TPF ..... Treatment Personalization Form

C-NIP ..... Cooper-Norcross Inventory of Preferences

SES ..... socio-economic status

EFA ..... exploratory factor analysis

CFA ..... confirmatory factor analysis

ESEM ..... exploratory structural equation model

ANOVA ..... analysis of variance

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An Exploration of Activity and Therapist Preferences and Their Predictors in German-Speaking Samples

1. Introduction

"*What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?*" (Paul, 1969, p. 111)

Dating back more than 50 years, this influential quote outlined the components necessary to treat patients effectively. To answer this question, both researchers and practitioners alike put an enormous effort into the development, implementation and evaluation of psychotherapeutic diagnostics and treatments. The dissemination of scientific results into general clinical practice marked an important step of implementing evidence-based practice (EBP) in psychotherapy. At present, numerous meta-analyses identified that, in general, psychotherapy treatment is highly effective in the treatment of mental disorders (e.g., depression, anxiety disorders, personality disorders, etc. (Gaskell et al., 2023; Munder et al., 2019; Rameckers et al., 2021)). These positive effects can be found across various therapeutic approaches like cognitive-behavioral therapy (CBT), psychodynamic (PD), psychoanalytic (PA) or systemic therapy (ST). Moreover, there are multiple treatment interventions that show particular effectiveness in the treatment of specific disorders, e.g., dialectic-behavioral therapy for Borderline personality disorder (Rameckers et al., 2021) or the cognitive behavioral analysis system of psychotherapy for the treatment of chronic or persistent depression (Negt et al., 2016). Taken together, so far, research has mainly addressed the question of what treatment is (most) effective for a multitude of specific symptoms and disorders. However, studies usually report symptom improvement or other outcomes on a group-level, i.e., averaged across all participants within a (sub-)sample. This depiction of scientific results masks individual treatment courses: Even within samples receiving an overall beneficious and effective treatment, there is a substantial amount of patients who do

not benefit from the treatment (Reuter et al., 2016). Moreover, some participants discontinue their treatment and are thus not included in the outcome (Swift et al., 2017; Swift & Greenberg, 2012). Therefore, to fully implement EBP into psychotherapy, other research questions posed by Paul (1969) need to be answered, e.g., what characteristics of an individual other than their diagnosis influence treatment processes and outcomes. Moreover, the American Psychological Association (APA) constituted the goal to further individualize psychotherapeutic treatment and tailor methods and therapy circumstances to the individual patient and their characteristics (American Psychological Association, 2006). However, not much was known about factors or predictors other than treatments and interventions influencing patient outcomes and engagement. Thus, investigations shifted increasingly towards other factors relevant for a successful therapy, e.g., therapist characteristics such as competence, interactional aspects such as the therapeutic alliance, or patient variables such as attachment styles, cultural backgrounds or preferences regarding different aspects of psychotherapy (Constantino et al., 2021). Meta-analyses suggest that preferences play an important role in psychotherapy processes and engagement, as patients who did not receive their preferred treatment (aspect) suffered from worse symptom improvement, higher dropouts or lesser therapeutic alliance (Lindhiem et al., 2014; Swift et al., 2018; Windle et al., 2020). However, so far, research focusing on other relevant preference factors other than preferred treatment such as preferred interventions, therapeutic styles or therapist characteristics lacks fundamental tools and evidence. Therefore, it is currently difficult for researchers and practitioners alike to implement preferences to tailor psychotherapy to the individual patient for potential improvements in therapy processes and outcomes. Therefore, the dissertation aims to a) provide a psychometrically sound assessment tool of preferences for research and practice, b) identify potential obstacles in the treatment process due to a lack of preference assessment and accommodation, and c) identify therapist characteristics important to a general public.

2. Theoretical and Empirical Foundations

In the theoretical part of this dissertation, I contextualize preferences as one important facet of EBP in psychotherapy that contributes to successful treatments and better patient outcomes. Following this section, I define, categorize and conceptualize preferences, summarize efforts to assess preferences and review which preference choices and associated predictors have been investigated so far. Last, I summarize all findings in a working model of preferences that informs the three studies of this dissertation.

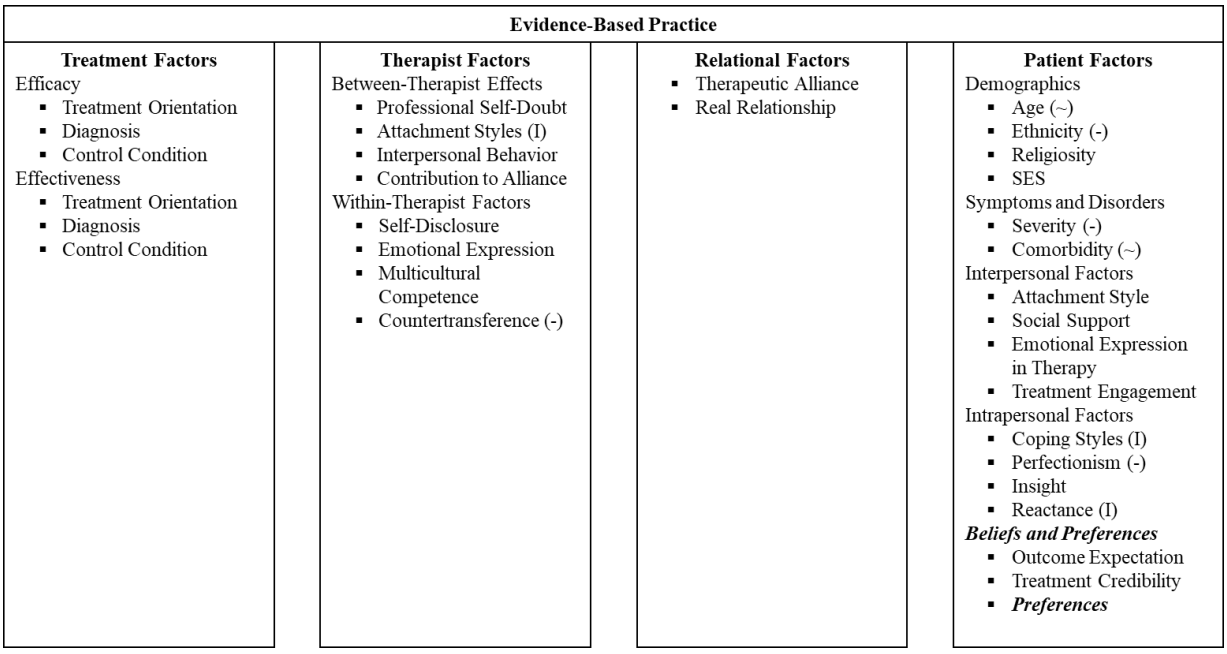
2.1. Preferences as Part of Evidence-Based Practice in Psychotherapy

Even though there are many effective and efficacious treatments for mental disorders at hand, not all patients equally benefit from treatments: Chances are that they do not show any improvements (Reuter et al., 2016) or drop out of treatment due to individually inacceptable features or circumstances of therapy (Swift & Greenberg, 2012). To maximize the likelihood of improvements and ensure high treatment quality, individuals as well as organizations argued for the integration of scientific evidence and clinical practice early on (Shakow et al., 1947). The APA defined that "[e]vidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." (American Psychological Association, 2006, p. 273). Thereby, the APA recognized four factors determining the outcome of psychotherapy: First, treatment factors describe the efficacy and effectiveness of treatments (Barkham & Lambert, 2021). Second, therapist factors (i.e., variations between therapists as well as within a single therapist between different patients) such as professional self-doubt or therapist self-disclosure can facilitate symptom improvement (Constantino et al., 2021; Heinonen & Nissen-Lie, 2020). Third, relational factors such as the therapeutic alliance or real relationship between patient and therapist are relevant for improved outcomes (Constantino et al., 2021; Flückiger et al., 2018). Fourth and most relevant for this dissertation, the APA explicitly stated the inclusion of cultural aspects as well as patient characteristics and preferences as

patient factors (Constantino et al., 2021). An overview of all factors that are associated with patient outcomes based on meta-analytic evidence is presented in Figure 1.

Figure 1.

Factors in Evidence-Based Practice Contributing to Patient Outcomes



Note: Figure adapted from Barkham & Lambert (2021), Constantino et al. (2021) and Wampold & Owen (2021). Figure presents only factors with meta-analytic evidence. (-) indicates negative association with patient outcomes, (~) shows inconclusive results and (I) indicates interaction effects with other relevant factors.

The APA put special emphasis on psychotherapy preferences as a central component of EBP to maximize patient choice between different approaches (American Psychological Association, 2006). EBP thus requires “balancing patient preferences and the psychologist’s judgment – based on available evidence and clinical expertise – to determine the most appropriate treatment” (American Psychological Association, 2006, p. 280). However, in order to implement a best practice-approach, psychologists are still in need for a reliable and valid diagnostic tool for psychotherapy preferences. Moreover, at this point, practitioners’

judgment is limited since there is little evidence what processes, interventions and therapist characteristics are actually important to patients. Furthermore, it is unclear how preferences can impact the psychotherapeutic process. Therefore, the dissertation will focus on these aspects by providing a validated questionnaire, investigating the relevance of preferences for a variety of therapist characteristics, and contrasting preferences of psychotherapists in training and laypeople.

2.2. Definition and Categories of Preferences

In psychotherapy, preferences are defined as anticipatory choices regarding specific characteristics or treatment aspects that individuals wish to have in psychotherapy (Swift et al., 2011, 2018). Preferences need to be distinguished from the similar concept of expectations which shares the anticipatory nature, but rather describes what is expected to happen during psychotherapy (Tracey & Dundon, 1988). For example, an Arabic refugee might prefer a psychotherapist with a similar cultural background and language (i.e., preference), but expect treatment by an English-speaking therapist as there might be very few Arabic therapists in their vicinity (i.e., expectation; Roberts, 2017). An early conceptual paper on preferences (Grantham & Gordon, 1986) described multiple characteristics of preferences: First, preferences are proposed to be multidimensional, i.e., people can have multiple different preferences regarding a variety of psychotherapy characteristics that can be independent from one another and differ in the degree of desirability. Second, preferences are proposed to be dynamic. Therefore, the content of their preferences as well as the degree of desirability can change over time. Third, preferences operate on different levels of consciousness, i.e., un-, sub- or consciously. To illustrate this aspect, imagine patients who drop out of treatment due to unfulfilled preferences: They might be able to state directly that they received pharmacological instead of psychotherapeutic treatment that they actually preferred (conscious), or they might be able to state that they did not want the treatment they received

without explicitly having a preferred alternative (subconscious), or they might simply think that the initial treatment is not the right one for them (unconscious).

The multitude of possible preferences are subsumed into three distinct categories (Swift et al., 2011, 2018): First, *treatment preferences* describe what kind of treatment an individual wishes to have. For example, patients might prefer a psychotherapeutic treatment rather than a psychopharmacological treatment, or they might prefer CBT over PD. Second, *activity preferences* include all characteristics and aspects that patients wish to happen during the course of psychotherapy treatment or within single sessions, e.g., the kind of interventions used, the directivity of the therapist or patient, or a confrontational and emotional-focused rather than a supportive and cognitive approach, respectively. Third, *therapist preferences* subsume all preferences regarding different characteristics of a preferred psychotherapist, e.g., gender, experience or religion of a therapist. Moreover, therapist preferences also include preferences regarding the personality of a psychotherapist.

2.3. Preference Conceptualization

So far, there is no comprehensive model for psychotherapy preferences and its determinants. However, as preferences are defined as choices for multiple treatment characteristics and processes (Grantham & Gordon, 1986), studies have suggested several mechanisms how individuals arrive at a specific preference choice, though many results were based on medical conditions rather than mental disorders. First, preferences are based on the knowledge and understanding of different options (Corrigan & Salzer, 2003; Miranda, 2004). One study in particular found that knowledge about different options shapes preferences: If exposed to information about effectiveness and disadvantages of different options, participants had stronger preferences (Miranda, 2004). Moreover, there are various studies reporting that prior experiences of psychotherapy (either personally or experiences of close other people) predicted specific preference choices (e.g., Dwight-Johnson et al., 2000; Khalsa et al., 2011; Russell et al., 2022; Sandell et al., 2011; Simiola et al., 2015). Preference

decisions do not have to be based on research evidence and established facts, but studies also suggested that mere beliefs and common understandings of preference choices are sufficient to form decisions (Ilagan & Heatherington, 2022). For example, patients could prefer a treatment alternative over CBT even though there is no scientific evidence for the alternative's effectiveness. Several studies showed that different etiological beliefs about the symptoms and disorders like biological or psychological reasons for depression led to different preference choices (Dunlop et al., 2012; Goldstein & Rosselli, 2003; Khalsa et al., 2011; Lin et al., 2005; Winter & Barber, 2013).

Second, it seems relevant how individuals perceive the credibility and acceptability of the treatment options or processes (Sidani, Epstein, et al., 2009). For example, when asked to imagine developing a posttraumatic stress disorder (PTSD) and seeking help, the most preferred options for treatment (exposure and CBT) were associated with higher ratings of treatment and intervention credibility and perceptions of positive personal reactions (Becker et al., 2007). Individuals have positive attitudes and attributions towards treatment characteristics when they perceive the treatment as appropriate and effective for the current symptoms (Sidani, Miranda, et al., 2009; Struch et al., 2008; Thacher et al., 2005) and that benefits outweigh costs and side-effects (Thacher et al., 2005; Winter & Barber, 2013). Moreover, perceptions of suitability to lifestyle and convenience also leads to more positive attitudes towards different options (Miranda, 2004; Thacher et al., 2005). One study showed that a student population rated treatment options for PTSD as acceptable if the treatment is non-intrusive, easy to apply, effective and appropriate (Tarrier et al., 2006). Accordingly, acceptability ratings were positively associated with preferences for treatment options (Milosevic & Radomsky, 2013; Tarrier et al., 2006).

Thus, depending on the knowledge and understanding as well as the perceived acceptability and credibility of different options, individuals differ in their preferences towards different treatments. However, most of the results were based on medical conditions

rather than psychological disorders. Moreover, they mainly focused on treatment preferences or preferences for different interventions rather than on different process variables or therapist characteristics. Thus, even if decision-making processes are likely to be similar for preferences towards other aspects such as therapist characteristics, the current lack of research leads to a limited generalizability. Furthermore, especially for therapist characteristics, other factors such as stereotypes towards different characteristics, public images of therapists (von Sydow, 2007) or personal comparators of specific characteristics (Russell et al., 2022) might factor into the perceived acceptability of therapists. Therefore, there is still a need to identify predictors of preference choices. With this information, researchers could implement measures accounting for preference differences between samples, such as comprehensive descriptions of treatments and relevant aspects for participants of clinical studies, whereas practitioners are enabled to anticipate and accommodate preferences of individual patients more easily.

2.4. Preference Assessment

2.4.1. Overview of Methods

There are several ways to measure patient preferences depending on the setting (Karlsson, 2005). In quantitative research, differences on the group-level are of interest, i.e., two (or more) different groups are compared to one another regarding specific preferences. Such preferences are preferably measured using closed questions (“What type of treatment do you prefer?”) with limited response options (e.g., CBT, PD, PA, ST, other). However, this method has three drawbacks: First, participants might not find the exact option that represents their preference, resulting in the extensive use of an “other”-category. Second, the degree of preference strength is unclear. Whereas one participant might tick the box for CBT although only having a slight preference over PD, other participants’ preferences for CBT might be so profound so that they are not willing to accept any alternative at all. Third, closed questions can result in socially desirable responses, i.e., participants do not use the option they actually

prefer due to fear of negative consequences of their choice. For example, a patient applying for an outpatient clinic might not state their preference for the only male therapist in the clinic as they might expect longer waiting periods to receive their preferred option.

To avoid these drawbacks, there are more indirect methods at hand (Karlsson, 2005). Participants in several studies rated the desirability or other secondary features like the therapists' competence in multiple (fictitious) case vignettes that only differed in a single aspect (Atkinson et al., 1989; Cole et al., 2019; Furnham & Swami, 2008; Helweg & Gaines, 1977; Kessler et al., 2020). The results are interpreted that participants prefer the aspect with the most favorable rating. Another method is a delay-discounting measure in which participants have the option to choose between a therapy with low efficacy that includes the preferred feature or a therapy with high efficacy, but without the desired feature (Swift et al., 2015). Across all trials, the efficacy of the preferred therapy is iteratively increased. The degree of preference is defined as the first time where participants switch to the preferred, but less efficacious treatment rather than sticking to the non-preferred, highly efficacious option. However, all described measures are only able to investigate the preference for one specific feature, and thus are less helpful for practitioners due to the high probability that the questions do not include the exact feature or option that an individual patient actually prefers. Therefore, there are options for practitioners that seek to implement preference assessment and accommodation into their treatments. First, clinicians can use open-ended questions like "What interventions do you prefer not to happen during your treatment?". This allows the patient to freely express all personal preferences. However, especially patients that are not experienced with psychotherapy or are not familiar with the procedure and content of psychotherapy might face difficulties to indicate any preferences. Therefore, and second, there are several English questionnaires at hand for patients to fill in. The following section including Table 1 presents the most influential questionnaires to measure preferences to date.

Table 1

Preference Questionnaires

Name	Authors	Number of Items	Exemplary Item	Factors	Reliability
Preference for Psychotherapy Approaches Scale (PPAS-R)	Petronzi & Masciale, 2015	4	I would willingly pay to see this therapist.	One factor each for CBT, PD, PCT	α = .88 - .92
Counseling Preference Form (CPF)	Goates-Jones & Hill, 2008	10	I prefer my counselor to help me gain a new perspective on my life.	Insight Preference Action Preference	Retest: *r* = .50
Treatment Preferences and Experiences Questionnaire (TPEX)	Levy Berg et al., 2008	29	It is important to help me define concrete goals.	Outward Orientation Inward Orientation Support Catharsis	α = .78 α = .77 α = .81 α = .82
Psychotherapy Preferences and Experiences Questionnaire (PEX)	Sandell et al., 2011	50	Be helped by setting concrete goals.	Externalization Internalization Catharsis Support Defensiveness	α = .85-.86
Preference for College Counseling Inventory (PCCI)	Hatchett, 2015	68	I would like to develop concrete, practical solutions for solving my problems.	Therapist Expertise Therapist Warmth Therapist Directiveness Task-Oriented Activities Experiential-/Insight-Oriented Activities	α = .89 α = .90 α = .89 α = .92 α = .92
Treatment Personalisation Form (TPF)	Bowens & Cooper, 2012	20 semantic differentials	I would like my therapist to focus on specific goals vs. I would like my therapist to just be with me in the therapeutic relationship.	Therapist Direction Past Focus Therapist's Use of Self	n.a.
Cooper-Norcross Inventory of Preferences (C-NIP)	Cooper & Norcross, 2016	18 semantic differentials	I would like my therapist to focus on specific goals vs. I would like my therapist not to focus on specific goals	Therapist vs. Client Directiveness Emotional Intensity vs. Emotional Reserve Past vs. Present Orientation Warm Support vs. Focused Challenge	α = .84 α = .67 α = .73 α = ..60

Note: CBT = cognitive-behavioral therapy. PD = psychodynamic therapy. PCT = person-centered therapy. n.a. = not available.

2.4.2. Questionnaires

For the measurement of treatment preferences (e.g., CBT or PD), most studies limit their approach to closed questions with several response options (e.g., Khalsa et al., 2011; Lin et al., 2005; Shepardson et al., 2021). The Preference for Psychotherapy Approaches Scale (PPAS) is an exception due to its thorough development and validation as well as its standardized approach. The original version by Holler (2006) gave participants three one-page vignettes describing the treatment options of PD, CBT, and person-centered therapy. After reading the vignettes, participants were asked to rate their preference for each treatment on a 10-point Likert scale (1 = *definitely not prefer* – 10 = *strongly prefer*). Five therapists provided ratings showing that each vignette represented the respective approach to a high degree. The scale was adapted first by Petronzi and Masciale (2015) who substituted the single item with four items and changed the response format to a five-point scale (1 = *strongly disagree* – 5 = *strongly agree*). Internal consistencies for all three vignettes were good to excellent (α = .88 - .92). Later, a vignette for positive psychology positive masculinity treatment was added for a study focusing on male participants (Cole et al., 2019). Reliabilities were slightly lower (α = .76 - .79). Overall, the PPAS is unique in its standardization and validation effort for a measure of treatment preference, as other studies usually used closed questions or conceived their own items (Dancey et al., 1992; Kealy et al., 2021; Tompkins et al., 2017). However, there are no studies that exclusively use the PPAS, but it is usually combined with the Counseling Approach Evaluation Form (Lyddon, 1989) for a "larger, more robust psychotherapy preference measure" (Cole et al., 2019, p. 49; Petronzi & Masciale, 2015, p. 301). Moreover, the design of vignettes for alternative treatment options as well as translations are time-consuming as cultural adaptations seem necessary and experts need to evaluate the representativeness of the adaptations. Another inferior option using vignettes for different treatments is the Treatment Acceptability and Preference Measure (TAP; Sidani et al., 2009), which rather focuses on treatment acceptability assessment rather than measuring

preferences. Moreover, except for one adaptation for depression treatments (Houle et al., 2013), it was only used for studies on insomnia treatments.

Other standardized measures focus on activity preferences, i.e., preferences regarding different interventions or therapy styles such as directivity, emotional focus or supportiveness. The Counseling Preference Form (CPF; Goates-Jones & Hill, 2008) adapted the helping skills approach (Hill, 2020) to measure preferences for insight-oriented (i.e., interventions helping the client to understand the influence of early life events on current problems) or action-oriented counseling (i.e., interventions helping the client to learn new skills). Choosing items of the insight factor scores +1, and items of the action factor score -1. The sum score indicates an individual's preference toward insight-oriented psychotherapy (sum ≥ 3) or action-oriented psychotherapy (sum ≤ -3). Scores between +2 and -2 result in no preferences for either option. The questionnaire was able to differentiate between preferences for one or the other orientation and was able to identify preference shifts of participants during psychotherapy and after watching a videotape demonstrating an insight-oriented session (Goates-Jones & Hill, 2008). However, the questionnaire lacks reliability, items cannot be answered dimensionally, and it is restricted to preferences regarding helping skills (Goates-Jones & Hill, 2008). Therefore, its usefulness in clinical practice is limited, especially in Germany where the helping skills approach is not common.

The Treatment Preferences and Experiences Questionnaire (TPEX; Levy Berg et al., 2008) and the Psychotherapy Preferences and Experiences Questionnaire (PEX; Sandell et al., 2011) are highly similar, as they both ask respondents to "rate the extent to which they believe they would be helped by specific interventions and therapist characteristics" (Levy Berg et al., 2008, p. 250) on 6-point Likert scales. Both scales result in four or five factors, respectively. Externalization / Outward Orientation focuses on problem solving, Internalization / Inward Orientation specifies internal mental processes such as reflection, Catharsis indicates the expression of strong feelings, and Support asks therapists to encourage and validate patients.

The PEX adds Defensiveness as an additional factor that focuses on avoidance. Both questionnaires were used for several mental disorders such as generalized anxiety disorders (Levy Berg et al., 2008), panic disorders (Svensson et al., 2021), or substance use disorders (Philips & Wennberg, 2014). The TPEX was able to predict psychology students' future choice of psychotherapy orientation, psychotherapy outcomes and treatment satisfaction (Levy Berg et al., 2008). Several factors of the PEX were able to predict clusters of participants preferring PD, CBT and cognitive therapy (CT) treatment based on credibility ratings and rank-ordered preferences (Sandell et al., 2011). However, the most important criticism of both scales is that they measure helpfulness beliefs of different activities rather than preferences. Since helpfulness and preference ratings are not congruent, it is possible for participants to believe that exposition interventions will be helpful, but still not to prefer this approach due to fear of being overwhelmed by strong emotions. Moreover, the factors do not only include items indicating beliefs about different interventions and activities, but also about characteristics of therapists. Thus, the accommodation of preference factors of the TPEX/PEX is difficult since characteristics of therapists are hardly changeable.

The Preference for College Counseling Inventory (PCCI; Hatchett, 2015) is another promising approach for standardized preference measurement and, despite its name suggesting a limit to counseling settings, could be used for several psychotherapy settings and orientations. On the first seven of its 68 items, respondents can choose their preferred options for type of counselling (e.g., individual or group), length of treatment, and preferred therapist gender, sexual orientation, ethnic background, professional background and religious background. All other items are rated on a 5-point Likert scale (1 = *not true* – 5 = *definitely true*). In comparison to the PEX that mixes activity and therapist preferences within its factors, the PCCI has three separate factors for therapist preferences (Therapist Expertise, Warmth, and Directiveness) and two factors for activity preferences (Task-Oriented and Experiential/Insight-Oriented Activities). All factors showed good to excellent reliabilities,

and were discriminant with help-seeking attitudes (Hatchett, 2015). However, there are some limitations to the PCCI: First, the scale showed high intercorrelations between the factors, as well as ceiling effects and limited variance for Therapist Expertise and Warmth. Thus, the factors might be redundant as almost all participants prefer a warm, supportive and well-trained psychotherapist. Second, implementation of the questionnaire into clinical practice can be limited due to the length of the questionnaire. Third, the questionnaire was validated using undergraduate students, and to the best of my knowledge, there are no further publications of the PCCI in the clinical context.

Bowens & Cooper (2012) used a separate approach for their Treatment Personalization Form (TPF): The scale can be used on a regular basis to track patients' wishes in order for the practitioner to adapt to changing needs. To this end and in contrast to prior assessment tools, the questionnaire asks respondents to fill in twenty semantic differential items, i.e., respondents can pick a score between two extreme poles. The midpoint of the 11-point scale shows practitioners that they do not have to change the relevant aspect, and variations towards either end of the scale conveys the degree of patients preferring to receive either more or less of an activity. The original study validates the scale using a qualitative approach: Both practitioners and patients found the scale useful and helpful for therapy (Bowens & Cooper, 2012). However, the TPF was rarely used, with two theses resulting in two different numbers of factors and only acceptable to low reliabilities (Cooper & Norcross, 2016).

In order to improve on the previous efforts of developing a standardized preference scale that can be used both in research and practice, Cooper and Norcross (2016) based their item development process for the Cooper-Norcross Inventory of Preferences (C-NIP) on all the previously mentioned scales and obtained 40 items. They kept the semantic differential approach of the TPF in order to avoid response biases toward either very high or very low preferences for every item. Respondents can indicate their preference on a 7-point scale.

Again, the midpoint of the scale represents no preference or equal preference for both extreme poles. For their development process, the authors were able to recruit *n* = 228 laypeople and *n* = 615 mental health professionals. After conducting an exploratory factor analysis (EFA) and optimizing scale length by excluding items without compromising reliabilities, the psychometric analysis process resulted in 18 items and four factors: *Therapist Directiveness vs. Client Directiveness* (5 items) indicates preference for either a structured, therapist-led therapy or an unstructured, client-led approach (item example: "I would like the therapist to focus on specific goals vs. not focus on specific goals."). *Emotional Intensity vs. Emotional Reserve* (5 items) captures respondents' preference for either a therapy with high emotional expression and a focus on the therapeutic relationship, or a cognitive, less emotional approach (example: "I would like the therapist to encourage me to go into difficult emotions vs. not encourage me to go into difficult emotions."). *Past Orientation vs. Present Orientation* (3 items) indicates whether a patient wants to talk about either past or present and future stages in their life (example: "I would like the therapist to focus on my life in the past vs. focus on my life in the present."). *Warm Support vs. Focused Challenge* (5 items) captures preferences for a supportive and understanding or a focused and challenging approach (example: "I would like the therapist to be challenging vs. be gentle."). The questionnaire also includes open-ended questions for therapist and treatment preferences such as preferred therapist language, gender, or religion as well as length of sessions and treatment or treatment orientation. However, the open-ended questions are only designed for use in clinical practice, and were not yet part of any analysis or publication. At the start of this dissertational project, there were no further publications of the C-NIP. Thus, it still lacked an independent replication of its factor structure, especially since the authors did not perform a confirmatory analysis after their item selection process. Moreover, the initial study only provided intercorrelations between all factors, but did not provide any evidence for the validity of the questionnaire (Cooper & Norcross, 2016).

Taken together, there were several efforts to develop a standardized measure to capture psychotherapy preferences. However, most scales suffered from ambiguous or fuzzy definitions of preferences and low reliabilities despite high numbers of items. Most importantly, none of the questionnaires was picked up by following research or was implemented into clinical practice as most questionnaires were only adapted for a few studies at most. Therefore, even more than one decade after their publication, the validity of most scales is still unclear. So far, the C-NIP was the most promising effort to measure psychotherapy preferences in a standardized and universal manner as it based its developmental process on all previous questionnaires. However, the C-NIP still lacked an independent replication of its initial factor structure, as well as a thorough validation. As there are no German questionnaires available to the best of my knowledge, part of this dissertation was the translation of the C-NIP into German to ensure consistency with international efforts of preference assessment (due to other translations into languages like Portuguese, Czech, or French (Malosso, 2019; Řiháček & Mikutová, 2022; Volders, 2021)), to replicate the initial factor structure of the original C-NIP and to validate the questionnaire (see Paper I).

2.5. Preference Choices and Predictors

In the following sections, I provide an overview of the research evidence on a) what specific treatments, activities and characteristics are preferred, and b) predictors of specific preference choices based on a non-systematic review of the literature. Tables 2 and 3 summarize the findings for treatment and therapist preferences, respectively.

2.5.1. Treatment Preferences

Treatment preferences indicate what kind of treatment a patient prefers (Swift et al., 2011). For example, patients could wish for psychotherapeutic or pharmacological treatment, or for specific psychotherapy orientations such as CBT, PD, or ST. Overall, treatment preferences are the most prominently investigated facet of preferences due to their easy assessment and implementation into randomized controlled settings (Delevry & Le, 2019).

Since the dissertation mainly focuses on activity and therapist preferences, I limit the review of treatment preferences to the most important aspects and predictors of preferences choices.

Psychotherapy or Medication. Most studies compared treatment preferences for either a psychotherapeutic or psychopharmacologic treatment (Charles et al., 2021; Churchill et al., 2000; Dwight-Johnson et al., 2000; Houle et al., 2013; Kealy et al., 2021; Khalsa et al., 2011; Kwan et al., 2010; Lang, 2005; Lin et al., 2005; McHugh et al., 2013; Mohlman, 2012; Riedel-Heller et al., 2005; Shepardson et al., 2021; van Schaik et al., 2004). Three separate meta-analyses found that a vast majority of participants preferred psychotherapy over psychopharmacological treatment (McHugh et al., 2013; Simiola et al., 2015; van Schaik et al., 2004).

There are various predictors that affect preferences towards psychotherapy over medication (as summarized in Table 2). Sociodemographic features associated with preference for psychotherapy were female gender on a meta-analytic level (McHugh et al., 2013; Simiola et al., 2015; van Schaik et al., 2004), African-American ethnicity (Dwight-Johnson et al., 2000; Khalsa et al., 2011; Lin et al., 2005), and higher socio-economic status (SES; Dwight-Johnson et al., 2000; Houle et al., 2013; Mohlman, 2012; Shepardson et al., 2021; van Schaik et al., 2004). Younger age was a significant predictor in a single meta-analysis (McHugh et al., 2013), whereas many studies reported no significant associations (Churchill et al., 2000; Dwight-Johnson et al., 2000; Houle et al., 2013; Mohlman, 2012). Participants with positive attitudes, beliefs and perceptions of treatments such as less stigma of psychotherapy treatment (Dwight-Johnson et al., 2000), internal attribution of symptoms (Churchill et al., 2000; Lin et al., 2005), endorsement for childhood or negative life events as reasons of current problems (Khalsa et al., 2011; Riedel-Heller et al., 2005) were more likely to prefer psychotherapy over medication. The effect of current symptom levels is inconclusive due to positive (Dwight-Johnson et al., 2000; Tompkins et al., 2017), negative (Lang, 2005; Lin et al., 2005) and non-significant findings (Churchill et al., 2000; Kealy et al., 2021) alike.

Different Psychotherapy Orientations. Patients preferred CT or CBT over various treatment orientations such as PD or PA (Bragesjö et al., 2004; Dancey et al., 1992; Mohlman, 2012; Ogunfowora & Drapeau, 2008; Pistrang & Barker, 1992; Sandell et al., 2011; Simiola et al., 2015; Tarrier et al., 2006), person-centered psychotherapy (McLeod & Sweeting, 2010), and humanistic approaches (Dancey et al., 1992; Ogunfowora & Drapeau, 2008). Some notable exceptions are clickworkers preferring PD or person-centered approaches (Petronzi & Masciale, 2015), men preferring an approach tailored to male patients over CBT (Cole et al., 2019), or primary care patients preferring other approaches like stress management (Lang, 2005; Mohlman, 2012).

Again, researchers identified predictors for preference choices: Women were more likely to prefer non-CBT and even niche approaches (Bragesjö et al., 2004; Ogunfowora & Drapeau, 2008; Sandell et al., 2011; Sobel, 1979), younger participants having higher preferences for both CBT (Cole et al., 2019; Mohlman, 2012) or PD (Petronzi & Masciale, 2015; Sandell et al., 2011) than older participants, and only three studies showing overall inconclusive results on SES due to heterogeneity of investigated SES factors (Cole et al., 2019; Helweg & Gaines, 1977; Mohlman, 2012). Patients with prior experience in psychotherapy were more likely to prefer PD in a single study (Bragesjö et al., 2004), whereas another study found no association with prior experience (Sandell et al., 2011). Current symptoms were positively associated with preference for evidence-based treatment (Lang, 2005; Pistrang & Barker, 1992). CBT preferences were predicted by beliefs that benefits of therapy are caused by problem-solving training (high externalization), and less by past-oriented emotional focus (low internalization), whereas preferences for PD were predicted by an opposite pattern (low externalization, high internalization, and focus on emotional expression) (Sandell et al., 2011). Only two studies investigated personality predictors of treatment preferences, with preferences for CBT being predicted by conscientiousness (Ogunfowora & Drapeau, 2008) and a lack of fearful attachment styles (Petronzi & Masciale,

2015), whereas low agreeableness, high extraversion and openness as well as high secure attachment predicted PD preference (Ogunfowora & Drapeau, 2008; Petronzi & Masciale, 2015)

In summary, participants primarily prefer CBT treatment over medication and other psychotherapeutic approaches. Overall, gender, age, ethnicity, SES as well as prior knowledge, beliefs and personality seem to predict treatment preference choices and are adequate to include for exploration in future studies on other preference choices.

Table 2

Treatment Preferences and Predictors

Preference	Predictors	General Tendency of Association
Preferring Psychotherapy over Medication		
	Gender	Women more likely than Men
	Age	Inconclusive
	Ethnicity	African American more likely than White
	SES	Positive Association
	Knowledge	Inconclusive, Tendency for Positive Association
	Attitudes towards PT	Positive Association
	Symptom Level	Inconclusive
Preferring CBT over Other Orientations		
	Gender	Women less likely than Men
	Age	Negative Association
	SES	Inconclusive
	Prior Experience with PT	Inconclusive
	Beliefs	Positive Association with High Externalization & Low Internalization
	Personality	Inconclusive

Note: SES = socio-economic status, PT = psychotherapy, CBT = cognitive-behavioral therapy, PD = psychodynamic therapy.

2.5.2. Activity Preferences

Activity preferences cover all aspects during the course of psychotherapeutic treatment or in single sessions such as preferred interventions as well as client or therapist activities. For example, activity preferences of a patient with an anxiety disorder might cover their preferences for exposition interventions, a focus on emotional rather than cognitive aspects and the preference for directiveness of the psychotherapist. The activity preference section focuses on descriptions of single studies, since activity preferences cover a large variety of process variables and due to the limited number of studies published on this topic.

Some studies focused on interactional aspects and therapeutic styles during psychotherapy sessions. In an early study, female students showed clear preferences towards therapists with an intimate treatment style, i.e., providing a warm, secure, and calm environment rather than being dominant and forceful (Mindingall, 1985). In a qualitative study prior to this dissertation, $N = 375$ laypeople preferred an individual, adaptive approach, and therapist directiveness (Kühne et al., 2021). Men preferred client-directed approaches and therapists who do not act in a "teacher-like manner" (Kealy et al., 2021, p. 31). Counseling clients endorsed an egalitarian therapeutic relationship most, followed by preferences for cognitive guidance, open communication and emotional support (Tracey & Dundon, 1988).

Other studies focused their effort on preferences regarding specific interventions or topics that participants wished over the course of their treatment. A majority of clickworkers and especially participants with prior therapy experience endorsed therapy based on common factors rather than an individualized approach (Swan & Heesacker, 2013). Other samples including laypeople, patients with generalized anxiety disorder or an African-American sample put emphases on problem-solving and self-management skills (Charles et al., 2021; Kühne et al., 2021; Levy Berg et al., 2008). Men receiving outpatient treatment wished to identify and understand underlying patterns in their experience and behavior (Kealy et al., 2021). Moreover, they expressed preferences to be encouraged to experience and express their

emotions and to learn effective coping techniques (Kealy et al., 2021; Levy Berg et al., 2008). Veterans and primary care patients with anxiety preferred psycho-education, mediation and mindfulness interventions over behavioral activation or exposure therapy (Shepardson et al., 2021). More specifically, they wished the treatment to focus on worries, sleeping problems and panic attacks rather than on bodily symptoms or mood. Moreover, there is extensive research on preferences regarding spiritual and religious topics in psychotherapy. A review of 64 studies with over 64,000 participants reported mixed findings (Harris et al., 2016): Whereas a majority of participants preferred spiritual topics in psychotherapy (especially religious people; Swift et al., 2022) for various reasons like essentiality or personal importance (Rose et al., 2001), there is a substantial number of participants who object spiritual or religious topics (S. Mohr & Huguelet, 2014). The importance of integrating spiritual or religious topics depended on the magnitude of beliefs (Oxhandler et al., 2021; Sandage et al., 2022; Stanley et al., 2011). However, almost all studies focused on US-American and Christian samples.

Several studies also investigated preferences for different treatment formats. Most samples preferred individual over group therapy (Charles et al., 2021; Hatchett, 2015; Kealy et al., 2021; Mohlman, 2012; Shepardson et al., 2021), especially participants with higher need for help (Shepardson et al., 2021), female gender, and less knowledge about psychotherapy (Dwight-Johnson et al., 2000). Other studies report predictors of preferences for group therapy such as older age (Kealy et al., 2021; Mohlman, 2012), higher education and financial resources (Kealy et al., 2021) or higher preferences of African-American participants in comparison to White participants (Charles et al., 2021). Male participants preferred 10-25 sessions or unlimited therapy over the options of less than 10 sessions or 26-50 sessions (Kealy et al., 2021). Moreover, preferred length of therapy was positively associated with age as well as degrees of work and social impairment. A majority of a veteran sample indicated that they preferred anxiety treatment with more than 13 appointments and

with one appointment of 45-60 minutes per month (Shepardson et al., 2021). However, in a sample of *N* = 387 students, 34.1% did not have preferences for length of therapy, and 23% preferred 2-5 sessions for college counseling (Hatchett, 2015).

Taken together, due to incoherent measurement approaches and the large variety of different activities that can be of interest for researchers, practitioners and patients, it is difficult to summarize and generalize results of the current literature. In order to receive more comparable and coherent study results, there is a need for a reliable and valid questionnaire that is useful in both research and practice. Such a measurement tool can also provide a clearly defined focus on the most relevant activities and provide comparable results across different samples. To this end, part of the dissertation is the translation and validation of the Cooper-Norcross Inventory of Preferences in order to provide a tool that can be implemented in a multitude of settings (see Paper I).

Activity Preferences of Mental Health Professionals. One major limitation of all studies reported in the previous section is the exclusive focus on laypeople or patients. There is one noteworthy exception of Cooper and colleagues (2019; 2016) reporting preferences of mental health professionals regarding the four factors of the C-NIP. Mental health professionals (i.e., [trainee or licensed] counselors, psychotherapists or psychiatrists) indicated preferences for client directiveness and emotional intensity, as well as no clear preference towards either past or present orientation and warm support or focused challenge. To the best of my knowledge, this study is the only investigation focusing on activity preferences of mental health professionals. However, the professional perspective is highly relevant for several reasons: First, consensus and agreement between patient and therapist leads to better outcomes (Chui et al., 2020; Tryon et al., 2018). Given that therapists perform and structure sessions and interventions primarily based on their own experiences and conceptions (Safran et al., 2011; Stewart & Chambless, 2007) due to false-consensus effects (Ross et al., 1977), differences between patient and professional preferences might lead to

disagreement, alliance ruptures or less favorable treatment progress (Lindhiem et al., 2014; Swift et al., 2018; Windle et al., 2020). Since there is only one study available with a perspective of mental health professionals, another aim of this dissertation was to test the assumption of differences between patients and practitioners in order to avoid potential obstacles during the treatment process. To this end, another part of the dissertation is the comparison of preferences between laypeople and psychotherapists in training (see Paper II).

2.5.3. Therapist Preferences

So far, research on therapist preferences focused on sociodemographic and personality characteristics of a preferred therapist. The former includes preferences regarding features such as gender, age, ethnicity, or experience of a therapist. The following paragraph reports the empirical findings for several preferred characteristics of psychotherapists. Table 3 summarizes relevant characteristics, their predictors and general associations.

Gender. Preferred therapist gender gathered the most interest of researchers so far, however, studies showed inconclusive results. Whereas most studies found evidence for congruency effects, i.e., female participants preferring female therapists (Dancey et al., 1992; Furnham & Swami, 2008; Ilagan & Heatherington, 2022; Landes et al., 2013; Lauber & Drevenstedt, 1994; Liddon et al., 2018; Pikus & Heavey, 1996; Walker & Stake, 1978) or male participants preferring male therapists (Furnham & Swami, 2008; D. H. Johnson, 1978; Stamler et al., 1991), other studies report no preferences for therapist gender of male participants (DeHeer et al., 1992; Lauber & Drevenstedt, 1994; Montiel et al., 2022; Pikus & Heavey, 1996; Seidler et al., 2022; Walker & Stake, 1978) or female participants (Bernstein et al., 1987). Moreover, some studies found preferences for the opposite gender, i.e., male participants being more likely to prefer female therapists or female participants being more likely to prefer male therapists (Black & Gringart, 2019; Fuller, 1964; Stamler et al., 1991). In a single study, African American participants were more likely to prefer male psychotherapists (Charles et al., 2021). However, in most studies that report descriptive

statistics, a substantial amount of participants indicated not having any preference regarding the therapist gender, ranging from 26.9% (Bernstein et al., 1987) to 70.2% (Williams et al., 2016). In summary, most participants do not have a specific gender preference. In case they indicate specific gender preferences, it is likely that women have preferences for female psychotherapists, whereas older studies point toward preferences for male therapists irrespective of the participants' gender.

The inconclusive results led researchers to investigate whether the preference for therapist gender is dependent on specific topics that make patients seek help in the first place. Across nine different topics such as career concerns, loneliness or problem with a partner, participants generally preferred male therapists. However, if asked for preference for the treatment of sexual issues, participants indicated preferences for the same gender (Bernstein et al., 1987). In a sample of $N = 187$ female students, significantly more participants preferred female psychotherapists for hypothetical gender-specific problems like pregnancy issues than for gender-neutral problems such as anxiety (Landes et al., 2013). Stamler et al. (1991) reported that participants were more likely to indicate gender preferences when presented with personal, interpersonal and environmental problems in comparison to career or educational problems. In another study, problem type slightly failed to predict gender preferences (Black & Gringart, 2019). Taken together, gender preferences seem to depend on the type of problem that patients want to address in therapy.

Age. Another characteristic of interest is the preferred age of psychotherapists. Overall, younger participants preferred younger therapists, and older participants preferred older therapists (Furnham & Swami, 2008; Lauber & Drevenstedt, 1994). Another study found the same effect, but only for female participants (Donnan & Mitchell, 1979). In an early study, the authors reported preferences for middle-aged therapists (40 years) over elder therapists (55 years) and young therapists (25 years; Simon, 1973). A recent German study found no preference for either young or old age of psychotherapists in a sample of $N = 79$

young female participants (Kessler et al., 2020). However, for age-specific problems of young participants such as bullying or lovesickness, participants preferred a young psychotherapist, whereas they preferred an elder psychotherapist for universal problems such as grief. In a Hong Kong college student sample, participants preferred younger therapists over older therapists (Ip et al., 2016). Again, the overall picture of age preferences points towards congruency, but preferences seem to be dependent on the type of problem.

Ethnicity. Given the high ethnic diversity in the population of the United States, several studies conducted in this area focused on preferences regarding therapists' ethnicity in diverse samples. Two separate meta-analyses and a narrative review reported clear evidence of people preferring therapists of their own ethnicity (d = 0.63, Cabral & Smith, 2011; d = 0.73, Coleman et al., 1995; Farsimadan et al., 2011). In detail, preferences were strong for African American and Hispanic American participants, whereas Asian and White American participants did not have preferences for a therapist of their own ethnicity (Cabral & Smith, 2011). Moreover, participants of an ethnic minority also perceived therapists of their own ethnicity more favorably as therapists of other ethnicities. A higher proportion of African American in comparison to White participants indicated a preference for therapists of the same ethnicity (Charles et al., 2021). Congruency effects were also shown for Native American participants (Beitel et al., 2020). However, similar ethnicity was only rated as the fourth most important quality in a preferred therapist, behind similar attitudes, more education and similar personality, respectively (Bennett & BigFoot-Sipes, 1991).

However, a narrative review stated that studies on ethnicity preferences often suffer from low validity, that samples did not represent psychotherapy patients and that homogenous ethnical groups are difficult to form (Karlsson, 2005). Therefore, two studies implemented a delay-discounting method to measure preferences regarding therapist ethnicity more validly and indirectly (Ilagan & Heatherington, 2022; Swift et al., 2015). In both samples, participants were willing to sacrifice a significant amount of treatment efficacy in order to

receive a therapist of the same ethnicity. Moreover, clients showed higher preferences than students, and preferences were dependent on the level of minority culture identification (Swift et al., 2015). Interestingly, patients were even willing to sacrifice treatment efficacy after being informed that ethnic matching (i.e., patients and therapist are of the same ethnicity) does not improve treatment outcomes (Ilagan & Heatherington, 2022). Again, moderated by the level of minority culture identification, African Americans showed higher preferences than Asian American or White participants. A separate study also showed that preferences in African American participants depended on how central their ethnicity was to their identity, and how much stress the participants experienced due to their ethnic minority status (Nioplias et al., 2018). Taken together, ethnicity seems to be an important preference factor especially for ethnic minorities who strongly identify with their minority status and experience discrimination. In contrast, the preferred ethnicity of the therapist is less important for members of an ethnic majority. However, almost all studies were conducted in the US, and to the best of my knowledge, there is no evidence from German samples despite approx. 40% of the German population sharing a migration background (Statistisches Bundesamt, 2022).

Religion. Another field of interest in the research of therapist preferences is the preference for religious or non-religious therapists. Again, to the best of my knowledge, findings are limited to US-American samples. In a naturalistic sample of N = 175 patients in 13 psychotherapy practices, patients preferred religious integration, the implementation of religious topics into psychotherapy as well as a religious psychotherapist on a moderate level (Swift et al., 2022). Preferences of religious patients were significantly higher than preferences of non-religious patients. Moreover, preferences actually predicted how many religious techniques were used in psychotherapy sessions, and also predicted lower psychotherapy dropout and better symptom improvement. In another sample of more than N = 1,000 patients, both religious and non-religious participants preferred a matching psychotherapist (Dimmick et al., 2022). Furthermore, preferences of non-religious patients for

a non-religious therapist were significantly higher than preferences of religious patients for religious therapists. Similar results were found in a diverse sample of African-American and White undergraduate students, with approx. 35% across both ethnicities endorsing a preference for a therapist with the same religion (Charles et al., 2021). Using a delay-discounting measure, members of the Church of Latter-Day Saints also showed preferences for a Latter-Day Saint therapist (Dimmick et al., 2020). The effect was even more pronounced for highly religious participants in comparison to lesser religious participants. Taken together, patients seem to prefer matching psychotherapists in terms of religion, with preference levels depending on the centrality of religion in the participants' lives. However, studies mainly focused on US-American and Christian samples without including other religions such as Islam or Judaism.

Profession and Experience. There is a branch in preference research investigating preferences regarding the profession of practitioners and their experience in treating patients. In a student sample in Hong Kong, participants indicated preferring clinical psychologists over clinical social workers, educational psychologists, counselors and psychiatrists for the treatment of mental health problems (Ip et al., 2016). Similarly, two other studies also found preferences for mental health professions such as psychologists and psychiatrists over behavioral consultants, emotional counselors, psychoanalysts and social workers (Hatchett, 2015; Simon, 1973). In an early study, students preferred counselors with professional experience over those with personal experience for the treatment of several different problems (Celotta & Bode, 1982). Danish participants with sexual dysfunction preferred either psychologists or physicians for their treatment (Højgaard & Laursen, 2017). Over the course of treatment, preferences shifted to either being indifferent or to the profession of the participant's current mental health professional. Members of the US military preferred a mental health professional who had previously served in the military (T. S. Johnson et al., 2018). In a recent study that we conducted in our lab, knowledge of psychology and different

psychotherapeutic approaches, life- and treatment experience as well as scientific experience were rated as indicators of competent psychotherapists (Kühne et al., 2021). Furthermore, competent psychotherapists should have professional training and adhere to legal and scientific guidelines. Moreover, a doctorate degree of psychotherapists was the least relevant indicator of competency. In summary, participants tend to prefer psychologists and psychotherapists for the treatment of mental health problems over other professions.

Personality. First investigations of preferences regarding specific personality traits of psychotherapists date back to the 1980s. Hartlage and Speer (1980) used a list of 128 adjectives and phrases to identify preferences of $N = 60$ patients. Over 80% of the participants agreed that therapists should be honest, open, and appreciative, whereas attributes like impatient, shy, dependent or overprotective were rated as undesirable. Across four different ethnic groups in the US, more than 60% of participants agreed to one item indicating preference towards a psychotherapist with similar personality (Atkinson et al., 1989). Greenberg and Zeldow (1980) defined prototypical feminine and masculine traits based on the zeitgeist of that time, and reported that male participants more often preferred feminine traits than female participants (such as nurturing, submissive, or deferent), whereas female participants preferred masculine traits (such as autonomous, dominant, confident) more often than male participants. Similar results were found in a replication study using $N = 258$ undergraduate psychology students in 2013, however, the differences were not as pronounced (DeGeorge et al., 2013). Moreover, a majority of the recent sample preferred personal adjustment, nurturance and endurance irrespective of the therapist's gender. Using a qualitative approach, a sample of German laypeople viewed neutrality, friendliness, honesty and patience as indicators of competency in psychotherapists (Kühne et al., 2021). In recent years, the widely-used Big Five-model of personality (Costa & McCrae, 1992) was implemented into psychotherapy preference research, i.e., researchers investigated the preferred levels of therapists' extraversion, agreeableness, conscientiousness, neuroticism and

openness for experiences. Using latent profile analysis in both an undergraduate student and community sample, three different profiles of preferred therapist personality were found (Anestis et al., 2021): a directive, demonstrative profile (low levels of extraversion, agreeableness, conscientiousness and openness, high levels of neuroticism), a warm, emotionally regulated profile (high levels of extraversion, agreeableness, conscientiousness, openness, low levels of neuroticism) and an average profile (average levels on all factors). In another sample of clickworkers and psychotherapy clients, participants preferred emotional stability (i.e., low neuroticism) and conscientiousness most, followed by high levels of agreeableness, openness and extraversion (Russell et al., 2022).

Both studies that integrated the Big-Five model tested different hypotheses to predict personality preferences: Anestis et al. (2021) showed that participants preferred therapists with personality profiles similar to their own, e.g., participants' extraversion correlated positively and significantly with preferred extraversion of therapists. This applied to all factors, with the exception of neuroticism. Russell et al. (2022) investigated how personality profiles of other close relationships (e.g., parents, close friend, romantic partner) or the personality of the participant's actual therapist were associated with preferred personality factors. In fact, personality scores of a close friend were most similar, and ratings of parents' personality were most dissimilar to preferred personality scores. The similarity depended on the relationship satisfaction with the other person, i.e., the more satisfied participants were with their relationship to a close other person, the more similar were the personality profiles of that close other person to a preferred psychotherapist. Summarizing personality preferences, people seem to prefer psychotherapist with similar personality to themselves and to persons with fulfilling and wholesome relationships. However, given these handful of studies, there still is a need for conceptual replication and more results from different samples in different countries other than the US.

Understudied Characteristics. So far, research has not yet investigated some therapist characteristics that might be of interest for laypeople. For example, to the best of my knowledge, there are no quantitative studies that investigate whether patients prefer research experience of therapists. Given the ideal postulated in scientist-practitioner models, both theoretical and practical scientific experience seem to provide benefits for the treatment of patients (Blair, 2010). Focusing on beliefs of helpfulness as indicators for preferences, on the one hand, scientists are perceived as hard-working, intelligent and curious (Ferguson & Lezotte, 2020). Thus, patients might prefer therapists with a scientific background as they could infer higher chances of positive outcomes. On the other hand, especially psychological science is perceived skeptically by the general public, stating the impossibility to find general consensus since all people are individual, or that results are not replicable (Lilienfeld, 2012). Therefore, it can also be hypothesized that laypeople do not prefer therapists with scientific expertise.

Another example of an understudied therapist characteristic which patients could prefer is political attitudes. As mentioned above, preferences do not have to correspond with actual experiences in the psychotherapy process where political controversies are often disregarded. However, prior perceptions of individuals about the political attitude of therapists might hinder them to seek therapy, especially if they perceive their political attitude as diametrically opposite to a perceived political mainstream or the public perception of psychotherapists. Moreover, a study conducted in the US found that therapists disclose their attitude over the course of therapy and that similar political attitudes of therapists and patients lead to higher alliance ratings (Solomonov & Barber, 2018). Given additional prior congruency effects on other characteristics, one could hypothesize that patients also prefer therapists with similar political attitudes to their own. Therefore, some understudied therapist characteristics could be relevant for laypeople in their help-seeking process, and thus need to be explored scientifically.

Overall, preference studies regarding sociodemographic characteristics and personality of therapists primarily showed congruency effects, i.e., patients preferred therapists with similar characteristics. However, for most other characteristics, the evidence is still inconclusive due to a significant number of opposite or null results. Some characteristics that might affect patients and their preferences like preferred experience and political attitudes have not been investigated before. Moreover, studies almost exclusively based their results on English-speaking samples. Furthermore, especially studies investigating personality preferences incorporating current personality models have only recently emerged and are still isolated. Therefore, part of this dissertation aims at a comprehensive study including the replication of therapist preference results, the exploration of new preferred characteristics and predictors of preferences in a German-speaking sample (see Paper III).

Table 3

Therapist Preferences and Predictors

Preference	Predictors	General Tendency of Association
Gender	Gender	Congruency for Female Participants
	Type of Problem	Congruency
Age	Age	Positive Relationship
	Type of Problem	Congruency
Ethnicity	Ethnicity	Congruency (Larger for Members of Minorities)
	Culture Identification	Positive Relationship
Religion	Religion	Congruency
Personality	Self-Reported Personality	Congruency
	Personality of Close Others	Congruency

Note: Congruency indicates preference for characteristics congruent to the predictor, e.g., preference for a therapist congruent to an age-specific problem or congruent to the personality of a close other person.

2.6. Preference Accommodation

After assessing patients' preferences, researchers and practitioners know what a patient prefers. However, preference choices in themselves do not seem to have an impact on the psychotherapy process and outcome, except for a single study reporting that patients with preferences for focused challenge showed better progress at the end of treatment (Cooper et al., 2022). Therefore, it is relevant how practitioners make use of preference choices. To this end, therapists can use a guideline for the accommodation of patients' preferences (Norcross & Cooper, 2021): First, therapists can either adopt and match the preferences of their patients. Second, they can adapt to the patient's preferences by offering an approach similar to the patient's wishes. In this case, they should weigh the benefits of preference accommodation with other relevant treatment aspects such as effectiveness. Third, therapists can show patients alternatives to their preferred options. Fourth, if preference accommodation is not possible, they can refer the patient to another therapist.

Multiple meta-analyses reported the positive effect of preference accommodation on process and outcome variables. Overall, accommodation leads to higher rates of treatment engagement and better outcomes (see Table 4; Lindhiem et al., 2014; Swift et al., 2011, 2018; Windle et al., 2020). In detail, all meta-analyses report better overall treatment outcome, i.e., improvements in symptom levels or overall functioning, with effect sizes ranging from d = 0.12 – 0.28. However, Windle et al. (2020) found a significant effect only for global outcomes and not for depression or anxiety symptoms (d = 0.01 [-0.18, 0.20]). Moreover, preference accommodation led to less dropout or higher treatment completion rates with large differences in effect sizes (d = 0.17 – 1.79). The benefit of improved treatment satisfaction was only shown by Lindhiem et al (2014). Windle et al. (2020) also reported the significant impact on the therapeutic alliance (d = 0.48 [0.15, 0.82]), and non-significant findings on attendance (d = 0.37 [-0.13, 0.39]) and remission rates (d = -0.02 [-0.24, 0.20]). To explain the differences between the meta-analyses, the studies used different definitions and samples: Whereas Swift

et al. (2018) included all preference categories and different types of treatment accommodation, the other two meta-analyses solely focused on randomized trials investigating treatment preferences and matching patients to a (non-)preferred treatment. Moreover, Windle et al. (2020) focused on psychosocial rather than psychotherapeutic treatments.

Table 4

Meta-Analytic Findings of Preference Accommodation.

	Swift et al., 2018			Lindhiem et al., 2014			Windle et al., 2020		
Variable	*k*	*n*	*d*	*k*	*n*	*d*	*k*	*n*	*d*
Outcome	51	16,269	0.28* [0.17, 0.38]	26	6,692	0.15* [0.08, 0.26]	4	686	0.12 [-.0.04, 0.33]
Dropout	28	3,237	1.79* [1.44, 2.22]	15	4,013	0.17*[1] [0.10, 0.20]	16	1,857	0.26*[2] [0.12, 0.40]
Satisfaction	-	-	-	14	7,347	0.34* [0.17, 0.50]	3	1,983	-0.03 [-0.12, 0.06]

Note: *k* = Number of Studies. *n* = Number of Patients. *d* = Cohen's d.

[1] Dependent Variable: Treatment Completion. Effect Size transformed from Odds Ratio = 1.37 [1.16, 1.61].

[2] Effect Size transformed from Risk Ratio = 0.62 [0.48, 0.80].

* $p < .05$.

At this point, there are three different hypotheses on how patients could benefit from preference assessment and accommodation (McLeod, 2012). First, participants might improve due to matching effects, i.e., patients are matched to a psychotherapist and treatment according to their preferences. Second, choice effects could lead to better treatment engagement and outcome improvements, i.e., patients who feel that they have a choice might

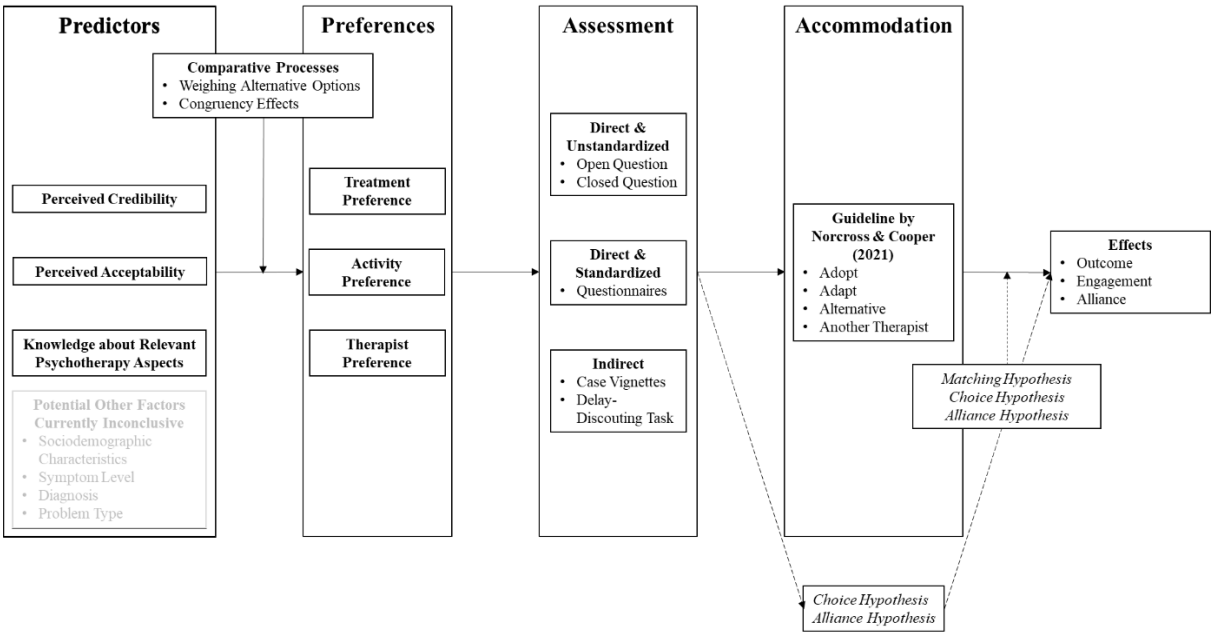
be more invested in the psychotherapy process regardless of whether their preferences are fulfilled. Third, there is also the possibility of alliance effects, i.e., even if preferences are not accommodated, patients benefit of the therapist investing more time and effort to meet the patient's expectations, perspective and life experience by constantly adjusting and responding to the patient's individual needs.

2.7. Working Model of Psychotherapy Preferences

Taken together all the findings reported in the previous sections of the dissertation, the current research on psychotherapy preferences depicts several steps from preference choices up to the beneficial effects of preference accommodation. To summarize and connect all research evidence previously mentioned, I outline a working model as pictured in Figure 2. The working model does not only apply to current patients undergoing treatment, but also to mental-health professionals as well as laypeople unfamiliar with psychotherapy up to the point of accommodation processes that solely take place during psychotherapy treatment.

Figure 2.

Working Model of Psychotherapy Preferences



Note: Dashed lines indicate hypothetical associations.

Before participants report specific preferences towards any treatment, activity or therapist characteristic, they integrate several *predictors* of preferences choices. First, individuals differ in levels of knowledge about relevant aspects of psychotherapy based on prior experience (either personally as patients, professionally as mental health workers, or indirectly as relatives of patients) (e.g., Cooper et al., 2019; Dwight-Johnson et al., 2000; Khalsa et al., 2011; Miranda, 2004; Sandell et al., 2011). Moreover, research suggests that mere beliefs rather than objective facts are sufficient for preference choices (e.g., Khalsa et al., 2011; Sidani, Epstein, et al., 2009; Winter & Barber, 2013). Second, perceptions of credibility and acceptability of therapeutic aspects are relevant for preference choices: Patients are more likely to prefer an option that they perceive as credible and helpful for their improvement, and acceptable considering costs and benefits of treatments (Becker et al., 2007; Sidani, Epstein, et al., 2009; Tarrier et al., 2006; Thacher et al., 2005). Other relevant predictors such as sociodemographic characteristics, symptom levels, diagnoses, or problem types seem to have an impact on preference choices. However, results are still too inconclusive, only apply to specific preferences or depend on other features such as specific samples or assessment methods. Thus, the working model incorporates these factors preliminarily.

To reach a conclusive decision on preference choices, participants then *compare* their alternatives. As evidence for treatment preferences shows, the degree of preference depends on the alternative treatment options that patients can choose from (McHugh et al., 2013; van Schaik et al., 2004). For example, preferences for CBT might be more profound if compared to PA rather than psychopharmacological treatment. Congruency effects in therapist preferences could indicate that individuals who do not have sufficient knowledge about the psychotherapy process and preference alternatives refer to their own personality and characteristics as references for credible and acceptable options (Anestis et al., 2021; Russell et al., 2022).

Subsequently, each person reaches a conclusion on their *preference* choice. According to the initial definition of preferences, preferences are multidimensional (i.e., dimensional for various aspects such as treatment, activity or therapist characteristics), dynamic and work on different levels of consciousness (un-, sub- or conscious) (Grantham & Gordon, 1986).

However, as stated above, merely having preferences does not seem to have in impact on the psychotherapy process and outcome. Therefore, researchers or practitioners should implement *assessment* tools in order to accommodate the preferred options at a later point in the treatment process. As pointed out above, there are several assessment methods at hand (Karlsson, 2005), like open and closed questions, standardized questionnaires or indirect measures.

With the additional information gained through preference assessment, therapists then should aim to *accommodate* preferences. Norcross and Cooper (2021) published a guideline for practitioners on how to accommodate patients preferences by either adopting preferences, adapting preference in relation to other relevant therapeutic aspects, proposing alternatives or referring to another psychotherapist.

At this point, the matching, choice or alliance hypotheses try to explain different processes of how patients can benefit from preference assessment and accommodation, i.e., either by receiving their preferred option (matching hypothesis), having (the perception of) choice and control over specific treatment aspects (choice hypothesis), or due to higher effort by the psychotherapist (alliance hypothesis; McLeod, 2012). The matching hypothesis represents the effect of adopting preferences as mentioned in the guideline, i.e., patients receive the option that they wished for. However, for the choice and alliance hypotheses, it is yet unclear at which point in the process their effects appear. Whereas the benefits can be viewed as effects of preference accommodation according to the guideline, it is also possible that patients' perception of choice or therapist effort is already increasing if they are simply asked for their preferences. In detail, if patients with strong preferences are asked for their

preferences at therapy onset, merely asking could be enough for them to have the perception that they are able to choose their preferred aspects in psychotherapy (choice hypothesis). Moreover, the patients could have a better initial impression of the therapist since the assessment is viewed as an effort to meet the patient (alliance hypothesis). Regardless which hypothesis holds true, meta-analyses already attest the beneficial *effects* of preference accommodation such as better treatment outcomes, less dropouts, higher satisfaction or better therapeutic alliance without clearly distinguishing between the three hypotheses (Lindhiem et al., 2014; Swift et al., 2018; Windle et al., 2020).

At this point, there are several objectives to support or falsify the working model. For example, currently inconclusive predictors need further replication in independent samples and more exploration to determine the most relevant factors. This evidence can inform easier identification for practitioners in therapy as well as prospective efforts to strengthen preferences towards evidence-based factors in the general public. Moreover, current preference research as well as the working model are largely based on evidence from treatment preferences. Thus, activity and therapist preferences need more investigation to evaluate the model as an overarching model of all preference categories. Moreover, the model is primarily based on the patient or client perspective. However, it needs to incorporate other stakeholders in psychotherapy to account for their individual preferences as well, such as mental-health professionals or supervisors. Furthermore, there is need for standardized preference assessment tools both for practice and research in order to accommodate patients' preferences for more beneficial therapy process and outcome. Assessment is also essential to test the three hypotheses explaining preference effects in order to facilitate interventions targeting the associated process like matching, choice or alliance.

3. Aims of the Dissertation

Summarizing the current research on preferences presented above, there are several drawbacks, open questions and hypotheses that can be derived from the working model. Addressing the most fundamental issues, first, questionnaires as an important prerequisite for both researchers and practitioners to accommodate preferences or investigate underlying hypotheses of preference choices and effects have major theoretical limitations, need thorough validation and are not available in German. Second, preferences of mental health professionals who are in charge of accommodating preferences in the psychotherapeutic process are unclear. Third, the working model is largely based on treatment preferences and lacks evidence for both activity and therapist preferences and their predictors. Most studies on activity and therapist preferences are inconclusive, investigate heterogeneous features, do not include aspects potentially relevant to patients or practitioners, need conceptual replication and are mainly based on English samples. To this end, the three studies of this dissertation address the following aims:

1. Translate and validate the Cooper-Norcross Inventory of Preferences (C-NIP) to measure relevant activity preferences in a standardized manner in order to use it in both research and practice as well as to ensure comparability and continuity with international research (Paper I)
2. Investigate activity preferences of psychotherapists in training and compare them to a broad population sample to identify potential disagreements and barriers in psychotherapy (Paper II)
3. Explore therapist preferences in a large German laypeople sample to add new relevant therapist characteristics and to identify predictors of therapist preference choices (Paper III)

4. Overview of Papers

The dissertation consists of three original studies on activity and therapist preferences in German-speaking samples. In the following section, I summarize each of the three studies including a short theoretical background, methods, major findings and short conclusion. The entire papers as published in international, peer-reviewed journals can be found in the appendix (Appendix 1 – 3). Paper I reports the translation of the Cooper-Norcross Inventory of Preferences as well as efforts to replicate the original factor structure and validate the questionnaire. Paper II builds on the results of the first study to investigate differences between laypeople and psychotherapists in training regarding activity preferences as measured by the C-NIP. Paper III focuses on preferences regarding various sociodemographic and personality characteristics of therapists (including previously neglected characteristics such as experience and political attitudes) and explores new predictors of therapist preferences in a German-speaking sample.

4.1. Paper I – Assessing Patient Preferences: Examination of the German Cooper-Norcross Inventory of Preferences

Heinze, P. E., Weck, F., & Kühne, F. (2022). Assessing patient preferences: Examination of the German Cooper-Norcross Inventory of Preferences. *Frontiers in Psychology, 12*:795776. https://doi.org/10.3389/fpsyg.2021.795776

Impact Factor: 4.23 (2021)

Theoretical Background

The accommodation of psychotherapy preferences leads to better treatment outcomes, lesser dropouts and higher overall satisfaction of patients (Lindhiem et al., 2014; Swift et al., 2011, 2018; Windle et al., 2020). However, results on activity preferences are still rare, highly heterogeneous and inconclusive due to different assessment methods and various questionnaires used in past studies. Furthermore, standardized questionnaires as an important cornerstone of preference assessment represent a prerequisite for hypotheses testing in research and preference accommodation in practice. Therefore, both research and practice could benefit from a standardized, psychometrically sound and validated questionnaire that can be used consistently in different national and international settings. To this end, the aim of the initial study was to translate the Cooper-Norcross Inventory of Preferences (Cooper & Norcross, 2016) and test its psychometric properties. I chose the C-NIP due to a thorough development process, promising first results of the original version including first implementation studies, as well as to ensure international comparability with translations into other languages such as Czech, Portuguese and French.

Methods

We obtained permission for the translation by the original authors and followed established guidelines for translations (Wild et al., 2005). For an online study to test the questionnaire's properties, I recruited two different samples from April to June 2020: a student sample (n = 236) and members of the German SoSci Panel (n = 733; Leiner, 2016).

Respondents filled in the C-NIP as well as trait questionnaires for adult attachment (Steffanowski et al., 2001), general self-efficacy (Beierlein et al., 2017), locus of control (Kovaleva, 2012), trait anxiety (Laux et al., 1981), temporal focus (Geiger et al., 2018), Big-Five personality traits (Rammstedt & John, 2005) as well as sociodemographic information. I performed confirmatory factor analyses (CFA) and exploratory structural equation models (ESEM) to replicate the original factor structure, as well as Cronbach's Alpha (Cronbach, 1951) as a marker for the reliability of the factors. Validity was tested using correlation analyses with self-reports of previously mentioned traits.

Major Findings

I was not able to replicate the original factor structure using CFAs. An ESEM-model resulted in sufficient model fit with a similar four-factor structure as the English version. However, for an improved alternative model, I excluded two items and reassigned two other items to a different factor. Reliabilities of all four factors and both models were good to questionable and comparable with the original C-NIP. The validation with different traits resulted in small effects according to most hypotheses, e.g., past and present temporal focus correlated significantly with the C-NIP's past vs. present orientation scale. I also identified associations between different preferences and gender, age or prior psychotherapeutic experience, such as women preferring less focused challenge than men.

Conclusion

Overall, the translation of the German C-NIP resulted in a slightly different factor structure with comparable reliabilities of both models to the English original. Correlations with personality traits just managed to cross the threshold of small effect sizes, i.e., personality plays a small, but significant role in the prediction of preferences. The C-NIP is a promising addition to activity preference assessment in German and can be implemented with both the original or alternative factor structure. However, the questionnaire needs independent replications of the both factor models as well as more validation and implementation efforts.

4.2. Paper II – Differences in Psychotherapy Preferences between Psychotherapy Trainees and Laypeople

Heinze, P. E., Weck, F., Hahn, D., & Kühne, F. (2023). Differences in psychotherapy preferences between psychotherapy trainees and laypeople. *Psychotherapy Research, 33*(3), 374-386. https://doi.org/10.1080/10503307.2022.2098076

Impact Factor: 4.12 (2021)

Theoretical Background

Currently, the perspective of mental health professionals on preferences is highly underrepresented despite their decisive role in the psychotherapy process. I chose to explore preferences of psychotherapy trainees for several reasons: First, studies show that consensus between therapists and patients can improve therapy outcomes (Chui et al., 2020; Tryon et al., 2018). However, the content and structure of therapy sessions largely depend on the psychotherapists' decisions and their prior experiences (Safran et al., 2011), thus increasing chances of adapting psychotherapy to their own rather than to their patients' preferences. Second, trainees perceive early professional experiences as stressful and suffer from low self-efficacy and high self-doubt (Orlinsky et al., 2005; Taubner et al., 2010). Given these challenges, disagreement with patients due to differences in preferences might present an additional obstacle and increase the chances of unsuccessful therapies.

Methods

I recruited an additional sample to the laypeople sample of Paper I (n = 969) by contacting German psychotherapy training institutes, resulting in a sample of N = 466 trainees in both adult and adolescent psychotherapy and all accredited therapy orientations. Trainees indicated how a therapist should treat their patients using the C-NIP items. I compared the laypeople and trainee sample regarding their preferences on item- and factor-levels using t-tests (Bonferroni-corrected). Furthermore, I explored the effect of different levels of experience with psychotherapy (laypeople without vs. with prior experiences vs. trainees)

performing an analysis of variance (ANOVA). Additionally, I conducted another ANOVA to explore differences in preferences between trainees of different psychotherapy orientations (CBT vs. PD/PA). Moreover, I performed CFA using the trainee sample for a replication of both the original and alternative factor structure of the C-NIP.

Major Findings

I found significant differences in 13 of 18 items, and three of four scales of the C-NIP. Trainees preferred significantly less therapist directiveness (d = 0.58) as well as more emotional intensity (d = 0.78) and focused challenge (d = 0.35) than laypeople. CBT trainees preferred more therapist directiveness (d = 2.00), present orientation (d = 0.76) and focused challenge (d = 0.33) as well as less emotional intensity (d = 0.51) than PD/PA-trainees. Both replication attempts of the original and alternative factor structure in the trainee sample yielded inconclusive results: Whereas some indices in both models indicated sufficient model fit, others did not.

Conclusion

The study shows significant differences between laypeople and psychotherapy trainees with medium effect sizes. Therefore, early career therapists could benefit from implementing standardized preference assessment to compare patients' preference to their own. This step could help to avoid disagreements and alliance ruptures due to different conceptualizations of the treatment process. Moreover, the results underline the importance of psychotherapists to reflect their own preferences, potentially with the help of standardized tools like the C-NIP or as part of the training curriculum. However, differences between trainees of different treatment orientations can open the possibility for patients to choose a therapist matching their preferences.

4.3. Paper III – Preferences regarding Psychotherapist Characteristics and their Predictors: Results of a German Online Survey

Heinze, P. E., Weck, F., & Kühne, F. (2023). Preferences for an ideal psychotherapist: What therapist characteristics do laypersons prefer? *Professional Psychology: Research and Practice*, *54*(3), 241-251. https://doi.org/10.1037/pro0000508

Impact Factor: 1.85 (2021)

Theoretical Background

Until recently, research has mainly focused on preferences regarding treatment approaches. However, as patient engagement in psychotherapy is influenced by their preferences (Lindhiem et al., 2014), especially salient factors such as therapist characteristics might hinder help-seeking individuals from starting psychotherapy. Thus, it is necessary to know preferences of laypeople regarding psychotherapist characteristics. Research mainly focused on age, gender and ethnicity preferences in English-speaking samples, and results are inconclusive. Moreover, some relevant aspects such as therapist experience or preferred personality traits have not been part of investigations yet or need conceptual replication. Therefore, the aim of the third study was to investigate therapist preferences regarding various characteristics and personality traits of psychotherapists and their relevance for persons of the general public. Furthermore, the study explores various predictors of preference choices to help practitioners identify markers for preferences.

Methods

Additional to the C-NIP validation effort reported in Paper I, the two subsamples of students and SoSci Panel members (N = 969) chose their preferences for gender and academic degree from a list of options. Items measuring preferences regarding age, years of experience in research or practice and number of patients treated used an open-response format. Moreover, participants could indicate whether they wanted a therapist to be of ethnic minority or religious background, and in case of a positive response, participants could use a free

format to indicate their preferred ethnicity and religion. Preferred political attitudes of therapists were measured using a 10-point differential with extremes labeled as left- or right-wing attitude, respectively. For all characteristics mentioned above, participants had the option to indicate having no preference. Moreover, personality preferences were measured using an adapted version of the Big-Five Inventory (Rammstedt & John, 2005). I computed multinomial regression models for categorial preference data, binomial regression models and subsequent linear regression models for interval-scaled preference options with sociodemographic and personality predictors. Due to the exploratory nature of a majority of the analyses, I applied Šidák-correction for significance testing (Šidák, 1967).

Major Findings

For most characteristics, more than half of the participants chose the no-preference option, except for preferred political attitude and practical experience. I identified several congruency effects, i.e., participants preferring therapists with similar characteristics to their own. Congruency effects were shown for age, political attitudes, religion and ethnic minorities. Moreover, congruency effects also applied for personality preferences, with the exception of neuroticism. Older participants were more likely to prefer experienced therapists, and anxious participants preferred male therapists and high academic degrees.

Conclusion

On the one hand, most participants had no clear preferences for most characteristics that can be interpreted as open-mindedness towards different psychotherapists. On the other hand, there were clear congruency effects for personality aspects, political attitudes and members of marginalized groups. Given the lack of diversity within the psychological and mental health workforce (American Psychological Association, 2018; Kassenärztliche Bundesvereinigung, 2021), preference accommodation may be difficult to establish. The results imply that psychotherapy might benefit from considering patients' preferences, especially if accommodation is implemented with specific (marginalized) groups.

5. Discussion

5.1. Overall Summary of the Studies

The APA placed a particular emphasis on psychotherapy preferences and underlined its important role in evidence-based practice (American Psychological Association, 2006). However, despite positive effects of preference accommodation, the working model introduced in this dissertation points towards various distinct drawbacks and barriers: First, whereas interest in treatment preferences led to a substantial body of research, there was a lack of evidence on activity and therapist preferences. Studies on activity and therapist preferences lacked generalizability, as they investigated heterogeneous preferences and their predictors, reported inconclusive results on their relationship, or did not include aspects that could be potentially relevant to patients and practitioners. Second, there was a lack of validated assessment tools for activity preferences as a prerequisite to accommodate preferences. Third, research focused on the patient perspective and neglected preferences of mental health professionals and practitioners despite their authority and decisive impact on psychotherapy processes. Therefore, the three studies of this dissertation aimed to address the most fundamental drawbacks in the working model and preference research. To this end, the studies cover the translation and validation of the German C-NIP (Paper I), an investigation and comparison of activity preferences in laypeople and psychotherapists in training (Paper II), as well as an investigation of therapist preferences of laypeople and their predictors (Paper III).

The first study introduces the first German assessment tool to measure psychotherapy preferences with the translation and validation of the C-NIP. The German version is in line with translations into other languages such as Czech (Řiháček & Mikutová, 2022), French (Volders, 2021) or Chinese (She et al., 2023). However, all translations have slightly failed to replicate the original factor structure of the English version (Cooper & Norcross, 2016) with similar drawbacks as found in the German version. I proposed an alternative factor structure

and small adjustments to a few items to circumvent potential problems that need further validation. However, even using the original structure to conform to international efforts of preference assessment using the C-NIP, the original factors still showed good reliabilities. Additionally, the study provides first evidence for validity as the factors showed significant correlations with personality traits such as attachment styles, locus of control or extraversion. Moreover, it is applicable in both a broad, heterogeneous laypeople sample and a mental health professional sample. In accordance with other translation efforts, there is a high probability that the questionnaire will yield similar results in other contexts, e.g., the implementation into clinical practice in both in- and outpatient settings, or its application in research projects to control for activity preferences in treatment efficacy studies.

Whereas the working model is almost exclusively based on the perspective of laypeople and patients, Paper II adds preferences of psychotherapy trainees. Paper II reports medium to large differences between trainees and laypeople on three of four C-NIP factors: Trainees preferred significantly less therapist directiveness as well as more emotional intensity and focused challenge than laypeople. The results replicate a finding from English-speaking mental health professionals including psychotherapists, counselors, or social workers (Cooper et al., 2019). In addition, the study revealed significant differences between therapists in training with the focus on CBT vs. other orientations, i.e., preference towards a more structured, confrontational and present-focused approach of CBT than PD or PA trainees. Thus, the variety of orientations that have proven effective in the treatment of disorders allows patients to choose an approach that closely resembles their preferences. However, the study did not cover licensed therapists as the main provider of mental health treatments. Moreover, it is still unclear whether preferences actually influence therapists' decisions and implementation of treatment interventions or therapeutic styles.

Additionally, Paper III provides evidence of therapist preferences regarding various sociodemographic and personality characteristics in a broad, heterogeneous sample of the

general public. Adding to the mostly English-speaking studies that primarily investigate gender, age and ethnic preferences, the study also includes previously neglected characteristics that are relevant to people seeking psychotherapeutic help, such as preferred political attitudes as well as therapeutic and research experience. On the one hand - and confirming the importance of the characteristics introduced as preferences in Paper III - political attitude and practical experience are the two characteristics with the highest rates of specific preference choices. On the other hand, a majority of the participants chose the “no preference”-option for all other characteristics such as gender or religion. In conjunction with other studies reporting a majority of participants choosing a “no preference”-option (e.g., Black & Gringart, 2019), it is possible that many people do not have specific preferences and are open towards different therapists. However, if participants indicated specific preferences, primarily members of marginalized groups (ethnic minorities, religious or political attitudes) preferred a therapist with similar characteristics, thus mirroring findings of English-speaking samples on gender, ethnic and religious preferences (e.g., Cabral & Smith, 2011; Ilagan & Heatherington, 2022; Swift et al., 2022). Moreover, the study provides a conceptual replication of preferences regarding the Big-Five personality traits (Anestis et al., 2021; Russell et al., 2022). There is evidence for congruency effects for all Big Five factors except for neuroticism.

Overall, all studies investigated which therapy activities or therapist characteristics are preferred by different samples. To this point, there are several open questions regarding the content of preferences and how preferences can lead to improvements of therapeutic process and outcome variables. First, it is unclear if the content of the preference per se is important for the therapeutic process. As reported above, positive effects in meta-analyses such as better symptom improvement or less dropout are based on preference accommodation rather than specific preferences of participants (Lindhiem et al., 2014; Swift et al., 2018; Windle et al., 2020), i.e., it seems important that patients receive their preferred aspect rather than having a

preference for a specific aspect. In this regard, the studies of the dissertation are in line with most other studies on activity and therapist preferences by reporting descriptive statistics as well as identifying predictors for specific preferences. One notable exception is a recent implementation study of the C-NIP in an outpatient clinic in the UK (Cooper et al., 2022). Overall, patients who preferred more active and challenging approaches benefitted more from therapy than patients preferring gentle, supporting approaches. In detail, preferences for more warm support over focused challenge at therapy onset predicted less improvement for depressive and phobia symptoms as well as in overall distress and functional impairment after treatment. Moreover, preferences for therapist directiveness were associated with better depressive and phobia symptom improvement, and preferences for emotional intensity was positively associated with general functioning improvement (Cooper et al., 2022). Given the unique approach of this study, it seems relevant that future implementations investigate the effects of specific preference choices on treatment process and outcome variables.

Second, and according to assumptions in the working model, preference assessment alone might already account for most beneficial effects according to the choice or alliance hypotheses (McLeod, 2012). Irrespective of whether preferences are accommodated, merely asking patients for their preferences could signalize that the therapist is interested in the patient's perspective and imply a sense of choice and participation of the patient. To assess whether different stages of preference assessment led to differences in alliance or treatment motivation, a master's thesis reported that $N = 78$ students were asked to fill in intake forms hypothetically as though they were about to start therapy with a real therapist (Hess, 2017). There were three different experimental groups: The first group was not asked for their preferences at all, the second group filled in the C-NIP to indicate their preferences, and a third group was told that the therapist will meet their preferences. The study did not find any differences between the three groups in respect to a perceived therapeutic alliance or treatment motivation. Future studies could pick up the approach in externally valid projects to

avoid the striking limitations of the study such as a hypothetical approach or a small student sample.

Alternatively, and third, preference accommodation might be necessary for patients to show improved outcomes. Choice and alliance hypotheses might only be relevant if therapists actually address patients' preference choices and talk about the implementation of preferences indications. As a special case, the matching hypotheses postulates that only matching or adopting preferences leads to better outcomes. More studies are needed to test all possible hypotheses with the help of standardized assessment tools and to differentiate the effects of assessment and accommodation efforts.

5.2. Implications

5.2.1. Research

There are several ways of how future research efforts can benefit from this dissertation. First, Paper I provides the first validated German questionnaire for activity preference assessment that can be used in other projects. I outline some areas of future applications below, e.g., implementation studies, C-NIP factors and their (perceived) level of accommodation as a moderating factor in the evaluation of new treatment approaches, or as a predictor of psychotherapy process and outcome variables. However, the original factor structure has yet to be confirmed. Therefore, I provided an alternative factor structure and argue for changes of single items. Such changes need to be tested empirically and, if proven beneficial, need implementation in other translations of the C-NIP.

Second, current research mainly investigated and implemented treatment rather than activity or therapist preferences. However, it might not be sufficient to ask patients for treatment preferences alone, as therapists of the same treatment orientation highly differ in their implementation of techniques and their therapeutic styles (Connolly Gibbons et al., 2003; Katz et al., 2021; Zhou et al., 2021). Therefore, patients who receive their preferred treatment might still be unsatisfied as the treatment delivery and the techniques used by the

therapist might not match their activity preferences. For example, a patient with anxiety disorder might prefer and receive a CBT treatment, but also prefer a supportive, gentle and unchallenging approach that is at odds with exposition therapy in CBT as an effective intervention for anxiety (Mayo-Wilson et al., 2014). Additionally, large preference variances within subsamples across all studies of the dissertation as well as significant differences between subgroups point toward the need for individual assessment and accommodation in the context of research projects such as treatment evaluation studies. Therefore, for research to fully account for all preferences, I recommend including activity and therapist preferences into efficacy studies as moderating factors between onset- or process variables, such as symptom level, problem type or therapeutic relationship, and outcomes, such as symptom improvement. Moreover, I recommend the implementation of activity and therapist preferences into study designs like double- or fully-randomized preference trials (Delevry & Le, 2019). Within these designs, participants could not only be allocated to a (non-)preferred treatment, but also to other conditions based on activity or therapist preferences. The dimensional nature of activity preferences could be incorporated by using cut-off points that are already included in the current version of the C-NIP. However, on the one hand, such an approach might need more financial, time and personnel resources of research projects: Rather than choosing treatment A or B, activity preferences for several interventions or therapeutic styles are measured dimensionally, and therapist preferences include various characteristics that might be important to the individual patient. On the other hand, validated assessment tools such as the C-NIP eases preference assessment. Moreover, Paper III shows that a majority of participants does not have specific therapist preferences for most characteristics so that accommodation efforts might be limited to a few characteristics at most.

Third, there are some meta-analyses reporting positive effects of preference accommodation on symptom improvement, dropout, or working alliance (Lindhiem et al.,

2014; Swift et al., 2018; Windle et al., 2020). However, these effects are primarily based on treatment preferences rather than activity or therapist preferences. Hence, research efforts should focus on the accommodation of other preference types. To this end, it might be necessary to develop new tools to measure preference accommodation of activity preference due to its dimensional nature and possible variations throughout the course of therapy (Tracey & Dundon, 1988).

Fourth, current approaches aiming at personalizing psychotherapy fall short to incorporate patients' preferences. They feed intake information of patients (such as gender, symptom severity, comorbidity, etc.) into a machine-learning algorithm to determine the treatment most likely to induce positive treatment outcomes (e.g., Lutz et al., 2005). Newer applications provide additional decision guidelines over the course of treatment for practitioners to adapt their treatment to the patient's current state (Lutz et al., 2019). However, to the best of my knowledge, there is not a single machine-learning algorithm that assessed patient's preferences at intake and included them as potential predictors for outcomes. Moreover, patients partaking in evaluation studies of algorithms receive treatment and interventions or are allocated to a therapist based on decisions made by an algorithm without being asked for their preferences. I hypothesize that patients who receive a promising intervention determined by an algorithm that does not reflect the patients' preferences have higher rates of treatment disengagement and worse outcomes. Therefore, I recommend that studies add a second step after an algorithm-based decision: At this point, patients should indicate their preference and decide whether they are willing to receive the treatment, intervention or therapist deemed most promising by the algorithm.

5.2.2. Practitioners

So far, practitioners were left to ask patients about their preferences in an unstandardized manner. Paper I provides the first German questionnaire for the assessment of activity and therapist preference that can be implemented at therapy onset as well as

continuously during the therapy process. In comparison to ad-hoc and open questions about preferences, the dimensional approach of the C-NIP allows practitioners to deduce the strength of preferences based on sum scores of the four factors and thus to infer the individual need for accommodation: The higher a patient scores towards either extreme pole of a factor, the higher the need for accommodation. Even though the implementation into practice has not been evaluated yet, implementations of both the German and English version in research did not point toward any problems for laypeople filling in the questionnaire such as incomprehension of items (Cooper et al., 2019, 2022). For easier interpretation of the factor scores, the C-NIP also provides cut-off scores. Overall, there are several recommendations for the assessment of preferences by practitioners (Tompkins et al., 2013): First, assessment should cover all preference aspects, i.e., treatment, activity and therapist preferences. Second, prior to assessment, descriptions of different options might help patients to gain a better understanding and make informed decisions. A third recommendation by Tompkins et al. (2013) claims that therapists should limit options to treatment aspects that they are able to accommodate. This approach could prevent misunderstandings and perceptions of choice that cannot be met. However, even indications of preferences that cannot be accommodated (such as most therapist characteristics) can help therapists to openly discuss their approach in order for patients to manage their expectations or look for alternatives rather than drop out of therapy after several sessions due to disappointment over non-preferred therapy.

According to Tompkins et al. (2013) and the working model, assessment of preferences is only the first step in incorporating patients' preference into therapy. After the assessment stage, Norcross and Cooper (2021) recommended four ways of preference accommodation. First, therapists can adopt and integrate their patients' preference. Second, adapting patients' preferences refers to offer an approach similar to the patient's wishes while taking other aspects such as treatment effectiveness into account. Third, therapists can suggest alternatives to the patients' preferences. To this end, they should explain the reason for not

accommodating the preference, validate and emphasize potential disappointment, and explain the alternative in detail (Norcross & Cooper, 2021). Fourth, if patients prefer evidence-based treatments, interventions or other justified aspects that the current therapist is not able to accommodate, it is possible to refer the patient to another therapist.

In addition to patient preferences, preferences of practitioners can also play a significant role. In accordance to a study of Cooper et al. (2019), Paper II of the dissertation shows medium preference differences between mental health professionals and laypeople. Such differences could increase the risk of worse treatment outcomes in case practitioners do not accommodate their patients' preferences (Lindhiem et al., 2014; Swift et al., 2018) and provide treatment based on their own preferences (Safran et al., 2011). Therefore, practitioners could fill in the C-NIP from their own perspective and contrast their answers with the patient's perspective. Furthermore, self-practice or training courses could help psychotherapists (in training) reflect on their own preferences or teach preference accommodation using role-plays or simulated patient sessions.

Moreover, Paper III provides evidence that members of marginalized groups are more likely to have specific preferences, especially for therapists with similar characteristics. Therefore, knowledge about such associations can help practitioners to anticipate potential mismatches based on more salient features such as ethnicity, age or sex. In that case, therapists could openly address perceived mismatches in order to help patients open up and speak about potential discomfort in therapy due to unaccommodated preferences. For less salient preferences such as political attitude or religion, a biographical anamnesis can help to identify the individual importance of such topics in order to address and discuss how to handle such topics throughout the treatment process.

5.2.3. Society

The results of this dissertation also have implications for the general public and policy-making. However, since the implications are based upon results from German samples

in all three studies, the implications are mainly aimed at Germany and, to a lesser degree, European and North-American societies. First, Paper III reported preferences regarding therapist characteristics. One of the main findings showed that especially members of marginalized groups (i.e., women, religious people, members of ethnic minorities) had strong preferences for a therapist with the same background. Even though matching patient and therapist based on sociodemographic features does not yield positive outcomes (Cabral & Smith, 2011; Karlsson, 2005), and inconclusive effects of matching on treatment retention (Ibaraki & Hall, 2014; Shiner et al., 2017), strong preferences point towards individuals of marginalized groups not seeking help in the first place if there are no similar therapists in their vicinity. Given sociodemographic homogeneity within the groups of psychologists and psychotherapists (American Psychological Association, 2018; Kassenärztliche Bundesvereinigung, 2021) and that most characteristics of therapists are hardly changeable, there is need for more diversity in the psychotherapeutic workforce to maximize patients' choices. To this end, members of marginalized groups should be encouraged to take up a career as psychotherapists. However, there are several barriers on the way to becoming a psychotherapist such as high numerus clausus, high (opportunity) costs and low incomes during postgraduate training as well as additional psychosocial stress due to treating patients with mental disorders. Thus, members of marginalized groups who disproportionally often suffer from a lower SES, worse educational attainment (Solga & Dombrowski, 2009) and more mental stress (e.g., Bamford et al., 2021; McClain et al., 2016) could face difficulties to afford such conditions. In ideal circumstances, structural changes can benefit people of marginalized groups by accomplishing less inequality and discrimination on a personal, social, educational and economical level. Smaller interventions to help members of marginalized groups take up the profession of psychotherapist could be individualized promotion programs at an early age, psychology courses in high school, standardized

performance screening tests for universities, easier access to financial funds with smaller interest rates as well as more scholarships for members of marginalized groups.

Second, in ideal circumstances, patients can choose therapists and treatment approaches according to their preferences. However, patients in almost all regions in Germany currently suffer from long waiting periods due to a lack of places in both outpatient and inpatient therapy programs (Wissenschaftliche Dienste des Deutschen Bundestages, 2022). Given high variances and the multidimensional nature of preferences as shown in this dissertation, chances are high that patients do not take up treatment at all (van Schaik et al., 2004), or they give up their preferences to start any treatment available (Cooper et al., 2023). As an effect, on the one hand, research suggests lower levels of treatment engagement and poorer outcomes (Swift et al., 2018). On the other hand, taking up therapy regardless of preferences allows patients to gather more relevant knowledge about psychotherapy and gain experience about the credibility and acceptability of therapy to revise their preferences. Ideally, more therapists are allowed to practice so that patients are able to choose a therapist according to their preferences without worries not to find an alternative therapy slot without having to sit through long waiting periods. Until this point, given overall benefits of therapy over passive control conditions in meta-analyses (D. C. Mohr et al., 2014), I hypothesize that patients willing to take up therapy regardless of their preferences are more likely to benefit than waiting for a preferred approach. Moreover, taking up therapy in the first place allows therapists to explain their approach transparently for patients to understand and contextualize the procedure.

Third, research suggests that preferences are a result of beliefs about the helpfulness of specific therapy aspects, the etiology of psychiatric disorders as well as convenience perceptions (Khalsa et al., 2011; Sidani, Miranda, et al., 2009; Tarrier et al., 2006). More efforts in broadly accessible research communication and education of the general public about mental disorders, treatment concepts and helpful aspects of therapy could aid

individuals to reflect and revise preferences and beliefs that are difficult to accommodate. For example, it is not necessary for therapists to have experienced similar traumata or a specific cultural upbringing similar to the patient in order to provide effective treatment. There are several possible solutions: First, educational efforts could include school courses, or series of lectures that are made available online for a broader audience. Second, experts should write comprehensive, easy-to-read and open-access publications for the general public rather than publications of non- or semi-professionals that reinforce laypeople's perceptions and preferences of therapy and that are based on economic interests. Third, comprehensive case studies or interviews with former patients could make the black box of therapy sessions more transparent to the public to demonstrate effective interventions and treatment courses.

5.3. Limitations

Additional to the limitations already stated in the single studies that this dissertation is based on, the following section focuses on overarching limitations of the dissertation. First, results and their interpretations are based on a single merged sample of students as well as laypeople that were recruited on the German respondent pool SoSci Panel (Leiner, 2016). Therefore, we did not recruit a representative sample of the German population to generalize results. However, Paper II added a sample of psychotherapists in training that closely represents the population as all training centers in Germany irrespective of their theoretical orientation were addressed for recruitment. Nevertheless, the studies' results need independent replication on a national and international level. Second, despite the factor structure and reliabilities of the C-NIP within the trainee sample closely matching the laypeople sample, the number of factors and corresponding items is still up for discussion, as the German translation as well as translations into other languages such as French or Czech slightly fall short of replicating the original factor structure of the C-NIP (Řiháček & Mikutová, 2022; Volders, 2021). I proposed an alternative factor structure and adjustments to single items in Paper I that needs independent evaluation. Third, results in all three studies are

presented with the help of group-level statistics such as means or odds ratios. Such coefficients mask individual preference patterns. For example, whereas one religious participant might have indicated solely preference for a religious therapist and no preference for any other characteristic, another religious participant might have several other preferences (e.g., for therapist gender, and strong preferences on the C-NIP) additional to preferring a religious therapist. Therefore, it is necessary for practitioners to assess, discuss and accommodate preferences on an individual level. Fourth, all studies asked participants to indicate preferences irrespective of any specific diagnosis or problem type. However, several studies showed that preferences differ if participants are asked to be treated for different problems (Bernstein et al., 1987; Landes et al., 2013; Stamler et al., 1991), e.g., preference for younger therapists when talking about problems associated with young adulthood (Kessler et al., 2020). Therefore, results are likely to vary if patients are asked for preferences regarding the treatment of a specific diagnosis, or specific problems.

5.4. Outlook

The aim of this dissertation was to address the most fundamental drawbacks of the proposed working model by adding activity and therapist preferences, the perspective of mental health professionals and by introducing a validated assessment tool. However, there is lots of work still left for upcoming projects. First, future projects could pick up the working model proposed in this dissertation and test all relevant interrelations and assumptions. For example, there are three different hypotheses (matching, choice, alliance) on how preferences can lead to positive psychotherapy outcomes that need to be distinguished from one another. For example, an investigation could test differences between four different conditions on variables such as symptom improvement, treatment engagement, alliance or locus of control for treatment decisions: a) group without preference assessment, b) group with assessment, but without accommodation, c) group with assessment and accommodation (but no matching), d) group receiving treatment matching their preferences. Moreover, there are many

inconclusive results on potential preference predictors. More single studies and future meta-analyses could identify potential moderators such as preferences only relevant to specific (sub-)samples or types of problems. For example, Paper III suggests that whereas therapist's religion seems to be important for both religious and non-religious participants. However, other studies on preferred therapist gender showed that gender is only important for female, not male, participants (e.g., Lauber & Drevenstedt, 1994; Pikus & Heavey, 1996). Moreover, different assessment methods could lead to different preference choices, such as indirect measures indicating unconscious preferences that questionnaires cannot. Therefore, preferences measured via direct and indirect measures could be compared regarding their impact on the therapeutic process.

Second, whereas Paper I presents a tool for upcoming projects, Papers II and III of this dissertation are merely able to state current differences between various stakeholders without addressing its impact on therapeutic process or outcome variables or potential solutions to overcome the differences. For example, Paper II shows preference differences between laypeople and psychotherapists in training, but neither does it test how these differences affect symptom improvement or treatment delivery nor does it evaluate potential solutions such as preference implementation in training facilities or an additional course on preferences in the curriculum for future psychotherapists. Similarly, Paper III shows differences regarding therapist preferences of different subgroups such as religious participants, but future studies need to identify its effect on symptom improvement or evaluate approaches to diversify the psychotherapeutic workforce. Accordingly, there is need for implementation studies to test the C-NIP's validity in psychotherapy practice, as well as to assess the suitability of different methods for activity and therapist preferences implementation and accommodation proposed by Norcross & Cooper (2021) and their effect on psychotherapy processes and outcomes.

Third, current research designs like the doubly- or fully randomized preference trials (Delevry & Le, 2019) are merely able to differentiate between different categories of

preferences rather than implementing dimensional preferences. Therefore, treatment intervention and evaluation studies could implement activity preferences and their (perceived) level of accommodation as moderating factors for process and outcome variables. Moreover, since it is unclear whether the mere content of specific preference choices has an effect on patient variables, studies could implement preference choices as predictors.

Fourth, studies need to contrast the positive effects of preference accommodation (Lindhiem et al., 2014; Swift et al., 2018) with a potential loss in treatment effectiveness due to preference for a less effective approach. This could allow patients to take an informed decision on whether to receive a preferred, but less effective treatment or a non-preferred, more effective approach. For example, it is currently unknown whether a patient with social anxiety disorder should receive their preferred approach of a lesser emotional challenging and confrontational treatment despite exposition being the most effective treatment method for such a diagnosis (Mayo-Wilson et al., 2014). Until such evidence emerges, practitioners might be faced with dilemmas and left with their clinical expertise to decide on an individual basis to adapt to patients' preferences or introduce alternatives (Norcross & Cooper, 2021).

Fifth, despite the APA stating the importance of preferences for EBP (American Psychological Association, 2006), to the best of my knowledge, preferences and their accommodation have not yet been integrated in any psychotherapy process model as a significant factor impacting various process variables such as alliance, treatment engagement or symptom improvement (Lindhiem et al., 2014; Windle et al., 2020). An integration can foster research on psychotherapy preferences as the topic gains awareness, preferences being included as moderating factors in studies and projects with other related questions. and being subject to more thorough evaluation and hypotheses-testing. Therefore, with the integration of preferences into psychotherapy process models, as well as more implementation and accommodation studies, evidence can benefit practitioners, researchers and patients alike.

5.5. Conclusion

Taken together, the dissertation summarizes the current literature on all preference aspects and subsumes the findings in a working model. The papers contribute to the research of psychotherapy preferences as an important cornerstone of EBP by addressing three major drawbacks of the working model: Past studies primarily focused on treatment preferences rather than activity or therapist preferences, lacked validated assessment tools, and neglected important preferences, predictors and perspectives of practitioners. Therefore, Paper I provides a promising questionnaire to measure activity and therapist preferences. Paper II adds preferences of psychotherapy trainees and showed medium differences to laypeople as well as between trainees of different orientations. Paper III identified the importance of various preferred therapist characteristics, especially for members of marginalized groups. In conclusion, the dissertation builds a solid groundwork for researchers, practitioners and patients in order to maximize patients' choice in psychotherapy. The results imply that preference assessment and accommodation should be implemented in both research and practice, practitioners should question their own preferences and engage in accommodation efforts for each individual patient, and barriers of psychotherapy studies and treatment for members of marginalized groups should be lowered.

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7. Appendix

7.1. Paper I

Assessing Patient Preferences: Examination of the German Cooper-Norcross Inventory of Preferences

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Heinze, P. E., Weck, F., & Kühne, F. (2022). Assessing patient preferences: Examination of the German Cooper-Norcross Inventory of Preferences. *Frontiers in Psychology, 12*:795776. https://doi.org/10.3389/fpsyg.2021.795776

Acknowledgments

We thank the members of the SoSci Panel for their contribution to this study, and Brian Bloch for the translation of the C-NIP and editing of the manuscript.

Funding

This work received funding from Deutsche Forschungsgemeinschaft (DFG, German Research Foundation, Open Access Publication Fund), no. 491466077 to PH.

Disclosure of Interest

On behalf of all authors, the corresponding author states that there is no conflict of interest.

Abstract

Despite the positive effects of including patients’ preferences into therapy on psychotherapy outcomes, there are still few thoroughly validated assessment tools at hand. We translated the 18-item Cooper-Norcross Inventory of Preferences (C-NIP) into German and aimed at replicating its factor structure. Further, we investigated the reliability of the questionnaire and its convergence with trait measures. A heterogeneous sample of $N = 969$ participants took part in our online survey. Performing ESEM models, we found acceptable model fit for a four-factor structure similar to the original factor structure. Furthermore, we propose an alternative model following the adjustment of single items. The German C-NIP showed acceptable to good reliability, as well as small correlations with Big-Five personality traits, trait and attachment anxiety, locus of control, and temporal focus. However, we recommend further replication of the factor structure and further validation of the C-NIP.

Keywords: Psychotherapy, Preference, Activity Preference, Preference Assessment, Validation Study.

Contribution to the Field

The American Psychological Association defines patient preferences as a cornerstone of evidence-based psychotherapy. Despite its positive effects on psychotherapy processes and outcomes, there are still few well-investigated assessment tools for both researchers and practitioners, with most questionnaires being solely available in English. Our study presents a German translation of the Cooper-Norcross Inventory of Preference (C-NIP), and one of the first to investigate the original factor structure in an independent, large heterogeneous sample of $N = 969$ participants. Moreover, we examined the C-NIP’s associations with personality traits. As a result, we were not able to replicate the original factor structure. However, we identified two models with good reliabilities after adjustments to single items. Preferences identified with the C-NIP were associated with anxiety, temporal focus and general personality traits. To this point, we recommend further investigations of the C-NIP. However,

the C-NIP is a promising addition to the preference assessment for researchers and clinicians alike.

1 Introduction

Psychotherapy is generally effective in the treatment of mental disorders (McAleavey et al., 2019), however, premature treatment termination is still common, with percentages ranging from 20% to 70% (Swift & Greenberg, 2012). Clients often mention dissatisfaction with perceived insufficient therapeutic alliance and therapist's multicultural competence as a reason for discontinuation (Anderson et al., 2019). Given that treatment dropout rates decrease when patients receive the psychotherapy they consider appropriate (Swift et al., 2018), it is likely that dissatisfied clients were not receiving a therapy that was tailored to their preferences. Even though the APA Task Force on Evidence-Based Practice highlighted that psychotherapeutic preferences should be considered to pursue better therapeutic outcomes (American Psychological Association, 2006), much is still to be desired in the assessment and implementation of patient preferences. Recent instruments to capture preferences are solely available in English, with some questionnaires not being validated thoroughly. Hence, our aim of the study is to provide practitioners and researchers alike with a German tool to capture psychotherapeutic preferences, the German Cooper-Norcross Inventory of Preferences. Furthermore, we validate the questionnaire to investigate the hitherto neglected influence of personality traits and demographics on activity preference choices.

Preferences are defined as anticipatory choices of psychotherapeutic and psychotherapist characteristics that clients wish during psychotherapy (Swift et al., 2011). Preferences are proposed to be multidimensional, dynamic and to operate on different levels of consciousness, i.e., a person might have multiple preferences that are either un-, sub-, or consciously aware and may change over time (Grantham & Gordon, 1986). Currently, preferences are conceptualized into three categories (Swift et al., 2011). First, *treatment preferences* reflect which specific type of intervention patients want. For instance, patients could choose between pharmacological or psychotherapeutic treatment. Second, *activity preferences* capture the clients' wishes of how they and their psychotherapists should act and

behave during psychotherapy (Swift et al., 2018). For example, clients may wish to avoid burdensome topics and want the therapist to lead the psychotherapy. Third, *therapist preferences* indicate which psychotherapist characteristic patients prefer, e.g. regarding gender, race, or personality traits.

Karlsson (2005) summarized particularly relevant methods of preference assessment. In addition to open-ended questions, patients can indicate whether they want treatment by an exemplary therapist that is introduced through vignettes, audiotapes or photos. However, participants might not be aware of their preference or might answer in socially desirable ways based on salient features. Another method described is to present participants with multiple cases and rank-order their ratings on relevant therapy aspects. Methodologically close to this approach is a delay-discounting measure proposed by Swift and colleagues (2015) allowing for comparisons between two particular characteristics. The more (hypothetical) effectiveness patients sacrifice for any characteristic, the higher their preference. However, external validity is questionable, as preference assessment for characteristics that might not be relevant for patients requires multiple responses to small iterations. Furthermore, in most cases, choosing any preference in an experimental setting does not have an impact on the participants and possible psychotherapy settings. Overall, most methods are well suited for experimental approaches due to their easy applicability and thorough comparability. However, these methods are not always suited to evaluate preferences before starting therapy since the methods mentioned focus on between-group comparisons rather than on individual preferences in consideration of specific treatment circumstances. Therefore, it is necessary to find easily applicable, yet standardized and valid tools to help practitioners and researchers alike to capture preferences of individuals economically.

To this end, different questionnaires are published in English. However, some instruments do not necessarily capture preferences, but therapy-related expectations, and

some instruments lack sufficient reliability or validity (for an extended overview: Cooper & Norcross, 2016; Swift et al., 2018).

Therefore, Cooper and Norcross (2016) developed a short and multidimensional measure to be used in clinical practice and research: the Cooper-Norcross Inventory of Preferences (C-NIP). The C-NIP measures clients' preferences for their therapists' behavior during psychotherapy or counseling. To avoid response biases in favor of positively keyed items (i.e., people choose high levels of therapist activity regardless of the content), the instrument consists of 18 semantic differential items, i.e., participants choose between two options using a seven-point Likert scale. Whereas positive scores represent stronger preferences towards the left side of the item spectrum and negative scores represent stronger preferences towards the right side, nil scores represent no or the same preference towards both options. Using principal component analysis, the authors identified four subscales: First, *therapist vs. client directiveness* expresses whether patients would want the therapist to lead and structure the therapy using psychotherapeutic techniques, or to leave the therapy unstructured and let the patient guide the therapy. This dimension consists of five items that are consistent (Cronbach's $\alpha = .84$; Cooper & Norcross, 2016). Another five items capture the preference towards e*motional intensity vs. reserve,* i.e., the preference for emotion expression and the importance of the therapeutic relationship ($\alpha = .67$). Third, *past vs. present orientation* is composed of three items asking the patient whether they want to focus on past or present life events and problems during therapy ($\alpha = .73$). Fourth, *warm support vs. focused challenge* consists of five items and captures participants' preferences towards support and understanding vs. confrontation and challenge ($\alpha = .60$).

As we are not aware of any comparable instruments in German, we thus translated the C-NIP by adhering to established guidelines (Wild et al., 2005) to introduce a tool for German-speaking practitioners and researchers. The guideline subsumes several steps as best practice for translations, i.e., obtaining permissions for translations, independent forward

translation as well as backward translation into the source language by a proficient native-speaker, and constant reviews and group discussions after each step. We investigated the factor structure, reliability and construct validity of the C-NIP in a large German sample of laypeople who are the target population of the instrument. Since there are no studies on the relationship between C-NIP preferences and personality so far, we used traits that were identified as predictors of preference choices in previous studies (e.g. Anestis et al., 2021; Helweg & Gaines, 1977; Petronzi & Masciale, 2015). The results could help practitioners to identify patient’s preferences more easily, consider them during therapy, and thus improve therapy outcomes.

However, the association of personality traits with C-NIP preferences is unclear, therefore we used a conservative approach towards hypotheses and expected small effect sizes. We used traits that were identified as particularly relevant for the individualization of psychotherapy, such as adult attachment (Levy et al., 2018), anxiety as an avoidance tendency (Edwards et al., 2019) as well as locus of control (Beutler et al., 2018). From this literature, we infer that anxious participants may prefer reassurance both regarding their relationship with the therapist and concerning the process of psychotherapy (Petronzi & Masciale, 2015). In detail, we first hypothesize small correlations between *trait anxiety*, *attachment anxiety* and *avoidance* with *emotional reserve* and *warm support* (H1). Moreover, as individuals with high *internal locus of control* and *self-efficacy* could expect to be prepared for challenging situations and emotions, we hypothesize small correlations between *internal locus of control* as well as *self-efficacy* with *patient directiveness* and *focused challenge* (H2.1). Furthermore, we expect that *external locus of control* will be associated with *therapist directiveness* and *warm support* (H2.2). Based on findings that Big-Five facets such as *conscientiousness*, *extraversion* and *openness* predict psychotherapy preferences (Anestis et al., 2021; Ogunfowora & Drapeau, 2008; Petronzi & Masciale, 2015), we hypothesize that *conscientiousness* and *extraversion* will be associated with *therapist directiveness* (H3.1) and

that *openness* will be associated with *emotional intensity* and *patient directiveness* (H3.2). We assume that preferences for *past* and *present orientation* show small correlations with overall *temporal focus* (H4).

For discriminant validity, due to a lack of prior studies on the validity of the C-NIP and to lower the workload for our participants, we used the same measures (but distinct subscales) as for the investigation of convergent validity. We expected that *temporal focus* does not show significant correlations with C-NIP subscales other than with *past vs. present orientation* (H5.1) as well as no other small Big-Five correlations beyond the ones we described above (H5.2). Additionally, based on previous findings that age (Petronzi & Masciale, 2015; Williams et al., 2016), gender (Furnham & Swami, 2008; Liddon et al., 2018; Ogunfowora & Drapeau, 2008), ethnicity (Cabral & Smith, 2011; Speight & Vera, 2005), prior psychotherapeutic experiences (Cooper et al., 2019; Speight & Vera, 2005) and participants' education (Houle et al., 2013; Ogunfowora & Drapeau, 2008) are significant predictors of preferences, we examined whether preferences differed depending on participant characteristics (e.g. prior psychotherapeutic experience, sociodemographic and personality variables). In detail, we aim to replicate results of Cooper and colleagues (2019) who found that women have a greater preference for *warm support* than men (H6). Furthermore, mental health professionals showed a greater preference for client directiveness and emotional intensity than did laypersons. Thus, we hypothesize that both participants with prior psychotherapeutic experiences as well as with participants with prior psychological knowledge show greater preferences for *client directiveness* and e*motional intensity* than participants without prior knowledge (H7.1) or experiences (H7.2), respectively.

2 Materials and Methods

2.1 Participants

As we expected low overall effect sizes (d_{min} = .20), we aimed for a sample of at least N = 779 participants based on a power analysis using GPower 3.1 (two-tailed, statistical

power = .80; Faul et al., 2009) for correlation analyses, or at least 400 participants per group to perform confirmatory factor analyses (Kyriazos, 2018). Since individuals who are currently in therapy tend to describe their current psychotherapist rather than indicating preferences (Russell et al., 2022) and due to the anticipatory nature of preferences (Grantham & Gordon, 1986), we aimed to recruit a heterogeneous sample irrespective of the participants' mental status: First, we recruited participants via our department's participant pool, student mailing lists and social media. N = 236 participants were included in this convenience sample. Second, we used the non-commercial SoSci Panel (Leiner, 2016) which is a convenience respondent pool of approximately 80,000 people who consented to be informed about and take part in current surveys and studies without remuneration. After an independent peer review of the study's approach by the SoSci Panel team, the study link was forwarded to 4,000 panel members, of which we were able to recruit n = 733. Overall, three of n = 972 participants were excluded from further analyses due to an age younger than 18. Therefore, all subsequent analyses were performed with the total sample of N = 969 participants (female: 66.97%; n = 649). Mean age was 40.01 years (SD = 16.09, range = 18 – 85). Participants were highly educated (high school diploma or above: 84.5%; n = 819), and two thirds had some kind of prior experience with psychotherapy (65.1%; n = 627). Only n = 24 participants (2.5 %) indicated having an ethnic minority background.

Members of the SoSci Panel were significantly older (t(756.66) = 22.30, p < .001), had less prior psychological experiences through jobs or studies (36.9% vs. 64.8%, X(1) = 47.49, p < .001), identified themselves more often as religious (44.3% vs. 33.1%, X(1) = 8.78, p < .01) and were less politically liberal (t(445.33) = 4.41, p < .001) than non-panel members. Furthermore, panel participants had proportionally fewer females (female: 62.9% vs. 79.7%, X(2) = 23.10, p < .001), were less often in training (employed: 44.9% vs. 20.7%, X(7) = 219.19, p < .001) and had higher education (master's degree or equivalent: 37.0% vs. 16.1%, X(11) = 130.83, p < .001) than participants of the convenience sample. Whereas members of

the SoSci Panel were primarily employed (58.9 %; *n* = 432), convenience sample members were primarily undergraduate students (61.9 %; *n* = 146).

2.2 Procedure

After obtaining permission to translate the questionnaire by the original author (MC), we translated the C-NIP into German (PH, FK). The initial translation was back translated by an independent English native proficient in psychology (BB). Discrepancies were discussed and consensually resolved within the team of researchers and by including the first author of the original instrument (MC). The study was conducted on the online platform soscisurvey.de (Leiner, 2019). Participants who followed the invitation link gave informed consent. At the end of the study, each participant had the chance to win one out of five 10€-vouchers, and students of the University of Potsdam additionally received course credit. The university’s ethics committee and data protection officer approved the study (no. 13/2020).

2.3 Measures

C-NIP

Following the approach on translation and cultural adaptation proposed by Wild and colleagues (2005), we translated the C-NIP into German (see Supplementary Material). In addition to the semantic differentials, the C-NIP includes 11 open-ended questions on activity and therapist preferences that were translated into German, but not part of the study. For the complete questionnaire and for instructions concerning scoring, please see www.c-nip.net.

Relationship Scales Questionnaire

The Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994; German: Steffanowski et al., 2001) captures attachment styles in adults’ relationships. The questionnaire consists of 30 items using a five point Likert-scale (1 = *not at all like me*, 5 = *very much like me*). Whereas the original authors proposed four subscales, a recent psychometric investigation showed an advantage for two factor models (Zortea et al., 2019). Therefore, we used the two subscales *anxiety* (Cronbach’s α = .85) and *avoidance* (α = .77).

General Self-Efficacy Short Scale [Allgemeine Selbstwirksamkeit Kurzskala]

We used a three item short scale to measure individual general self-efficacy beliefs (Allgemeine Selbstwirksamkeit Kurzskala [AKSU]; Beierlein et al., 2017). Items were rated on a five-point Likert scale (1 = *strongly disagree*, 5 = *strongly agree*). The internal consistency of the ASKU was good (α = .89) in the current study.

Internal-External-Locus of Control-4 [Internale-Externale-Kontrollüberzeugng-4]

We measured internal and external locus of control using the instrument Internale-Externale-Kontrollüberzeugung-4 (IE-4; Kovaleva, 2012). Participants rated four items using a five-point Likert scale (1 = *strongly disagree*, 5 = *strongly agree*). Since both subscales consist of two items each, we used corrected Spearman-Brown coefficients to investigate reliability (*internal locus of control*: *r* = .68; *external locus of control*: *r* = .84).

State-Trait Anxiety Inventory

Participants rated their trait anxiety on the 20-item State-Trait Anxiety Inventory (STAI; Spielberger et al., 1983; German: Laux et al., 1981) using a four-point Likert scale (1 = *not at all*, 4 = *extremely*). Internal consistency was excellent (α = .95).

Temporal Focus Scale [Zeitlicher-Fokus-Skala]

Participants rated their cognitive temporal focus on the past or the present on the subscales past focus and present focus of the Zeitlicher-Fokus-Skala (ZFS; Geiger et al., 2018). Its eight items were rated on a seven-point Likert scale (1 = *never*, 7 = *always*). Both 4-item factors *past focus* (α = .92) and *present focus* (α = .90) showed excellent internal consistencies.

Big-Five Inventory (short version)

The Big-Five Inventory (BFI-K; Rammstedt & John, 2005) is a 21-item short questionnaire to measure the Big Five personality factors. All items were rated on a five-point Likert scale (1 = *strongly disagree*, 5 = *strongly agree*). Cronbach’s alpha for *Extraversion* (α

= .85) and *Neuroticism* (α = .82) were good, whereas reliabilities for *Agreeableness* (α = .65), *Conscientiousness* (α = .73) and *Openness* (α = .75) were acceptable to questionable.

Sociodemographics

Participants indicated their gender (female, male, diverse), education, employment status, religion and ethnicity. Moreover, participants indicated whether they had prior psychotherapeutic experiences or psychological knowledge. Furthermore, we used a ten-point differential with extremes labeled “left” or “right” to measure the political attitude of the participants (Breyer, 2015).

2.4 Data Analyses

To investigate the factor structure, we conducted three analyses: a confirmatory model, a simple exploratory model, and an advanced exploratory model. (1) First, we tested whether our data is suitable for factor analysis as indicated by Kaiser-Meyer-Olkin-criterion (> .80) and significant Bartlett test. Afterwards, we used confirmatory factor analysis (CFA) with four latent factors, no fixed covariances and with weighted least squares (WLSMV) estimator (Sellbom & Tellegen, 2019) to replicate the factor structure reported by Cooper and Norcross (2016). Model fits were determined by the comparative fit index (CFI), the root mean square error of approximation (RMSEA) and the standardized root mean square residual (SRMR). Whereas a CFI of > .90 indicates acceptable model fit and CFI > .95 indicates a good fit, RMSEA and SRMR values below .08 or .05 show acceptable or good model fit, respectively (Hu & Bentler, 1999).

(2) As the CFA did not yield acceptable model fit (see Results), we randomly split the data set into two subsamples. First, we extracted the factor structure by performing exploratory factor analysis (EFA) with oblimin rotation using the first subsample. Subsequently, we replicated this model by using CFA on the second subsample.

(3) However, the approach described under section (2) is highly restrictive as it does not allow for cross-loadings of items on different factors, thus constraining the CFA model.

Therefore, we performed exploratory structural equation models (ESEM) with WLSMV estimator (Sellbom & Tellegen, 2019). Adding to the first approaches, we did not only implement the factor structure, but also the factor loadings extracted from the initial exploratory factor analysis (EFA) on the first subsample to the ESEM. Again, model fit was assessed using the indices listed above.

For indicating reliability, we computed Cronbach’s alphas for the entire sample. Values above .70 indicate acceptable reliability.

For determining construct validity, we used the sum scores according to the best model identified during factor analyses. Convergent and discriminant validity were determined using Pearson’s correlation coefficients. Given the large sample size and power of the analyses, we only interpret correlations exceeding small effect sizes ($r > .10$) as meaningful. Group differences (e.g., regarding prior psychotherapeutic experience or sociodemographics) were investigated using independent t-tests. All analyses were conducted using R 4.0.2 software (R Core Team, 2020). Data files and scripts are available from the Open Science Framework (https://osf.io/n6xbq/).

3 Results

3.1 Factor Structure

(1) Kaiser-Meyer-Olkin (KMO = .84) and a significant Bartlett test showed suitability of our data for factor analyses. The model fits of the first CFA to confirm the factor structure proposed by Cooper & Norcross (2016) did not prove sufficient: RMSEA = .090, SRMR = .112, CFI = .506. When adding fixed covariances derived from the original publication to the model, model fits dropped further due to higher model constraints (RMSEA = .099, SRMR = .197, CFI = .371). Therefore, we conclude that we cannot replicate the factor structure with the German C-NIP translation.

(2) We first performed an exploratory factor analysis with oblimin rotation with a randomly drawn subsample that represented half of the entire sample (n = 484). According to

PCA, the scree plot and parallel analysis suggested a three-factor-solution. Then, we conducted CFA with a three-latent-factor model with fixed covariances and maximum likelihood estimates on the other half of the data set resulting in insufficient model fit (RMSEA = .076, SRMR = .123, CFI = .582; see Table 1).

(3) We therefore calculated three ESEMs with different specifications, as outlined in Table 1. Replicating the original four-factor structure including all 18 items, model fits were acceptable to good (RMSEA = .032, SRMR = .053, CFI = .922). Therefore, we conclude that the German C-NIP retains a similar factor structure as the English version. The factor loadings for this model are presented in Table 2. However, factor loadings slightly differ from the original English version, i.e. items 6 and 9 load primarily on the first factor and items 10 and 15 have item complexities > 2, i.e. it takes more than two factors to account for each item’s variance. Therefore, we excluded items 10 and 15 to yield better model fits (RMSEA = .024, SRMR = .046, CFI = .959). In this model, items 6 and 9 were reassigned to factor 1, leaving the second factor with only two items (7 and 8) and a more pronounced focus on preferences regarding the therapeutic relationship (see Supplement 1). However, to ease implementation and assessment in clinical practice as well as comparability of studies using different language versions, we recommend using the original factor structure instead of an alternative structure. Therefore, the following results are based on the original factor structure proposed by Cooper and Norcross (2016). For the results on the alternative factor structure, please refer to the supplementary material (see Supplements 1 and 2).

3.2 Reliability

Cronbach’s alpha for *therapist vs. client directiveness* (α = .78), *emotional intensity vs. reserve* (α = .74) and *past vs. present orientation* (α = .89) were good to acceptable, whereas the reliability of *warm support vs. focused challenge* (α = .65) was questionable.

3.3 Convergent validity

Descriptive statistics and correlations are presented in Table 3. Overall, correlation coefficients were small, with eight correlations exceeding the limit for small effect sizes of $r > .10$. As expected, *attachment avoidance* was associated with *emotional reserve* (H1), and *external locus of control* correlated with *warm support* (H2.2). Furthermore, temporal focus on past or present was associated with *past or present orientation*, respectively (H4). The significant correlations between *attachment anxiety* and *avoidance* with *warm support*, *trait anxiety* with *emotional reserve* and *warm support* (H1) as well as *conscientiousness* with *therapist directiveness* (H3.1) and *openness* with *emotional intensity* (H3.2) were according to our hypotheses, but failed to exceed the threshold of relevant effect sizes ($r > .10$). Contrary to our hypotheses, there were no relevant associations between *attachment anxiety* and *emotional reserve* (H1), *internal locus of control* and *focused challenge* (H2.1), *extraversion* and *therapist directiveness* (H3.1) as well as *openness* and *patient directiveness* (H3.2).

3.4 Discriminant validity

As hypothesized, *temporal focus* did not correlate with any scale other than *past vs. present orientation*, except for an association between *past focus* and *attachment intensity* (H5.1). Contrary to our hypothesis, *extraversion* and *agreeableness* were correlated with *emotional intensity* (H5.2).

3.5 Group differences regarding individual variables

As expected, women preferred less *focused challenge* (M = -1.11 vs. -1.96; $t(675.04)$ = -2.58, $p < .05$, $d = .17$) than men (H6). Participants with previous psychological knowledge preferred more *emotional intensity* than participants without previous psychological knowledge (H7.1; 6.59 vs. 5.67; $t(896.65) = -2.84$, $p < .001$, $d = .19$). The same pattern emerged for participants with prior psychotherapeutic experiences preferring more *emotional intensity* than participants with no experiences (H7.2; 6.38 vs. 5.60; $t(662.30) = -2.30$, $p < .05$, $d = .16$).

On an exploratory level, there emerged small, significant correlations between older age and *emotional intensity* (r = .12, p < .001). There is also a small, significant association between higher education and preferences towards *present orientation* (τ = -.11, p < .001). There were no significant or meaningful associations between the C-NIP factors and religiosity, ethnicity and political attitude.

4 Discussion

We translated the Cooper-Norcross Inventory of Preferences (Cooper & Norcross, 2016) into German and aimed for a replication of the factor structure and an investigation of the nomological network of the questionnaire using a large, heterogeneous sample. In addition to translations into other languages such as Portuguese, French and Turkish, our study represents one of the first independent and elaborate investigations of the C-NIP of this magnitude. We found that a CFA conducted in an independent sample did not support the original factor structure. However, ESEM models indicated good to acceptable model fit indices for a similar 18-item, 4-factor structure. Furthermore, we identified an improved alternative 4-factor model in which items 10 and 15 were excluded, and items 6 and 9 were reassigned to a different factor.

Just as the Portuguese, French and Turkish C-NIP translations, we were not able to replicate the original factor structure (Malosso, 2019; Özer & Yalçın, 2021; Volders, 2021). As one explanation for divergent results, the authors of the original C-NIP performed a single PCA to extract suitable items out of a 40-item pool. Thus, it is likely that factor loadings will change if another PCA is performed using the 18-item version. Second, Cooper & Norcross recruited a sample mainly consisting of psychotherapy experts, whereas we included laypersons, as they are defined as the target population of the C-NIP. However, our sample was quite similar to the original one since two-thirds of our sample reported having prior experiences with psychotherapy. Third, there might be cultural differences, even though our group followed the approach on (back)translation and cultural adaptation by Wild and

colleagues (2005) which should have contributed to comparability. Still, items 10 and 15 showed significant cross-loadings and high item complexity. Both items were also difficult to integrate in the factor structures of other translations. For example, item 10 of the French translation primarily loaded on the scale *therapist vs. client directiveness* instead of the factor *emotional intensity vs. reserveness* (Volders, 2021). In the Portuguese version, item 15 was excluded as it did not contribute significantly to the factor *warm support vs. focused challenge* (Malosso, 2019). In line with these studies, we assume different reasons for the cross-loadings: Whereas all items describe a dichotomy of preferring a certain behavior or not, item 10 (focus on emotions vs. focus on thoughts) differs from this pattern. The content of item 15 (be supportive vs. be confrontational) could be mistaken as supportiveness through directiveness, i.e. rather than being emotionally supportive, a therapist could support the patient by structuring the therapy or by giving homework. Above, we argue that two items (6, 9) previously belonging to the factor *emotional intensity vs. reserve* could be reassigned to the first factor *therapist vs. client directiveness*. Content wise, both items focus on the preference whether the therapist should encourage the patient to go into emotions or feelings, respectively. In our view, both items more closely match the facet of directiveness. Therefore, we are left with two items of the former *emotional intensity vs. reserve* facet that both focus on how therapists are supposed to manage the therapeutic relationship. This factor could indicate whether the participants want the therapist to focus on the therapeutic alliance. Due to its consistently found positive effects on therapy outcomes (Flückiger et al., 2018), it seems reasonable to have a distinct factor focusing on this aspect of psychotherapy.

We found several expected correlations between the C-NIP factors and trait variables. For example, *temporal focus* on past or present was associated with preferences towards *past or present orientation*, respectively (H4). As expected, *attachment avoidance* was related to *emotional reserve* (H1), and *external locus of control* was correlated with *warm support* (H2.2). However, eight correlations barely exceeded the threshold of small effect sizes ($r >$

.10), and most significant correlations (*n* = 20) even failed to cross the threshold. Therefore, the results suggest that personality may play a significant, yet minor role concerning preference choices. Moreover, due to a more detailed and facet-oriented approach, a few results are contrary to our hypotheses and to previous findings on treatment preferences. For example, *extraversion* was associated with *emotional intensity* that could be ascribed to represent a psychodynamic rather than a CBT approach (H5.2; Petronzi & Masciale, 2015). However, this result does not necessarily counter the results of previous studies, but rather shows that it is not sufficient to ask for preferences towards a specific treatment approach. Instead, future studies on treatment preferences should also implement therapist activity preferences, i.e., preference towards specific behavior of the therapist.

According to our study, participants high in attachment avoidance, and, to a smaller degree, attachment and trait anxiety, preferred a gentle and supportive approach in psychotherapy. However, past studies on anxiety disorders found that psychotherapy is often preferred over pharmacological treatment during which no confrontation with the anxiety-inducing stimuli is necessary (Arch, 2014; Mohlman, 2012). We assume that, at this point, laypersons and patients might be aware that psychotherapy including exposition interventions is the most effective treatment of anxiety (Mayo-Wilson et al., 2014). As some patients prefer to be treated gently in advance, it is important to measure patients’ preferences and concerns with standardized methods such as the C-NIP in order to adjust the therapeutic process to an equilibrium between effective, evidence-based treatments and the accommodation of patients’ preferences.

Overall, the effect sizes were too small to clearly determine construct validity of the instrument. However, to our knowledge, our study presents the first comparison of the C-NIP with diverse personality questionnaires. Relatively stable trait measures such as trait anxiety, adult attachment and locus of control might fail to capture the dynamic nature of preferences (Grantham & Gordon, 1986). As personality measures seemed inadequate to determine

construct further investigations might rather use less stable constructs such as expectations, current mood or well-being.

Limitations and Future Directions

Recruiting a large heterogeneous sample of $N = 969$ laypeople, the sample size goes along with well-powered analyses. In order to avoid false positive results, we limited our interpretation to correlations exceeding small effect sizes ($r > .10$). Overall, participants were highly educated with 84.5 per cent of our sample holding at least a high-school diploma. Therefore, our results and interpretations are limited and need to be replicated with different samples including participants with more heterogeneous educational backgrounds. Moreover, although two thirds of our sample indicated that they had some kind of prior psychotherapeutic experiences, we did not recruit a patient sample. Previous studies showed that patients' preferences are similar to their actual psychotherapists (Russell et al., 2022), thus we included laypersons perspectives so that biases due to current symptoms and ongoing psychotherapeutic treatments are less probable. Like in the original publication, the C-NIP factor *warm support vs. focused challenge* showed questionable reliability of <.70. Furthermore, overall means of each factor are significantly different from zero. As Cooper & Norcross (2016) point out, this result merely represents a preference towards *therapist directiveness, emotional intensity, present orientation* and *focused challenge* in our sample. Furthermore, the questionnaire might not capture every aspect that is relevant for a patient. In practice, if patients did not think about their preference yet, the C-NIP might act as a facilitator for reflection. Furthermore, it might help therapist to explain their approach, to individualize therapy or to clear out misconceptions.

Due to the above-mentioned issues regarding validity and factor structure, we strongly recommend further replication studies by independent researchers. Still, the implementation of the C-NIP into clinical practice might prove useful in order to investigate its clinical utility and its impact on variables such as therapeutic alliance or treatment termination. We propose

implementing the C-NIP after making a first appointment and before the first therapy session to minimize potential biases. A longitudinal study of patient preferences during the course of psychotherapy could shed light on preferences’ variability as an important aspect of managing and guiding the therapy.

Conclusion

Overall, the reliability, validity and factor structure of the German Cooper-Norcross Inventory show promising results, yet there is room for improvement: were associated with positive and improvable aspects alike. To date, research lacks replication of the original factor structure as well as evidence for the instrument’s validity and usefulness for research purposes. However, first small associations with personality traits hint at its usefulness. Thus, the instrument needs further independent investigations of its psychometric properties as well as on its practical utility in different clinical samples.

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Table 1

Model Fits of Confirmatory Approaches

Model	Number of Factors	Number of Items	Second Subsample (n = 485)		
			CFI	*RMSEA*	*SRMR*
PCA + CFA Confirmation					
Fixed Covariances, Maximum Likelihood	3	18	.582	.076	.123
ESEM					
Free Covariances, Weighted Least Square	4	18	.922	.032	.053
Free Covariances, Weighted Least Square	4	16	.959	.024	.046
Free Covariances, Weighted Least Square	3	16	.869	.043	.062

Note: Second subsample randomly drawn from the entire sample. CFA = Confirmatory factor analysis; PCA = Principal component analysis; ESEM = Exploratory structural equation model.

Table 2

Factor Loadings of Fitted ESEM-Model

Nr	Item	TD-CD	EI-ER	PaO-PrO	WS-FC
1	Focus on goals vs. Not focus on goals	**.62**	.07	-.08	.12
2	Give structure vs. Allow unstructured	**.65**	.08	-.10	.03
3	Teach skills vs. Not teach skills	**.89**	-.04	-.09	.00
4	Give homework vs. Not give homework	**.48**	.18	-.03	-.07
5	Take lead vs. Allow client lead	**.39**	.05	.09	.02
6	Encourage difficult emotions vs. Not encourage	**.72**	.13	.07	-.04
7	Talk about relationship vs. Not talk	.24	**.63**	-.02	-.01
8	Focus on therapy relationship vs. Not focus on therapy relationship	-.01	**.71**	.06	.05
9	Encourage strong feeling vs. Not encourage	**.47**	**.30**	.13	-.02
10	Focus on feelings vs. Focus on thoughts	.22	.10	**.37**	.23
11	Focus on past vs. Focus on present	.03	-.01	**.87**	.01
12	Reflect childhood vs. Reflect adulthood	.01	.04	**.84**	-.01
13	Focus on past vs. Focus on future	-.06	-.01	**.90**	.01
14	Be gentle vs. Be challenging	.01	-.06	.11	**.48**
15	Supportive vs. Confrontational	**.50**	-.12	.08	**.41**
16	Not interrupt vs. Interrupt	.13	-.03	.13	**.49**
17	Not challenge beliefs and views vs. Challenge beliefs and views	**-.31**	-.01	-.05	**.64**
18	Support behavior unconditionally vs. Challenge behavior	**-.45**	.12	-.01	**.62**

Note: Exploratory Factor Analysis with Geomin-Rotation. Bold numbers indicate factor loadings > .30. TD-CD: Therapist vs. Client Directiveness; EI-ER = Emotional Intensity vs. Reserve; PaO-PrO = Past vs. Present Orientation; WS-FC = Warm Support vs. Focused Challenge. Horizontal lines separate the factors according to the original English version.

Table 3

Descriptives and Correlations with C-NIP Scale Sums

Scale	*M*	*SD*	*α*	*r(TD-CD)*	*r(EI-ER)*	*r(PaO-PrO)*	*r(WS-FC)*
C-NIP							
Therapist vs. Client Directiveness	6.85	5.36	.78	1			
Emotional Intensity vs. Reserve	6.07	5.00	.74	**.53*** **	1		
Past vs. Present Orientation	-0.53	4.39	.89	**.13*** **	**.35*** **	1	
Warm Support vs. Focused Challenge	-1.38	5.05	.65	.02	**.14*** **	**.38*** **	1
Relationship Scales Questionnaire							
Anxiety	2.43	0.91	.85	-.08**	-.02	**.14*** **	.08**
Avoidance	2.37	0.86	.77	-.09**	**-.10** **	.06	.08*
General Self-Efficacy							
Overall	3.97	0.72	.89	.06	.04	-.07*	-.06
Locus of Control							
Internal	3.93	0.77	.68[1]	**.15*** **	.09**	-.04	-.02
External	2.35	0.84	.58[1]	-.07*	-.07*	.06	**.10** **
Trait Anxiety							
Overall	2.08	0.62	.95	-.09**	-.09**	.08*	.09**
Temporal Focus							
Past	3.75	1.15	.92	-.03	-.02	**.15*** **	.04
Present	4.92	1.08	.90	.06	.06	**-.11*** **	-.07*
Big Five							
Extraversion	3.33	0.95	.85	.04	**.12*** **	.02	-.08*
Agreeableness	3.16	0.78	.65	.02	**.10** **	-.02	.00
Conscientiousness	3.72	0.74	.73	.09**	.04	-.01	-.02
Neuroticism	3.09	0.98	.82	-.09**	-.07*	.08*	.09**
Openness	4.05	0.69	.75	-.02	.07*	-.01	-.06

Note: Correlations show Pearson's correlation coefficients. Negative correlations resemble increasing preference towards the right anchor of each C-NIP's scales. Bold correlation coefficients mark (at least) small effect sizes ($r > .10$). TD-CD = Therapist vs. Client Directiveness; EI-ER = Emotional Intensity vs. Reserve; PaO-PrO = Past vs. Present Orientation; WS-FC = Warm Support vs. Focused Challenge.

[1] Spearman-Brown Coefficent due to 2 item scale.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Supplementary Material

Supplement 1. Cooper – Norcross Inventar für Präferenzen (C-NIP)

Bitte geben Sie bei jeder der folgenden Fragen Ihre Präferenz dafür an, wie ein/e Psychotherapeut/in mit Ihnen arbeiten sollte, indem Sie die zutreffende Zahl ankreuzen. Eine 3 entspricht einer starken Präferenz in die jeweilige Richtung, eine 2 entspricht einer moderaten Präferenz in die jeweilige Richtung, eine 1 entspricht einer leichten Präferenz in die jeweilige Richtung und eine 0 entspricht keiner Präferenz in eine Richtung bzw. eine gleich starke Präferenz in beide Richtungen.

„Ich würde mir wünschen, der/die Therapeut/in…“

1.	konzentriert sich auf spezifische Ziele	3	2	1	keine oder gleiche Präferenz 0	-1	-2	konzentriert sich nicht auf spezifische Ziele -3
2.	strukturiert die Therapie	3	2	1	keine oder gleiche Präferenz 0	-1	-2	lässt die Therapie unstrukturiert -3
3.	vermittelt mir Fertigkeiten zum Umgang mit meinen Problemen	3	2	1	keine oder gleiche Präferenz 0	-1	-2	vermittelt mir keine Fertigkeiten zum Umgang mit meinen Problemen -3
4.	gibt mir „Hausaufgaben“ auf	3	2	1	keine oder gleiche Präferenz 0	-1	-2	gibt mir keine „Hausaufgaben“ auf -3
5.	übernimmt die Führungsrolle in der Therapie	3	2	1	keine oder gleiche Präferenz 0	-1	-2	ermöglicht, dass ich die Führungsrolle in der Therapie übernehme -3
6.	ermutigt mich, auf für mich schwierige Gefühle einzugehen	3	2	1	keine oder gleiche Präferenz 0	-1	-2	ermutigt mich nicht, auf für mich schwierige Gefühle einzugehen -3
7.	spricht mit mir über die therapeutische Beziehung	3	2	1	keine oder gleiche Präferenz 0	-1	-2	spricht nicht mit mir über die therapeutische Beziehung -3
8.	konzentriert sich auf unsere Beziehung	3	2	1	keine oder gleiche Präferenz 0	-1	-2	konzentriert sich nicht auf unsere Beziehung -3
9.	ermutigt mich, starke Gefühle auszudrücken	3	2	1	keine oder gleiche Präferenz 0	-1	-2	ermutigt mich nicht, starke Gefühle auszudrücken -3
10.	konzentriert sich hauptsächlich auf meine Gefühle	3	2	1	keine oder gleiche Präferenz 0	-1	-2	konzentriert sich hauptsächlich auf meine Gedanken -3
11.	konzentriert sich auf mein Leben in der Vergangenheit	3	2	1	keine oder gleiche Präferenz 0	-1	-2	konzentriert sich auf mein gegenwärtiges Leben -3
12.	hilft mir, über meine Kindheit nachzudenken	3	2	1	keine oder gleiche Präferenz 0	-1	-2	hilft mir, über mein Leben als Erwachsener nachzudenken. -3
13.	konzentriert sich auf meine Vergangenheit	3	2	1	keine oder gleiche Präferenz 0	-1	-2	konzentriert sich auf meine Zukunft -3
14.	verhält sich schonend	3	2	1	keine oder gleiche Präferenz 0	-1	-2	verhält sich fordernd -3
15.	ist unterstützend	3	2	1	keine oder gleiche Präferenz 0	-1	-2	ist konfrontierend -3
16.	unterbricht mich nicht	3	2	1	keine oder gleiche Präferenz 0	-1	-2	unterbricht mich und hilft mir, mich zu fokussieren -3
17.	hinterfragt meine eigenen Überzeugungen und Ansichten nicht	3	2	1	keine oder gleiche Präferenz 0	-1	-2	hinterfragt meine eigenen Überzeugungen und Ansichten -3
18.	unterstützt mein Verhalten bedingungslos	3	2	1	keine oder gleiche Präferenz 0	-1	-2	hinterfragt mein Verhalten, wenn er/sie denkt, dass es falsch ist -3

Supplement 2

Factor Loadings of the Fitted ESEM-Model (alternative factor structure)

Nr.	Item	TD-CD	EI-ER	PaO-PrO	WS-FC
1	Focus on goals vs. Not focus on goals	**.71**	.00	-.03	.15
2	Give structure vs. Allow unstructured	**.68**	.03	-.06	.04
3	Teach skills vs. Not teach skills	**.87**	-.05	-.02	-.03
4	Give homework vs. Not give homework	**.52**	.11	-.03	.00
5	Take lead vs. Allow client lead	**.43**	.00	.12	.04
6	Encourage difficult emotions vs. Not encourage	**.65**	.16	.11	-.08
7	Talk about relationship vs. Not talk	.13	**.73**	-.05	.00
8	Focus on therapy relationship vs. Not focus on therapy relationship	-.04	**.70**	.03	.07
9	Encourage strong feeling vs. Not encourage	**.40**	**.32**	.15	-.05
~~10~~	~~Focus on feelings vs. Focus on thoughts~~				
11	Focus on past vs. Focus on present	.04	-.01	**.87**	.01
12	Reflect childhood vs. Reflect adulthood	.00	.06	**.84**	-.01
13	Focus on past vs. Focus on future	-.05	-.01	**.90**	.02
14	Be gentle vs. Be challenging	.03	.00	.21	**.32**
~~15~~	~~Supportive vs. Confrontational~~				
16	Not interrupt vs. Interrupt	.20	-.01	.22	**.37**
17	Not challenge beliefs and views vs. Challenge beliefs and views	-.01	-.10	-.02	**.76**
18	Support behavior unconditionally vs. Challenge behavior	-.21	.08	.01	**.71**

Note: Exploratory Factor Analysis with Geomin-Rotation. Bold numbers indicate factor loadings > .30. TD-CD: Therapist vs. Client Directiveness; EI-ER = Emotional Intensity vs. Reserve; PaO-PrO = Past vs. Present Orientation; WS-FC = Warm Support vs. Focused Challenge. Horizontal lines separate the factors according to the original English version.

Supplement 3

Descriptive Statistics of and Correlations with Alternative C-NIP Scales

Scale	*M*	*SD*	*α*	*r(TD-CD)*	*r(RI-RR)*	*r(PaO-PrO)*	*r(WS-FC)*
C-NIP							
Therapist vs. Client Directiveness	10.53	6.97	.82	1			
Relationship Intensity vs. Reserve	1.89	2.65	.67[1]	**.43*** **	1		
Past vs. Present Orientation	-0.53	4.39	.89	**.19*** **	**.18*** **	1	
Warm Support vs. Focused Challenge	-2.42	4.26	.63	**-.11*** **	-.02	**.34*** **	1
Relationship Scales Questionnaire							
Anxiety	2.43	0.91	.85	-.07*	-.04	**.14*** **	.09**
Avoidance	2.37	0.86	.77	**-.11*** **	-.06	.06	.10**
General Self-Efficacy							
Overall	3.97	0.72	.89	.06	.02	-.07*	-.05
Locus of Control							
Internal	3.93	0.77	.68[1]	**.15*** **	.04	-.04	-.01
External	2.35	0.84	.58[1]	-.09**	-.04	.06	**.12*** **
Trait Anxiety							
Overall	2.08	0.62	.95	**-.10** **	-.08*	.08*	.09**
Temporal Focus							
Past	3.75	1.15	.92	-.03	-.02	**.15*** **	.03
Present	4.92	1.08	.90	.06	.08*	**-.11*** **	-.05
Big Five							
Extraversion	3.33	0.95	.85	.06	.09**	.02	-.08*
Agreeableness	3.16	0.78	.65	.04	.08*	-.02	-.02
Conscientiousness	3.72	0.74	.73	.08*	.06	-.01	-.01
Neuroticism	3.09	0.98	.82	-.08**	-.08*	.08*	.09**
Openness	4.05	0.69	.75	.02	.07*	-.01	-.07*

Note: Correlations show Pearson's correlation coefficients. Negative correlations resemble increasing preference towards the right anchor of each C-NIP's scales. Bold correlation coefficients mark (at least) small effect sizes ($r > .10$) TD-CD = Therapist vs. Client Directiveness; RI-RR = Relationship Intensity vs. Reserve; PaO-PrO = Past vs. Present Orientation; WS-FC = Warm Support vs. Focused Challenge.

[1] Corrected Spearman-Brown coefficient due to 2 items per factor.

* $p < .05$. ** $p < .01$. *** $p < .001$.

7.2. Paper II

Differences in Psychotherapy Preferences between Psychotherapy Trainees and Laypeople

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Heinze, P. E., Weck, F., Hahn, D., & Kühne, F. (2023). Differences in psychotherapy preferences between psychotherapy trainees and laypeople. *Psychotherapy Research*, *33*(3), 374-386. https://doi.org/10.1080/10503307.2022.2098076

Acknowledgments

We would like to thank Dr. Brian Bloch for his editing of the English.

Funding

The research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Disclosure of Interest

We declare a potential conflict of interest, as Prof Florian Weck is an advisory editor for Psychotherapy Research.

Abstract

Objective: Despite increasing research on psychotherapy preferences, the preferences of psychotherapy trainees are largely unknown. Moreover, differences in preferences between trainees and their patients could a) hinder symptom improvement and therapy success for patients and b) represent significant obstacles in the early career and development of future therapists.

Method: We compared the preferences of n = 466 psychotherapy trainees to those of n = 969 laypersons using the Cooper-Norcross Inventory of Preferences. Moreover, we compared preferences between trainees in cognitive-behavioral therapy (CBT) and psychodynamic trainees.

Results: We found significant differences between both samples in 13 of 18 items, and three of four subscales. Psychotherapy trainees preferred less therapist directiveness (d = 0.58), more emotional intensity (d = 0.74), as well as more focused challenge (d = 0.35) than laypeople. CBT trainees preferred more therapist directiveness (d = 2.00), less emotional intensity (d = 0.51), more present orientation (d = 0.76) and more focused challenge (d = 0.33) than trainees in psychodynamic/psychoanalytic therapy.

Conclusion: Overall, the results underline the importance of implementing preference assessment and discussion during psychotherapy training. Moreover, therapists of different orientations seem to cover a large range of preferences for patients, in order to choose the right fit.

Keywords: Psychotherapy Process, Psychotherapy Training, Activity Preference, C-NIP, Assessment

Clinical or methodological significance of this article

The study identifies that preferences for specific therapy activities differ significantly between psychotherapy trainees and laypeople, as well as between trainees of different therapy orientations. The findings highlight the need for psychotherapy trainees to implement

preference assessment for self-reflection, for adapting therapy to patient preferences and for discussing disagreements with their patients in order to increase the chances of therapy success and prevent unfavorable therapy processes in the early career of psychotherapists.

Differences in Psychotherapy Activity Preferences between Psychotherapy Trainees and Laypeople

In most countries, becoming a psychotherapist requires several years of theoretical and practical training (e.g., American Psychological Association, 2014). For example, in order to become a licensed psychotherapist in Germany, one has to have a Master's Degree in psychology, followed by full-time training of at least three years (PsychThG, 2019). During training, trainees change from laypeople in psychotherapy to professionals. Furthermore, at this young age, trainees are expected to grow on a personal and a professional level, mostly through personal practice and supervision (Orlinsky et al., 2005). The newly formed identity as therapists includes specific preferences and expectations towards certain aspects of psychotherapy (Pieterse et al., 2013). However, with the individual development of psychotherapists during the course of their training, as well as prior psychotherapy experience as a general predictor of preference choices (Cooper et al., 2019; Speight & Vera, 2005), it is unclear how psychotherapy trainee preferences differ from laypeople preferences (and potential patients). Our aim was thus to investigate the preferences of psychotherapy trainees and of laypersons, and to compare commonalities and differences between the two.

Definition of Preferences and Empirical Results

We need to differentiate treatment expectations and preference from one another, despite both sharing a priori stances towards psychotherapy (and its content and external circumstances), as well as a dynamic and multidimensional nature and operations at different levels of consciousness (i.e., un-, sub- or conscious; Constantino et al., 2018). Whereas expectations refer to individual predictions of different aspects actually occurring in psychotherapy (i.e., outcome, treatment, or change expectations), preferences are desirable aspects of psychotherapy that people wish for (Swift et al., 2011). Preferences can be unrealistic, whereas expectations take into account different anticipated barriers and practical constraints. For example, Hispanic patients might *prefer* psychotherapy in Spanish, but

expect it in English (expectation), if there are few Spanish-speaking therapists in their vicinity. Positive outcome expectations are associated with better outcomes (Constantino et al., 2018), and preference accommodation is associated with lower dropout, better alliance and outcomes (e.g., Swift et al., 2018). Three subcategories distinguish most preferences (Swift et al., 2011, 2018). First, people can prefer different *forms of treatment*, e.g., cognitive behavioral therapy (CBT), psychodynamic therapy (PD) or pharmacological treatment. Second, participants might have preferences towards specific *characteristics of a psychotherapist*, e.g., regarding gender, age or personality. Third, preferences regarding the *activities that take place during psychotherapy* might differ. Thus, a client could prefer a directive approach by the therapist, a focus on cognitive rather than emotional aspects and homework after each session.

Several studies have pointed out the association between psychotherapeutic experience and preference choices for all three subcategories. Concerning preferences towards psychotherapists' characteristics, participants with prior psychotherapeutic experience were more likely to express any preference in an open-ended format, whereas non-experienced participants less often indicated specific preferences (Speight & Vera, 2005). In a recent study investigating preferences towards therapist characteristics, German participants with prior psychotherapeutic experience were significantly more likely to prefer female therapists (Heinze et al., 2023). For treatment preference, knowledge of psychotherapy and prior psychotherapeutic experience were associated with preferring subsequent psychotherapeutic treatment (Churchill et al., 2000; Houle et al., 2013; van Schaik et al., 2004). Moreover, an early study established that activity preferences of patients changed over the course of psychotherapeutic treatment, i.e. preferences for approval, advice, audience and relationship differed, depending on the treatment phase (Tracey & Dundon, 1988).

Most studies on this topic were conducted primarily with laypeople (without therapy experience, e.g. Cooper & Norcross, 2016; Heinze et al., 2022) or with mental health patients

(e.g., Houle et al., 2013; Speight & Vera, 2005; van Schaik et al., 2004). On the one hand, prior experiences can act as anchors for preferences regarding future treatments. If one has already experienced psychotherapy and its elements, it might be easier to judge the relevance of specific features. Moreover, preferences correspond with past experiences, so that people prefer treatments or therapists they already experienced (van Schaik et al., 2004). On the other hand, others suggest that preferences were indicated irrespective of the satisfaction with prior treatment (Kealy et al., 2021; Stiggelbout & de Haes, 2001). However, only a few empirical studies have investigated the preferences of therapists and how they may differ from non-therapist preferences.

Preferences of Psychotherapists

So far, there has been an abundance of investigations on why therapists choose a specific theoretical orientation. Predictors range from personality traits such as openness and conscientiousness, to organismic vs. mechanistic worldviews or the need for security (e.g., Buckman & Barker, 2010; Safi et al., 2017; Tartakovsky, 2016). Furthermore, several investigations have focused on the treatment preferences of therapists. For example, most therapists who were in psychotherapeutic treatment themselves chose therapists of another theoretical orientation than their own (Norcross et al., 2009; Norcross & Grunebaum, 2005). Interestingly, psychiatrists showed different treatment preferences when asked whether the treatment is supposed to be for patients suffering from generalized anxiety disorder (GAD) or for psychiatrists suffering from GAD. In comparison to recommendations for general patients, psychiatrists more often recommended psychotherapy, and less often recommended psychopharmacological treatment for themselves (Latas et al., 2018).

Regarding activity preferences, there are very few studies at hand that describe psychotherapists' preferences towards particular methods, approaches and attitudes both during the course of treatment as well as in single sessions. One notable exception is a study conducted by Cooper and colleagues (2019) who investigated the preferences of mental health

professionals and of laypeople. Overall, mental health professionals preferred an approach that resembled psychodynamic therapy, i.e. client directiveness and emotional intensity. In comparison, laypersons preferred an approach more closely resembling CBT, as they preferred significantly more therapist directiveness and less emotional intensity than mental health professionals. The authors argue that therapists should not project their own preferences onto their patients, but rather use questionnaires or interviews to identify the patients' preferences, and to adjust therapy accordingly. Furthermore, it seems necessary not only to look at treatment preferences, but also at preferences at the micro level (i.e., activity preferences), because approaches of different therapists adapting the same treatment orientation may differ markedly (Katz et al., 2021).

Why Psychotherapist Preferences Matter

Despite these findings, other studies on psychotherapist's activity preferences are rare, leaving us with a highly relevant gap in research for several reasons. Psychotherapists' own therapy experiences were the primary influence on how treatment and single sessions were conducted within two previous studies (Safran et al., 2011; Stewart & Chambless, 2007). Given that one's own choices and behaviors are considered as more common than alternatives (i.e. false consensus effect; Ross et al., 1977), therapists who have specific preferences might not adapt their approach to their patients' needs, but rather to their own preferences. This can be problematic for at least two reasons. First, congruence in alliance ratings (Laws et al., 2017; Zilcha-Mano et al., 2017), as well as goal consensus and collaboration between therapists and clients were associated with better psychotherapy outcomes and lower symptom levels (Tryon et al., 2018). Moreover, a recent study revealed that agreement between patients and their therapists on the helpful aspects of psychotherapy was associated with reductions in symptoms and interpersonal problems (Chui et al., 2020). Therefore, consensus and agreement seem to have a beneficial influence on therapy. Second, several meta-analyses underlined that preference accommodation, i.e., whether patients received their

preferred psychotherapy, was associated with more positive treatment outcomes, lower dropout as well as higher treatment satisfaction (Lindhiem et al., 2014; Swift et al., 2011, 2018; Windle et al., 2020). Therefore, it is necessary to measure therapist preferences and compare them to those of their (potential) patients.

Why Psychotherapy Trainee Preferences Matter

Psychotherapy trainees and their preferences should also be taken into account thoroughly, as trainees often struggle with low self-efficacy, self-doubt and challenging first-time therapy encounters. Psychotherapists early in training experience sessions as stressful and challenging (Orlinsky et al., 2005; Taubner et al., 2010). However, students' initially low levels of counseling self-efficacy increased throughout the course of their training (Mullen et al., 2015). Moreover, self-confidence increased and professional insecurity decreased with the number of years since beginning their training and with the number of supervision sessions received (Junga et al., 2019). Similarly, experiences of professional self-doubt and negative personal reaction decreased during CBT training (Odyniec et al., 2019).

Given these challenges early in the professional career of a psychotherapist, disagreement over preferences between trainees and patients may become an obstacle for psychotherapy trainees, as the benefits of agreement and consensus (fewer symptoms, better alliance, less dropout) cannot be utilized, potentially increasing the chances of unsuccessful therapies and disappointment during the course of therapy. Since, to the best of our knowledge, there are no empirical investigations of the preferences of psychotherapy trainees so far, we investigated the preferences of psychotherapy trainees and differences between them and laypeople's preferences (i.e., their potential patients). Thus, our study adds to the previous investigation of mental health professionals by Cooper and colleagues (2019), by now investigating the activity preferences of both laypeople and psychotherapy trainees. To the best of our knowledge, the Cooper-Norcross Inventory of Preference (C-NIP) is the only validated and standardized questionnaire available in German (Heinze et al., 2022). Referring

to previous results with licensed therapists (Cooper et al., 2019), we hypothesized that psychotherapy trainees preferred less therapist directiveness and more emotional intensity than laypeople. Furthermore, we explored differences in preferences between trainees of different theoretical orientations (i.e., CBT or PD trainees).

Methods

Procedure and Participants

The study was conducted online, using the survey provider SoSciSurvey (Leiner, 2019). Participants gave informed consent and provided their data fully anonymized. The ethics committees of both affiliated universities approved the study (University of Mainz: no. 2017-JGU-psychEK-018; University of Potsdam: no. 13/2020).

We recruited two samples from April until June 2020. First, the convenience sample of laypeople was recruited via the German non-commercial SoSciPanel respondent pool (n = 733; Leiner, 2016). The panel included approximately 80,000 participants in total (59% female) who voluntarily signed up to be informed about current studies, with half of them holding a university degree. Our study link was forwarded to 4,000 members of the panel after an independent review of the study design. The link was also forwarded via social media, student mailing lists and the University of Potsdam's participant recruitment platform (n = 236). Students of the University of Potsdam received course credit, and we randomly selected five participants for a 10€ voucher. Inclusion criteria were sufficient German skills to complete the questionnaire, as well as age ≥ 18 years. After excluding n = 3 participants who were younger than 18, the sample included n = 969 participants (female = 66.97%, n = 649). The mean age was 40.01 (SD = 16.09, range = 18-85), and two thirds had some kind of prior experience with psychotherapy (65.1%; n = 627), for example as (former) patients, acquaintance with a patient or on a professional basis. For more detailed sample characteristics, refer to the C-NIP validation using the same sample (Heinze et al., 2022).

Second, after creating a list of German postgraduate training institutes (including adult/adolescent psychotherapy as well as behavioral, psychodynamic or systemic therapy; *n* = 210), we contacted all institutes asking them to distribute the link of the online survey to their trainees. Data acquisition took place between January and February 2020. Participants were eligible if a) they were currently in psychotherapy training and b) gave informed consent. N = 468 participants completed the online survey. Two were excluded due to a lack of informed consent or not participating in psychotherapy training. Accordingly, the trainee subsample consisted of *N* = 466 participants (female = 86.48%, *n* = 403). The mean age was 32.08 (*SD* = 6.83). 53.21% (*n* = 248) received training in CBT, 27.25% (*n* = 127) in PD, and 13.30% (*n* = 62) in psychoanalysis. Most participants focused on psychotherapy for adults: 66.95% (*n* = 312). For more details on the trainee sample, refer to Hahn et al. (2023).

As expected, trainees were significantly more often female (86.48% vs. 66.98%, $X(2) = 61.67$, $p < .001$) and significantly younger ($M = 32.08$ vs. 40.01, $t(1415.4) = 13.08$, $p < .001$) than the laypersons.

Measures

We used the 18-item Cooper-Norcross Inventory of Preferences (C-NIP; Cooper & Norcross, 2016; German translation: Heinze et al., 2022) to measure different activity preferences on an item- or factor-level (e.g., “I would like the therapist to focus on specific goals” vs. “I would like the therapist to not focus on specific goals”). Psychotherapy trainees were asked to indicate their preference as to how a psychotherapist should work with their *patients*, whereas laypeople indicated their preference as to how a psychotherapist should work with *them*. Participants indicate their preferences using 7-point semantic differentials with scores ranging from -3 to +3. Zero scores indicate no preference or an equal preference for both options. The authors of the original measure proposed a four-factor structure[1]:

[1] The factor structure of the C-NIP is still the subject of debate, and multiple models have been proposed (Cooper et al., 2016; Heinze et al., 2022). Therefore, we performed confirmatory factor analysis using the trainee sample prior to all other analyses. The results are presented in the supplementary material.

therapist vs. client directiveness, *emotional intensity vs. reserve*, *past orientation vs. present orientation* and *warm support vs. focused challenge.* Overall, reliabilities ranged from .65 *(warm support vs. focused challenge)* to .89 *(past vs. present orientation).* Psychometrically, there is no evidence to support a total score for all 18 items (Cooper & Norcross, 2016; Heinze et al., 2022).

Furthermore, laypeople were asked whether they had any prior psychotherapeutic experience. If they indicated *yes*, participants could specify the source of their experience (as patient, professional, acquaintance or other).

Analytic Approach

(I) To investigate differences between laypeople and trainees, we used t-tests for independent samples. Due to the exploratory nature of the approach used for single C-NIP item analyses, we employed Bonferroni-correction. Therefore, p-values below .003 were considered significant. We indicated effect sizes with Cohen's *d* (small: 0.2, medium: 0.5, large: 0.8; Cohen, 1992). Moreover, we calculated sum scores for the four factors. Depending on the number of items per factor, preferences can range from +9 to -9 (i.e. *past vs. present orientation*) or +15 to -15, respectively, with positive scores indicating a preference towards the left-hand option. Furthermore, we investigated the influence of psychotherapeutic experience of participants on preference choices using a one-way ANOVA with trimmed means, due to significant Levene's tests of homoscedasticity. We compared participants of the layperson sample that indicated having therapy experience or not, and psychotherapists in training (0 = laypeople: no experience, 1 = laypeople: self-reported experience, 2 = trainees). The effect size ξ (Xi) can be interpreted as small (.15), medium (.35) or large (.50; Wilcox & Tian, 2011).

(II) We further investigated differences between psychotherapy trainees of different theoretical orientations. We compared CBT trainees (n = 248) with those having a psychodynamic or psychoanalytic focus (n = 189) using t-tests for independent samples.

Again, we indicated effect sizes using Cohen's *d*. All analyses were performed using the statistic software R v.4.0.2 with lavaan and WRS2 packages (Mair & Wilcox, 2020; R Core Team, 2020; Rosseel, 2012).

Results

Differences between Trainees and Laypersons

We calculated independent t-tests to compare the means of the C-NIP items between the two samples. The results are presented in *Table 1*. Overall, there were significant differences between the two samples in 13 of 18 items. Most differences reached a medium effect size ($d > .50$), indicating relevant differences in preference choices.

Moreover, we investigated differences in scale means between both samples (*Table 2*). Laypersons preferred significantly more *therapist directiveness* ($M = 6.85$ vs. 3.47, $p < .001$, $d = 0.58$ [0.46; 0.69]), less *emotional intensity* ($M = 6.07$ vs. 9.54, $p < .001$, $d = 0.74$ [0.63; 0.86]) and less *focused challenge* ($M = -1.38$ vs. -3.07, $p < .001$, $d = 0.35$ [0.24; 0.47]) than psychotherapy trainees.

Psychotherapeutic Experience

Additionally, we explored differences between levels of psychotherapeutic experience. We found significant influences of psychotherapeutic experience on *therapist vs. client directiveness* ($F(2, 480.74) = 33.87$, $p < .001$, $\xi = .36$ [.26; .45]), *emotional intensity vs. reserve* ($F(2, 482.49) = 105.55$, $p < .001$, $\xi = .45$ [.36; .52]), and *warm support vs. focused challenge* ($F(2, 491.44) = 20.77$, $p < .001$, $\xi = .21$ [.15; .27]). There was no significant effect on *past vs. present orientation* ($F(2, 472.64) = 0.99$, $p = .37$). *Figure 1* shows the means (± 1 SD) and the data distribution of the three groups across all C-NIP subscales. Post-hoc tests showed that laypeople with or without therapy experiences preferred significantly more *therapist directiveness* than psychotherapy trainees ($M = 7.69$ or 7.84 vs. 4.55, $p < .001$). Moreover, participants with and without some kind of experience differed significantly in their preference for *emotional intensity* ($M = 6.88$ vs. 5.85, $p < .01$). Again, trainees preferred

significantly more *emotional intensity* than participants with self-reported experience (M = 6.88 vs. 9.92, $p < .001$) or participants without prior experience (M = 5.85 vs. 9.92, $p < .001$). However, trainees preferred less *warm support* than laypeople with or without therapy experiences (M = 4.97 or 5.23 vs. 4.16, $p < .001$).

Psychotherapy Orientation

Within the trainee sample, we further investigated whether there were differences in preferences between psychotherapists trained in CBT or in psychodynamic/psychoanalytic therapy. There were significant differences between both orientations on all four C-NIP scales (see *Figure 2*): *therapist vs. client directiveness*: $t(297.81) = 19.45$, $p < .001$, $d = 2.00$ [1.74; 2.25]; *emotional intensity vs. reserve*: $t(409.47) = 5.29$, $p < .001$, $d = 0.51$ [0.32; 0.70]; *past vs. present orientation*: $t(424.43) = 7.97$, $p < .001$, $d = 0.76$ [0.56; 0.96]; *warm support vs. focused challenge*: $t(368.48) = 3.34$, $p < .001$, $d = 0.33$ [0.14; 0.52]. Specifically, CBT trainees preferred more *therapist directiveness*, less *emotional intensity*, more *present orientation* and more *focused challenge* than trainees in psychodynamic/psychoanalytic therapy.

Discussion

In the current study, we investigated the activity preferences of psychotherapy trainees, and how they differed from the preferences of laypeople. Trainees preferred less *therapist directiveness* and less *emotional intensity* during psychotherapy than laypeople. Moreover, laypersons significantly preferred less *focused challenge*. In subsequent analyses, trainees preferred significantly less *therapist directiveness*, more *emotional intensity* and more *focused challenge,* than laypeople both with or without psychotherapy experience. Laypeople without experience preferred less *emotional intensity* than laypeople with self-reported experience. Moreover, CBT trainees preferred significantly more *therapist directiveness*, *present orientation* and *focused challenge*, as well as less *emotional intensity* than trainees trained in psychodynamic and psychoanalytic approaches.

Using a German-speaking trainee sample, we replicated the findings of an English-speaking therapist sample, using the same questionnaire (Cooper et al., 2019). In both studies, psychotherapists preferred less *therapist directiveness* and more *emotional intensity* than laypeople. However, differing from the original study, trainees in our sample preferred more *focused challenge* than laypeople, i.e., a more challenging and confrontational approach rather than unconditional support. This might be because, on the one hand, trainees are taught the effectiveness of confrontational methods such as exposition interventions, and subsequently prefer effective treatment options (Mayo-Wilson et al., 2014). On the other hand, therapists are often reluctant to implement confrontational interventions, as they have negative beliefs about exposition and worry about distress for both patients and therapists (Deacon & Farrell, 2013; Pittig et al., 2019). Moreover, demographic differences between the groups of laypeople and trainees might also account for different preferences. Most importantly, our trainee sample primarily included highly educated, female participants in their late twenties to early thirties, due to the postgraduate nature of psychotherapy training, whereas the laypeople sample was more heterogeneous (age ranging from 18 to 85, 67% female). In an earlier

validation of the C-NIP, we already found that, within the laypeople sample, women preferred less *focused challenge* than men, as well as a positive correlation between age and *emotional intensity* (Heinze et al., 2022). Given these prior results, the difference between the younger sample of trainees preferring less *emotional intensity* than laypeople, confirms previous findings. However, trainees prefer more *focused challenge* than laypeople, possibly because trainees are more likely to be aware of the benefits of experience-based methods and exposition, given their theoretical and practical experience. There might be other potential confounds, such as (higher) levels of education, agreeableness, or empathy in the trainee sample (Cooper et al., 2016, Heinze et al., 2022). Furthermore, preferences depend on the type and severity of the specific problem that leads people to seek therapy in the first place (Dancey et al., 1992; Landes et al., 2013). For example, younger participants preferred older therapists for treating universal problems, whereas they preferred younger therapists for problems associated with a lower age (e.g. cyberbullying; Kessler et al., 2019), We recommend accounting for such effects in future studies by anchoring the problem type or including patients of various diagnoses.

In our sample, CBT trainees preferred more *focused challenge* than therapists trained in psychodynamic or psychoanalytic orientations. There were no differences on the scale for *past vs. present orientation* between laypeople and trainees. However, within the trainee sample, CBT trainees preferred more *present orientation*, whereas psychodynamic trainees preferred more *past orientation*. Thus, whereas there is no consensus between trainees of different orientations about a sole focus on either the causes of psychological distress or how a patient's problems should be approached, our results suggest that laypeople prefer an equal focus on childhood experiences and present situational challenges rather than focusing exclusively on either present or past events. Interestingly, a recent study found that PD therapists are most effective if they incorporate CBT interventions and methods into their therapy (Katz et al., 2021). Taken together, undogmatic and individualized approaches for

each patient seem to conform to laypeople's preferences more closely and could promote symptom improvement. Overall, since the authors of the original study did not provide any information on the therapeutic orientation of their mental health professional samples (Cooper et al., 2019), our study underlines the distinction in preferences between therapeutic orientations.

Moreover, CBT trainee preferences resembled the preferences in our laypeople sample more closely, i.e., a clear preference for *therapist directiveness* and slightly less *emotional intensity*. In line with our results, another study showed that laypeople valued and preferred treatments that were based on a scientific rationale, tested in clinical trials and had proved to be effective (Farrell & Deacon, 2016). Moreover, therapists underestimated how much laypeople preferred such scientifically based treatments, especially if the therapists did not value research themselves. Possibly, CBT therapists were more familiar with scientific principles, and therefore closer to the laypeople's preferences in our sample. However, common factors such as relational aspects or following a treatment rationale were also preferred by laypeople in previous studies (Farrell & Deacon, 2016; Swan & Heesacker, 2013; Swift & Callahan, 2010). As all therapy orientations use common factors, though through different means (Wampold & Imel, 2015), common factors might not contribute much to differences in preferences between different therapeutic approaches.

Implications

Psychotherapists should bear in mind that their patients do not necessarily share their preferences and perceptions of therapy. If patient preferences are not met, or if there is no communication about differences, dissatisfaction with therapy, ruptures or dropout may result (Lindhiem et al., 2014). Therefore, we recommend implementing preference assessments at the beginning of the therapy, especially for trainees, in order to explore different areas of preference and potential incongruence. Open communication about divergent preferences can help the patient to adjust their expectations, or if necessary, to find a more suitable therapist.

Norcross & Cooper (2021) recommend various options for dealing with patient preferences. It is possible to either adopt the preferences, adapt them by adjusting to therapy circumstances, propose alternatives or to refer patients to other therapists. The significant differences between CBT trainees and trainees in psychodynamic and psychoanalytic approaches open up the opportunity to account for a broad range of patient preferences.

So far, it remains unclear whether trainees choose their therapy orientation based on prior preferences, or if preferences form and amplify during the course of psychotherapy training. Furthermore, there is no research on the impact of flexibility or rigidity of therapists' preferences and their consequences for therapy. However, we encourage training curricula to include reflection on preferences and opportunities, in order to gain experience with interventions that do not necessarily reflect the trainee's preference. For example, we recommend using role plays with simulated patients, as they may not only improve competence, communication skills and alliance in trainees (Kühne et al., 2022), but are a safe space for trying out new behaviors (Kühne et al., 2021). We assume that trainees who have learned how to adapt to patient preferences and have experienced both the advantages and challenges of different therapeutic approaches first-hand, are more likely to be flexible and adaptive in future therapies, and thus might benefit from positive effects of patient accommodation, such as lower dropout or enhanced symptom improvement (Swift et al., 2018).

On the other hand, preference accommodation and patient personalization for the mere sake of accommodation might be counterproductive for several reasons. First, trainees are already exposed to numerous challenges such as low levels of self-efficacy (Mullen et al., 2015), professional insecurity and self-doubts (Junga et al., 2019; Odyniec et al., 2019). Therefore, the implementation of methods that trainees do not really want could entail even higher workload and error-proneness. Second, just as therapists should accept different beliefs, personalities and preferences on the part of their patients, there are ethical concerns as

to whether programs to challenge therapist preferences are justified. However, limited options and insufficient resources in terms of offering psychotherapy to everyone in need, does not always enable preference accommodation through differences in preference between practitioners, so that it might be necessary for individual therapists to be flexible towards different patient wishes. Third, patient preferences might contradict evidence-based treatment methods, e.g. a patient with phobia preferring not to have exposition treatment. In such cases, preference accommodation might lead to malpractice. Taken together, we are advising trainees to reflect on their preferences and identify areas where accommodation to patient preferences is feasible. To quantify the impact of preference accommodation, we encourage studies that investigate the gains and losses if therapists use a therapeutic approach with which they are less familiar, but which really matches the patient's preferences.

Strengths, Limitations and Future Directions

We recruited two adequately sized samples in order to perform high-power, sophisticated statistical analyses, including a good representation of all psychotherapy trainees in Germany, through contacting every training institute. Despite being one of the first to investigate differences between laypeople and trainees, our study is not without its limitations. First, we conducted a cross-sectional study. Future studies should investigate how preferences change during psychotherapy and over the course of training. Possibly, during the course of training, initial preferences that led to the decision for a specific orientation might intensify, due to a thorough study of the orientation paradigms and methods.

Second, we did not determine the effect of preference disagreements on clinically relevant outcomes such as symptoms, dropout or the therapeutic relationship. However, in a recent study with a patient sample, preferences for active input (i.e. focused challenge, therapist directiveness and emotional intensity) were indeed associated with symptom improvement over the course of psychotherapy (Cooper et al., 2022).

Third, although single-fit indices of the C-NIP were acceptable, the confirmatory factor analysis failed to confirm the original factor structure (Cooper & Norcross, 2016; Heinze et al., 2022). As in all other studies conducted with the C-NIP (Cooper & Norcross, 2016; Özer & Yalçın, 2021; Volders, 2021), the *warm support vs. focused challenge* scale only showed acceptable reliability. Specifically, items 17 (challenge vs. not challenge beliefs and views) and 18 (support behavior unconditionally vs. challenge behavior) seemed to differ from the other three items statistically and in their content. Therefore, a revision of the C-NIP should focus on its factor structure, and specifically consider these items.

Fourth, there are some limitations regarding our sample. Overall, since the data acquisition took place online, we might have excluded people with little experience or interest in web applications, particularly older people. Moreover, members of the respondent pool signed up voluntarily and thus might be a) more interested in scientific studies, and b) more interested in psychological and psychotherapeutic topics, than other individuals. By contrast, the respondent pool more closely approximates the diversity and heterogeneity of the general public than other common recruitment methods such as convenience sampling (Leiner, 2016). Furthermore, our study investigated laypeople who are not representative, might not be in need of psychotherapy or might struggle to estimate the impact of given preferences. However, since patients tend to describe their actual psychotherapist rather than indicating preferences (Russell et al., 2022), and given that preferences as anticipatory choices need to be assessed prior to psychotherapy by definition (Grantham & Gordon, 1986), we decided to recruit a heterogeneous sample of people who could engage in psychotherapy at some point. Moreover, we argue that all preferences should be considered, even if they are not based on experiences or insight into the therapy process. Moreover, controlled trials could investigate the impact of the implementation of preference assessments on process and outcome measures of psychotherapy.

Conclusion

Laypeople and therapists in training, as well as trainees of different treatment orientations, differed significantly in their preferences for psychotherapy activities. Therefore, we highly recommend practitioners in the early phases of their career to assess their patients' preferences, and to carefully reflect on their own preferences as well. Both parties should discuss significant disagreements in order to manage expectations, lessen the likelihood of alliance ruptures, and increase the chances of better therapy processes and outcomes.

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Table 1

Item Level Comparison between Samples

	Laypeople (*N* = 969)		Trainees (*N* = 466)			
Item	*M*	*SD*	*M*	*SD*	*t*	*d*
1. Focus on goals vs. not focus on goals	1.20	1.54	1.04	1.71	1.75	0.10
2. Give structure vs. allow unstructured	1.54	1.47	0.98	1.73	6.07*	0.36
3. Teach skills vs. not teach skills	2.24	1.36	1.75	1.59	5.72*	0.34
4. Give homework vs. not give homework	1.00	1.52	-0.05	2.13	9.58*	0.61
5. Take lead vs. allow client lead	0.86	1.48	-0.24	1.63	12.39*	0.72
6. Encourage difficult emotions vs. not encourage	2.04	1.28	2.47	1.09	-6.60*	0.35
7. Talk about relationship vs. not talk	1.36	1.43	2.17	1.19	-11.25*	0.60
8. Focus on therapy relationship vs. not focus on therapy relationship	0.53	1.62	1.74	1.27	-15.45*	0.80
9. Encourage strong feeling vs. not encourage	1.64	1.33	2.29	1.09	-9.86*	0.52
10. Focus on feelings vs. focus on thoughts	0.50	1.44	0.86	1.24	-4.92*	0.26
11. Focus on past vs. focus on present	-0.17	1.56	-0.26	1.26	1.13	0.06
12. Reflect childhood vs. reflect adulthood	-0.06	1.70	-0.03	1.44	-0.29	0.02
13. Focus on past vs. focus on future	-0.31	1.59	-0.31	1.21	0.00	0.00
14. Be gentle vs. be challenging	-0.04	1.55	-0.41	1.21	4.97*	0.26
15. Supportive vs. confrontational	1.04	1.62	0.50	1.32	6.77*	0.36
16. Not interrupt vs. interrupt	0.14	1.61	-0.21	1.52	4.05*	0.22
17. Not challenge beliefs and views vs. challenge beliefs and views	-1.20	1.56	-1.55	1.34	4.36*	0.23
18. Support behavior unconditionally vs. challenge behavior	-1.36	1.45	-1.39	1.26	0.97	0.05

Note: Larger scores resemble preferences for left-hand option. Cohen's *d*: small effects: 0.2 - 0.5, medium effects: 0.5 - 0.8, large effects ≥ 0.8. Items 1-5: *therapist vs. client directiveness*; Items 6 – 10: *emotional intensity vs. reserve*; Items 11 – 13: *past vs. present orientation*; Items 14 – 18: *warm support vs. focused challenge*.

* $p < .003$ (Bonferroni-corrected significance level)

Table 2

Scale Level Comparisons between Samples

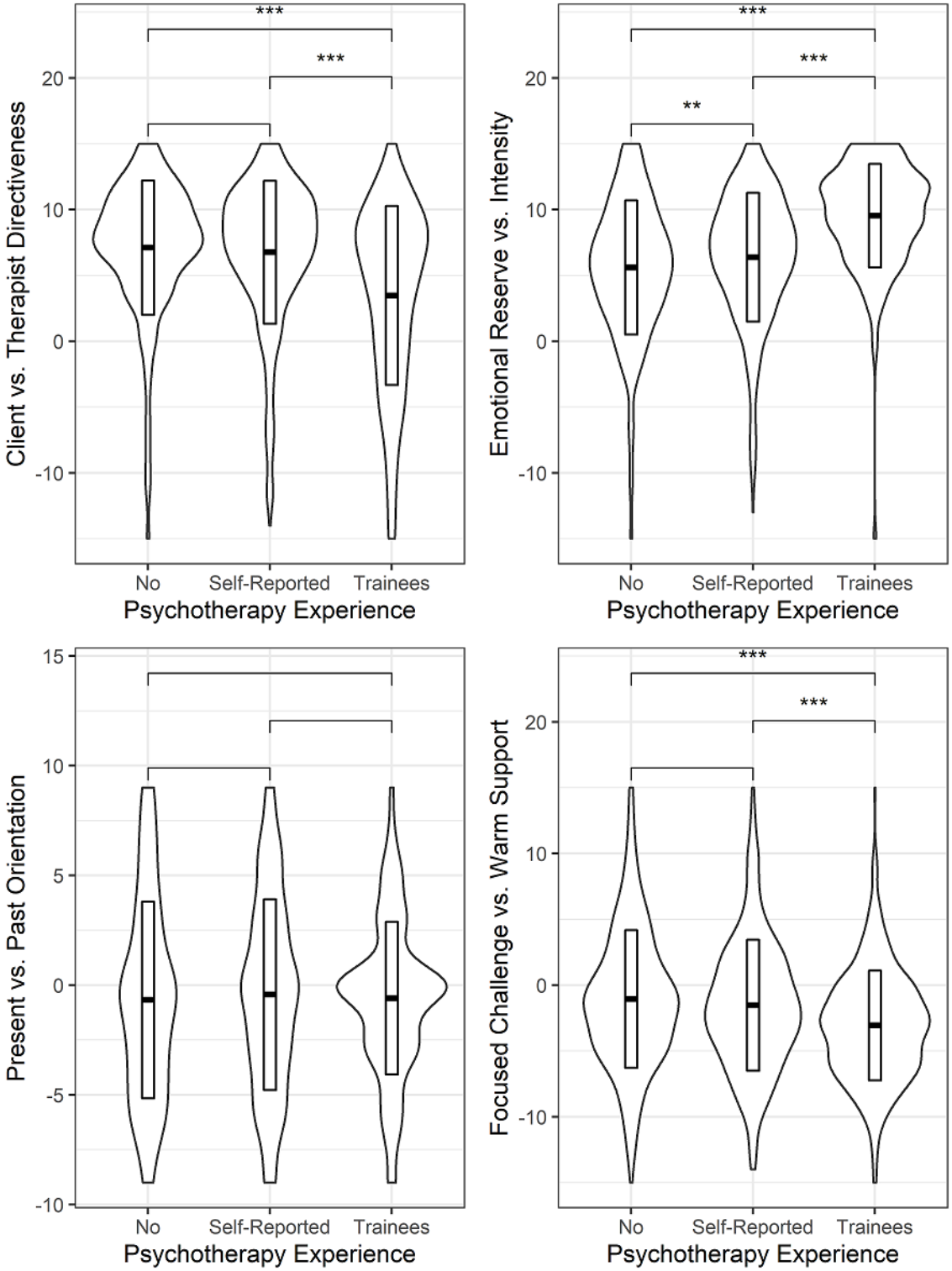
Scale	Laypeople (*N* = 969)			Trainees (*N* = 466)			*t*	*d*
	M	*SD*	α	*M*	*SD*	α		
Therapist vs. Client Directiveness	6.85	5.36	.78	3.47	6.80	.83	9.40*	0.58
Emotional Intensity vs. Reserve	6.07	5.00	.75	9.54	3.93	.69	-14.27*	0.74
Past vs. Present Orientation	-0.53	4.39	.89	-0.59	3.48	.87	0.29	0.02
Warm Support vs. Focused Challenge	-1.38	5.05	.65	-3.07	4.16	.61	6.71*	0.35

Note: Larger scores resemble preference for left-hand option. Cohen's *d*: small effects: 0.2 – 0.5, medium effects: 0.5 – 0.8, large effects ≥ 0.8.

* $p < .001$

Figure 1

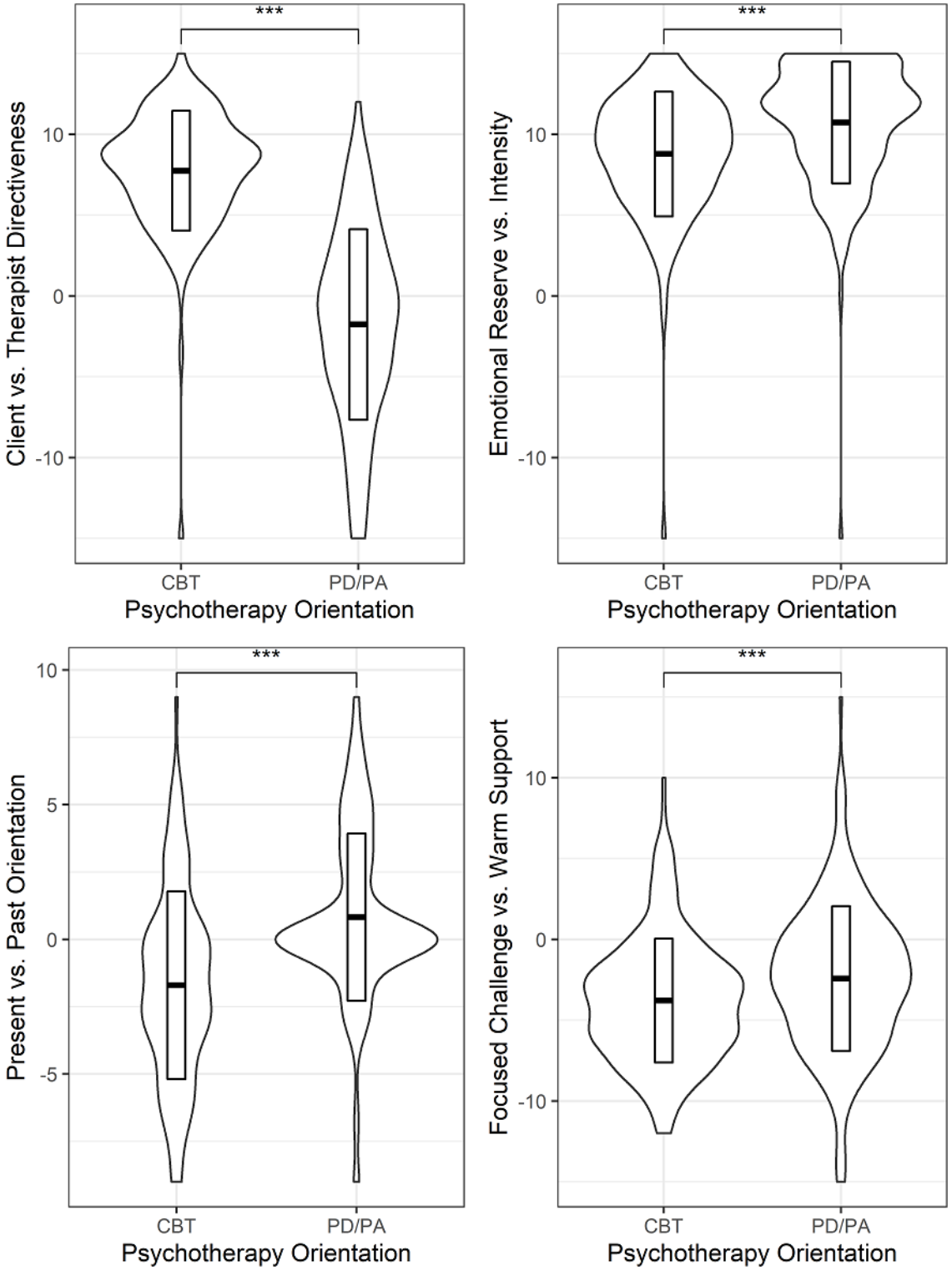
Descriptives and post-hoc-differences of psychotherapy experience on C-NIP subscales



Note: Plots show means ± 1 SD and data distribution.
** p < .01, *** p < .001.

Figure 2

Descriptives and post-hoc-differences of trainees' psychotherapy orientation on C-NIP subscales



Note: Plots show means ± 1 SD and data distribution. CBT = cognitive behavioral therapy; PD/PA: psychodynamic / psychoanalytic therapy.

*** $p < .001$.

Supplementary Material

Supplement 1 – Confirmatory Factor Analysis of the C-NIP

Analytic Approach

We performed confirmatory factor analysis (CFA) using the trainee sample. Adequacy of the sample for factor analysis was derived from the Kaiser-Meyer-Olkin criterion (KMO) > .70 and a significant Bartlett test of sphericity (Kaiser, 1970). We performed CFA with diagonally weighted least square estimator due to non-normal, continuous data, and oblimin rotation due to the lack of statistical independence between the factors. To evaluate the CFA model, we examined three fit indices: Whereas the confirmatory fit index (CFI) shows good fit with values above .95 and acceptable fit with values above .90, the root mean square error of approximation (RMSEA) as well as the standardized root mean square residual (SRMR) below .05 indicate good model fit and values below .08 show acceptable model fit (Hu & Bentler, 1999).

Results

Our dataset proved to be suitable for factor analysis as indicated by a KMO-value of .80 (Kaiser, 1974) as well as a significant Bartlett test of homogeneity ($p < .001$). The CFA with diagonally weighted least square estimation to replicate the four-factor structure proposed by Cooper et al. (2016) yielded mixed results: Whereas the CFI = .68 and SRMR = .085 failed to reach acceptable levels, the RMSEA of .063 can be interpreted as acceptable (Hu & Bentler, 1999). Similar results were obtained when evaluating the alternative model proposed by Heinze et al. (2022): The CFI of .86 as well as the SRMR of .082 almost reached acceptable levels, whereas the RMSEA of .047 can be interpreted as good. Therefore, based on the fit indices, neither model was clearly supported. In order to compare results between studies, we used the four-factor structure as proposed by Cooper and Norcross (2016) for further analyses. Factor loadings of a principal component analysis with four factors and oblique rotation are displayed in Supplementary Table 1.

Supplementary Table 1

Factor loadings of exploratory factor analysis using the trainee sample

Item	TD-CD	EI-ER	PaO-PrO	WS-FC
Focus on goals vs. not focus on goals	**.81**	.05	-.03	.00
give structure vs. allow unstructured	**.84**	-.02	-.05	.01
teach skills vs. not teach skills	**.78**	.13	.00	-.01
give homework vs. not give homework	**.78**	-.12	-.12	.00
take lead vs. allow client lead	**.63**	-.08	.21	.01
encourage difficult emotions vs. not encourage	.28	**.56**	.08	-.06
talk about relationship vs. not talk	-.08	**.78**	-.11	.11
focus on therapy relationship vs. not focus on therapy relationship	-.12	**.72**	.03	.04
encourage strong feeling vs. not encourage	.14	**.71**	.06	-.14
focus on feelings vs. focus on thoughts	-.06	**.42**	**.43**	-.02
focus on past vs. focus on present	.01	-.01	**.88**	.00
reflect childhood vs. reflect adulthood	.01	-.01	**.88**	-.01
focus on past vs. focus on future	-.11	.01	**.82**	.06
be gentle vs. be challenging	-.07	.16	-.15	**.71**
supportive vs. confrontational	.27	.09	.14	**.56**
not interrupt vs. interrupt	-.20	-.02	.20	**.49**
not challenge beliefs and views vs. challenge beliefs and views	.06	-.12	.07	**.66**
support behavior unconditionally vs. challenge behavior	.00	-.13	.06	**.62**

Note: Factor loadings of a principal component analysis with oblique rotation. Bold numbers indicate factor loadings > .30. TD-CD = Therapist vs. Client Directivness. EI-ER = Emotional Intensity vs. Reserve. PaO-PrO = Past vs. Present Orientation. WS-FC = Warm Support vs. Focused Challenge.

7.3. Paper III

Preferences regarding psychotherapist characteristics and their predictors: Results of a German online study

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Acknowledgments

We would like to thank Dr. Brian Bloch for his editing of the English.

Funding

The research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Disclosure of Interest

On behalf of all authors, the corresponding author states that there is no conflict of interest.

Abstract

Despite a growing body of studies on therapist preferences, research so far remains limited to isolated characteristics, such as therapist gender or ethnicity that patients prefer. Furthermore, the interplay between participants' characteristics and their preferences regarding therapists is unclear. The present study aims to identify previously neglected preferences regarding therapists and their predictors. We recruited a heterogeneous sample of N = 969 laypersons, including a respondent pool (n = 733) and a student sample (n = 236). Participants completed self-reports on sociodemographic characteristics, Big Five traits and anxiety. Additionally, participants reported their preferences on sociodemographic and personality characteristics of their preferred psychotherapist. We identified predictors of preferences using logistic and linear regression models. Overall, for almost all characteristics, less than half of the participants reported any preference, except for preferred political attitude and practical experience. However, there was evidence of congruency effects (i.e., preferring therapists similar to oneself), especially concerning minorities, political convictions and personality traits. Furthermore, older participants preferred more experienced psychotherapists, whereas trait anxiety predicted preferences for more stereotypical depictions of psychotherapists. Although many participants were inconclusive about their preferences, we identified important predictors of preference choices that are worth addressing in both psychotherapy practice and research. Our results imply that psychotherapy might benefit from considering patients' preferences, especially if implemented with specific groups.

Keywords: Therapist Preference, Preference Assessment, Personality, Congruency, Respondent Pool Sample

Public Significance Statement: This study on preferences for psychotherapist characteristics suggests that whereas most participants do not have specific preferences, participants tend to prefer psychotherapists with similar attributes. The results underline the need to incorporate

preference assessments and to offer psychotherapy by psychotherapists with diverse characteristics.

Preferences regarding psychotherapist characteristics and their predictors: Results of a German online survey

Evidence-based practice has proven to be highly effective and cost-efficient in the treatment of mental disorders (e.g., Hayes & Hoffmann, 2018). However, not all patients equally benefit from psychotherapy treatments, and substantial numbers of patients drop out of therapy (e.g., Swift & Greenberg, 2012). Among other factors, individual expectations and preferences seem to be relevant in determining the degree to which people engage in psychotherapy (Kwan et al., 2010; Radcliffe et al., 2018). In fact, accommodation of patients' preferences is associated with higher therapeutic alliance and fewer dropouts (Swift et al., 2018; Windle et al., 2020). Therefore, in order to make treatments more engaging, psychotherapists should anticipate preferences and expectations accordingly. Thus, among other factors, we need to know what members of the general public prefer, such as preferences on treatment orientations or psychotherapist characteristics. However, despite an increase in research on patient preferences in recent years, current findings on preferred psychotherapist characteristics are rare, and often focus on isolated characteristics of specific samples (e.g., DeGeorge et al., 2013; Seidler et al., 2022). Therefore, the aim of this study was to investigate the preferences for psychotherapist characteristics in a heterogeneous sample of laypersons.

Definition of Preferences

Preferences are defined as anticipatory choices of psychotherapeutic characteristics that clients wish to have in their psychotherapy (Swift et al., 2011). By contrast, expectations share their anticipatory nature, but in particular reflect what the patient thinks will actually happen during their psychotherapy (Tracey & Dundon, 1988). Preferences are proposed as being multidimensional, dynamic, and operating at different levels of consciousness, i.e., people can have multiple preferences of which they are either un-, sub-, or consciously aware and that can change over time (Grantham & Gordon, 1986). Currently, preferences are

divided into three categories (Swift et al., 2011, 2018). First, *treatment preferences* reflect which specific type of intervention patients want, for instance, pharmacological treatment or psychotherapy. Second, *activity preferences* capture client preferences regarding how they and their psychotherapists should act and behave during psychotherapy. Third, *therapist preferences* indicate those regarding characteristics of a psychotherapist, such as gender, ethnicity, or personality traits.

The beneficial effect of preference accommodation on therapy processes and outcomes has already been reported in a series of meta-analyses (Lindhiem et al., 2014; Swift et al., 2011, 2018; Windle et al., 2020): Adjusting therapy to patient preferences leads to lower dropout rates, a better therapeutic alliance and significantly better post-treatment outcomes. However, the abovementioned results were based primarily on activity and treatment preferences, whereas research on therapist-related preferences is rare. As patient engagement in psychotherapy is influenced by their preferences among other factors such as therapist behaviors, financial issues or accessibility (Kwan et al., 2010; Lindhiem et al., 2014; Radcliffe et al., 2018), patients might be reluctant to start psychotherapy if they do not find a psychotherapist who conforms to their preferences. This is especially relevant for preferences for psychotherapist characteristics, as the high salience of characteristics allow even unexperienced people to determine the extent to which a therapist fits their preferences.

Preferences regarding Therapist Sociodemographics

Although there is more research on preferences relating to characteristics such as age, gender and ethnicity of therapists, publications on aspects such as practical experience or personality traits are rare or have only recently emerged (Anestis et al., 2021). Even for characteristics that have been investigated more often, the results are inconclusive. For example, whereas some studies suggest that a majority of participants prefer a therapist of their own gender (e.g., Furnham & Swami, 2008), other studies found that men were more likely to prefer female psychotherapists (Liddon et al., 2018), or that women were more likely

to prefer male psychotherapists (Black & Gringart, 2019). Other studies reported that neither male (Pikus & Heavey, 1996) nor female participants (Bernstein et al., 1987) had preferences regarding the therapist's gender. Overall, it remains unclear whether there are pronounced gender preferences and if so, how they come about. In addition, similar patterns of inconsistent results are found with respect to ethnic preferences (Karlsson, 2005). However, studies differ in their methodological approaches, i.e., preferences have been measured, among other methods, by using vignettes and likeability ratings, rank-orders of preferred characteristics, or open-ended questions. Furthermore, the inconclusive results necessitate a broader focus on factors other than congruent client variables (i.e., participants' gender predicting preferred therapist gender) that could further predict (gender or other) preferences.

In addition to gender, age and ethnicity, other relevant therapist characteristics have barely been investigated, e.g. research and clinical experience or political attitudes of preferred psychotherapists. In a mixed-method design, Kühne et al. (2021) asked participants what, in their view, characterizes an ideal psychotherapist. In both the qualitative and quantitative approach, therapeutic and research experience were identified as relevant aspects, especially for inexperienced participants. The authors argue that, presumably, participants relied on external information that are easy to gather, e.g. through internet research. Regarding political attitudes, a recent article showed that patient-reported alliance was higher if patients perceived that their psychotherapist shared their own political views (Solomonov & Barber, 2018). The authors conclude that psychotherapists should be aware of and explore their patients' political attitudes. Given that more polarized societies currently prevail (Twenge et al., 2016), it seems plausible that inferred political attitudes and other convictions of the psychotherapist may play a significant role in the evaluation of current or future psychotherapeutic relationships and preferences. However, to the best of our knowledge, there are no studies investigating preferred experience levels (in both practice and research) or political attitudes.

Preferences regarding Therapist Personality

Until recently, studies of preferences regarding therapist personality have been sparse. However, the first reports on preferred personality traits date back to the 1980s. In a study by Hartlage and Sperr (1980), 60 patients were asked to rate their ideal psychotherapist, using a 128-item list. Most participants agreed that a psychotherapist should be appreciative, self-respecting and honest, whereas being impatient, dependent, and shy were considered undesirable (Hartlage & Sperr, 1980). In another study, Greenberg and Zeldow (1980) found that female participants preferred stereotypical masculine traits such as dominance, and male participants preferred stereotypical feminine traits such as nurturance in an ideal psychotherapist. More than 30 years later, these results were replicated, although the differences were not as pronounced (DeGeorge et al., 2013). Only recently, the widely used Big-Five model (Costa & McCrae, 1992) to describe most aspects of each individual's personality on five distinct dimensions (extraversion, agreeableness, conscientiousness, neuroticism, openness to experience) was integrated into the investigation of therapist preferences. Anestis et al. (2021) described how participants preferred psychotherapist's Big-Five profiles that were similar to their own. On average, participants preferred higher levels of therapist conscientiousness and openness as well as low neuroticism (Russell et al., 2022). Furthermore, ideal psychotherapist characteristics closely resembled personality ratings of people with whom the participants had a satisfying relationship, e.g. close friends or romantic partners, as well as the personality of the participants' actual psychotherapist. Anestis and colleagues (2021) argue that the implementation of personality assessment and matching could be beneficial to the treatment process as the Big Five traits can be implemented efficiently and reliably to utilize improved outcomes if patient and therapist personalities match (Coleman, 2006) or if treatments are matched to patients preferences (Swift et al., 2018). Despite the handful of studies reported above, results on preferred psychotherapist personality remain rare and there is a need for conceptual replication.

Aims of the Current Study

Taken together, research on preferences with respect to therapist characteristics and their predictors is either inconclusive (especially regarding gender and ethnicity preferences), does not include important characteristics such as political attitudes or therapist experience, or needs further replication in independent and non-English samples. Therefore, we pursue three goals. First, we aim to evaluate a broad range of predictors of psychotherapist preferences. We argue that preferences regarding therapists are not only determined by congruency with patient characteristics, but also by other sociodemographic and personality predictors. For instance, prior psychotherapeutic experience might provide participants with more information on which characteristics they valued or benefitted from in previous therapies. For personality factors, anxious participants might be more hesitant and wary towards therapy and thus might worry and think about subjectively relevant characteristics regarding the therapist in order to feel safer and be willing to talk to a therapist. Second, we explore and investigate characteristics that have *not* been investigated before, such as political attitudes or clinical and research experience. Third, we contribute to diversified results by using a German-speaking sample. Given a lack of a comprehensive theory on preferences, and based on prior results on merely a few (therapist) preferences (e.g., Anestis et al., 2021; Cabral & Smith, 2011), we hypothesize that preferences are positively significantly predicted by congruent participant characteristics in logistic or linear regression models, e.g., female participants having higher odds of preferring a female therapist or significant associations between self-rated and preferred personality factors. Above and beyond this, our explorative models use previously identified predictors of preferences regarding therapists (Anestis et al, 2021; Helweg & Gaines, 1977; Speight & Vera, 2005) to explore whether preferences are predicted by sociodemographic (e.g., gender, age and prior psychotherapeutic experience) and personality characteristics (i.e., Big Five factors and trait anxiety).

Methods

Transparency and Openness

This article follows the JARS reporting standards (Kazak, 2018). Data analyses were performed using the statistics software R v.4.0.2 (R Core Team, 2020). The data and analysis code that support the findings of this study are available from the corresponding author upon request. The study and analysis plan were not preregistered.

Participants

We used two different approaches to recruit a large, heterogeneous sample. First, we used our university's student participant pool, mailing lists and social media to recruit N = 236 participants. Second, we used the non-commercial German SoSci Panel (Leiner, 2016) to enable a large sample of volunteers across different sociodemographic variables to participate. After an independent review of the study's methods as part of the submission process of the respondent pool, a link to the online survey was forwarded to 4000 people, of whom N = 733 (18.33 %) responded. The response rate is similar to those of other nonprobability samples (Pedersen & Nielsen, 2016). Detailed sample characteristics and comparisons of sociodemographic variables are presented in *Table 1*. Participants of the respondent pool sample were significantly older (44.31 vs. 26.65; $t(756.66) = -22.30$, $p < .001$, $d = 1.24$) and less politically liberal (4.02 vs. 3.50; $t(445.33) = -4.41$, $p < .001$, $d = .31$) than participants of the student sample. Since we aimed for heterogeneity, and as we found only small to moderate differences for variables such as age, education and employment (that can be expected when comparing a student and broad population sample), we merged both samples into one for our analyses. Overall, we recruited a total of N = 972 participants, three of whom were excluded from further analyses due to being younger than 18 years old. Therefore, subsequent analyses were performed with an overall sample of N = 969 participants (female: 66.97%, n = 649). Participants had a mean age of 40.01 years (SD = 16.09, range = 18 – 85). Participants who indicated having prior psychotherapeutic experience had been patients

before (49.12%, *n* = 476), worked in the field (13.42%, *n* = 130), had relatives undergoing psychotherapeutic treatment (25.28%, *n* = 245) and indicated other prior experiences (6.50%, *n* = 63). Ethnic minority background mentioned most often were Turkish (*n* = 3), Southeast Asian (*n* = 3), Arabic (*n* = 3), from other European countries (*n* = 4) or Germans living abroad (*n* = 2).

Procedure

The study was conducted online on the non-commercial survey platform www.soscisurvey.de (Leiner, 2019) from April to June 2020. The study was conducted in German, including recruitment efforts and measures. Participants who accepted the invitation link to our study also gave informed consent. At the end of the study, each participant had the chance to win one of five €10 voucher, and students of the University of Potsdam received course credit. The study was approved by the university's ethics committee (no. 13/2020).

Measures

Sociodemographic Variables

Participants indicated their age, and psychotherapy experience (either as patient, relative of patient or working in the field or other). Participants further indicated their gender (male, female or non-binary) according to German legislation. Furthermore, we asked whether participants were religious or members of any ethnic minority[2]. To address political attitudes of the participants, we used a ten-point differential with extremes anchored as "left" or "right" to indicate the respective attitude (Breyer, 2015).

Therapist Characteristics

[2] Despite the wording of the question ("Are you a member of any ethnic minority?"), responses were not limited to ethnicity (i.e., other than German), but included other marginalized statuses such as disabilities.

To test therapist preferences, participants indicated the preferred gender and academic degree from a list of options. Furthermore, they entered their preferred age, preferred years of working in research or clinical practice, or the preferred number of patients treated using free response. For preferred religion and ethnicity, we asked participants whether a psychotherapist should ideally be a member of a religion or ethnic minority, respectively. If participants chose yes, they could indicate their preferred religion or ethnicity using free response. Again, we used a ten-point differential to measure preferred political attitudes of the therapist (Breyer, 2015). For each characteristic, participants were able to indicate having no preference for any of the options.

State-Trait Anxiety Inventory

Participants rated their trait anxiety on the State-Trait Anxiety Inventory (STAI-G; Spielberger et al., 1983; German: Laux et al., 1981). It consists of 20 items that can be answered on a four-point Likert scale (1 = *not at all*, 4 = *extremely*). Internal consistency in the current sample was excellent (original study: Cronbach's $\alpha = .90$; current study: $\alpha = .95$).

Big-Five Inventory (short version)

The Big-Five Inventory (BFI-K; Rammstedt & John, 2005) is an established short questionnaire for measuring the Big Five personality factors. In our study, participants responded to the 21 items twice. First, they rated their own personality characteristics. Second, the instruction was adapted for preference ratings ("To what extent would you like the following statements to apply to your ideal psychotherapist?"). All items were rated on five-point Likert scales (1 = *strongly disagree*, 5 = *strongly agree*). In our sample, Cronbach's alphas ranged between good and questionable, and were consistently lower for preference than for self-ratings: Extraversion (original study: $\alpha = .81$/self-rating: $\alpha = .85$/preference rating: $\alpha = .54$), Agreeableness (.67/.65/.53), Conscientiousness (.62/.73/.64), Neuroticism (.65/.82/.63) and Openness (.70/.75/.69).

Data Analysis

1. Participants indicated preferences on a categorical (i.e., gender, religion, ethnicity) or ordinal (i.e., academic degree) scale, which is why we used multinomial logistic regression with the reference category of "no preference". Two different models predicted each preference choice due to interdependence of personality and sociodemographic predictors. a) The first model included participants' sociodemographic variables age, gender and prior psychotherapeutic experience as predictors. Referring to prior research on patient-therapist matching (e.g., Cabral & Smith, 2011; Furnham & Swami, 2008), we also added the participants' political attitudes, religion, and ethnicity to the respective preference models. b) The second model used the trait variables trait anxiety and the Big-Five facets as predictors.

2. For interval-scaled variables (i.e., age, political attitudes, years of research/therapy experience, number of patients treated), we used a two-step approach. First, we examined whether participants indicated *any* preference or not (yes/no), using binomial logistic regression. We then used the subsample of participants who had indicated a preference in linear regression models, in order to investigate the influence of participants' sociodemographic data or trait variables on specific therapist preferences. Like in the categorical and ordinal preference models, we computed two separate models for both steps: a sociodemographic predictor model (age, gender, prior psychotherapeutic experience) and a trait predictor model (Big Five, trait anxiety).

We excluded $n = 19$ participants indicating non-binary gender due to the low sample size, as well as $n = 6$ participants indicating both having and not having psychotherapeutic experience in models where gender and prior psychotherapeutic experience acted as predictors. Furthermore, after identifying a number of outliers in interval-scaled criteria ($n = 49$; $z > \pm 1.96$), we chose to exclude them in linear regression models. Except for outlier removal, there were no missing data. We z-standardized all interval-scaled predictors in logistic regressions, whereas predictors of linear regression models remained unstandardized

for the sake of interpretability. Furthermore, we applied the Šidák-correction to all tests in order to avoid Type I-error (i.e., $p < 1\text{-}(1 - .05)^{1/14} < 0.0037$; Šidák, 1967). Significant regression estimates indicate whether a predictor influences the overall preference choice. Odds ratios (OR) above or below 1.00 indicate a higher or lower likelihood of choosing an option, respectively.

Results

Descriptive Therapist Preferences

Table 2 shows the descriptive results of preferred therapist characteristics. In all cases except political attitudes and psychological experience, more than half of the sample indicated having no preference towards any option. Despite a lack of preferences for most characteristics, on average, those who indicated preferences preferred a female, middle-aged, center-left, non-religious psychotherapist with low research experience and substantial treatment experience.

Predicting Preference Choices

Overall, we found congruency effects for eight out of ten possible congruent characteristics or personality factors (with the exceptions being gender and neuroticism). In the following section, we limit the report to significant results only. All predictors that are not mentioned explicitly did not show significant results. Comparisons between models with and without outliers are presented in the supplementary material.

Gender

We used multinomial logistic regression to investigate predictors of preferred therapist gender (reference category: no preference). The results are summarized in *Table 3*. In the first model testing sociodemographic variables, the odds of choosing a female psychotherapist as opposed to having no preference, were significantly higher for participants with prior psychotherapeutic experiences ($B = 0.57$, $t = 3.45$, $p < .0037$, OR = 1.77 [1.28, 2.44]).

In a second model including personality variables as predictors, anxiety significantly predicted higher odds of choosing male psychotherapists (β = 1.00, t = 3.21, p < .0037, OR = 2.72 [1.48, 5.02]) as opposed to having no preference.

Academic Degree

Participants with higher levels of anxiety preferred psychotherapists with a postdoctoral degree rather than having no preference (β = 1.20, t = 3.47, p < .0037, OR = 3.31 [1.68, 6.51]).

Religion

Religious participants clearly indicated a preference for religious psychotherapists (B = 1.77, t = 4.99, p < .0037, OR = 5.85 [2.92, 11.70]), whereas non-religious participants preferred non-religious psychotherapists (B = -1.44, t = -9.03, p < .0037, OR = 0.24 [0.17, 0.32]), as opposed to having no preference.

Ethnicity

Older participants preferred psychotherapists without an ethnic minority background (β = 0.02, t = 4.38, p < .0037, OR = 1.42 [1.21, 1.66]). In contrast, participants who were members of any marginalized group strongly preferred to be treated by a psychotherapist who had a minority background as opposed to indicating no preference (B = 4.20, t = 4.99, p < .0037, OR = 66.93 [12.85, 348.67]).

Age

Using binomial logistic regressions, there were no significant predictors for the choice of reporting any specific age preference (p < .0037). In a subsequent linear regression model including n = 343 participants who indicated an age preference, the preferred age of an ideal psychotherapist was predicted by the participants' gender (B = 2.58, t = 3.13, p < .0037) and age (B = 0.14, t = 6.15, p < .0037), i.e., male and older participants preferred older psychotherapists.

Political Attitudes

Preferred political attitudes of a psychotherapist were significantly predicted by the participant's own political attitudes (n = 786; B = 0.68, t = 28.20, p < .0037), i.e., the more conservative the participants, the more they tended to prefer a psychotherapist with similarly conservative political attitudes. For personality variables, participants with higher levels of openness (B = -0.30, t = -3.64, p < .0037) tended to prefer more liberal psychotherapists, whereas more conscientious individuals preferred more conservative therapists (B = 0.27, t = 3.53, p < .0037).

Therapy Experience in Years

For participants who had a preference regarding therapist experience, the preferred number of years was dependent on the participants' age (n = 565, B = 0.03, t = 4.25, p < .0037) and anxiety (n = 574, B = 1.08, t = 3.33, p < .0037), i.e. older and more anxious participants preferred therapists with more years of therapeutic experience ($n_{outlier}$ = 29).

Number of Patients Treated

If participants indicated a preference for the number of patients treated over time, older participants would choose therapists who had treated more patients (n = 327; $n_{outlier}$ = 15; B = 0.64, t = 3.16, p < .0037). However, some participants indicated high numbers, i.e. n = 93 participants wanted a therapist to have treated more than 100 participants.

Research Experience

Female participants were less likely to indicate a preference regarding a therapist's research experience (B = -0.66, t = -4.09, p < .0037, OR = 0.52 [0.38, 0.71]). 236 participants ($n_{outlier}$ = 5) indicated a preference, with age (B = 0.03, t = 3.06, p < .0037) as significant predictors for more years of research experience.

Therapist Personality

We computed two models for each Big-Five facet of an ideal psychotherapist (*Table 4*). Participants' gender significantly predicted preferences for therapist agreeableness, i.e.,

female participants preferred more agreeable therapists than male participants. Furthermore, participants' age and prior psychotherapeutic experience predicted the preference for openness, i.e., older and experienced participants preferred more open therapists.

For personality traits (Model 2), except for neuroticism, Big-Five preferences were significantly predicted by the participants' respective facet, e.g., participant extraversion was positively associated with preferred therapist extraversion. In addition, conscientiousness predicted preferred extraversion and agreeableness. Overall, explained variance was low, with R^2 values ranging from .00 to .07. However, the coefficient of determination of the openness preference model stood out at $R^2 = .23$.

Discussion

The aim of the current study was to investigate therapist preferences and predictors for preferences that have barely been considered in research so far. In a large heterogeneous sample of laypeople, a majority did not indicate specific preferences regarding most psychotherapist characteristics, except for political attitudes and psychotherapeutic experience. Moreover, we found evidence of congruency effect for a majority of characteristics, i.e. participants tended to prefer psychotherapist with similar characteristics and personality traits. Overall, the results represent four major findings:

First, for almost all preferences, except for political attitudes and psychotherapeutic experience, a majority of participants indicated that they did not have any preference towards either of the given options. It is possible that participants did not find the exact preference they had in mind, and thus chose the "no preference"-option. However, we aimed to provide exhaustive options, and especially for interval-scaled preferences, participants were able to pick whatever option they wanted. Thus, it is more likely that participants indeed did not have any preference. Despite a majority of our sample indicating prior psychotherapeutic experience, it is possible that, for most of the characteristics, participants were not able to infer how their decision might affect the psychotherapeutic process. For example, if

participants were to indicate a preference for the research experience of a psychotherapist, they might not have known how the treatment by a psychotherapist with or without a postgraduate degree would differ, and how they would benefit from any of the given preference options. Overall, for most psychotherapist characteristics, our results revealed no clear advantage for any option, which we interpret as openness on the part of possible future patients, and as an opportunity for alliance building. In conjunction with previous research reporting that a majority of their participants did not have any preference for the therapist gender (Black & Gringart, 2019; Pikus & Heavey, 1996), our result underlines the importance to include a "no preference"-option if participants are asked directly. However, other methodological approaches to measure preference more indirectly such as ratings of vignettes or delay-discounting might not be able to include "no preference"-options (Furnham & Swami, 2008; Swift et al., 2015).

Second, we found evidence of congruency effects, that is, participants preferred psychotherapists with rather similar sociodemographic and personality characteristics to their own. These results are in line with other studies that also reported congruency effects, e.g., for ethnicity, age or personality (e.g., Anestis et al., 2021; Cabral & Smith, 2011; Furnham & Swami, 2008). Interestingly, in our sample, congruency effects were most pronounced for religious and political views, as well as for marginalized ethnic groups. However, the latter result needs to be interpreted with caution, since participants seemed to have a hard time distinguishing ethnic minorities from other marginalized statuses such as disabilities. Moreover, as participants indicated a preference for *any* ethnic minority, the higher odds of ethnic minority participants may reflect a preference for therapists with a different background other than German. Given these caveats, our results clearly resemble findings from other studies. For example, a meta-analysis reported strong preferences of ethnic groups towards psychotherapists of their own ethnicity (Cabral & Smith, 2011). Moreover, despite a majority of our participants indicating a clear preference with respect to political attitudes of

the psychotherapist, to the best of our knowledge, such preferences have not been investigated before. Contrary to our hypothesis, we did not find a congruency effect for gender. This result adds to the inconclusive literature on whether there are gender congruency effects (e.g. Black & Gringart, 2019; Furnham & Swami, 2008) or not (Seidler et al., 2022; Pikus & Heavey, 1996). There are likely two different aspects factoring into the incongruence: First, gender preference seems to depend on the type of problem that participants present (e.g. sexual problems; Bernstein et al., 1987; Landes et al., 2013). Second, publication bias might prevent the publication of non-significant effects.

For personality preferences, we also found congruency effects, that is, participants preferred psychotherapists similar to themselves. These results are in line with a recently published study by Anestis et al. (2021). However, comparing our results to those of Anestis et al. (2021), in contrast to their medium to large effect sizes, our correlations were mostly small to medium. Moreover, we did not replicate some of their previous findings. For example, preferred conscientiousness was not associated with any other self-reported Big-Five factor other than conscientiousness itself. However, the results of the two studies are not directly comparable because of different methods (i.e., Interpersonal Adjective Scales vs. Big-Five Inventory) and samples (mostly undergraduate vs. laypeople respondent pool sample). There are a few studies that show positive effects of patient-therapist personality match on therapy outcomes and alliance (Fletcher & Delgadillo, 2022). Interestingly, participants did not rate neuroticism as preferable for therapists, even though therapist neuroticism is associated with higher therapeutic alliance ratings (Chapman et al., 2009) and reduced patient symptoms (Rieck & Callahan, 2013). However, on the downside, neuroticism is also linked to aspects that are more salient for patients such as more stressful and less healing involvement in therapy (Evers et al., 2019) and less professional efficacy (Hurt et al., 2013). It remains unclear how these preferences arise. According to Russell et al. (2022), preferred personality is similar to the attributes of the current psychotherapist (especially if patients perceived the

therapeutic alliance as good), or are similar to other people with whom the participants had a good relationship (e.g. close friend, romantic partner). It is probable that well-known individuals are used as anchors and examples of supportive and empathic interpersonal relationships.

Third, participant age emerged as a significant predictor for preferring more experienced therapists, i.e. more patients treated, as well as years working as a therapist or researcher. Given these results, it seems that older participants relied on the ascribed expertise of psychotherapists. However, studies suggest that experience does not improve therapist expertise and patient outcomes in psychotherapy (Germer et al., 2022; Goldberg et al., 2016). As reasons for the missing link between experience and expertise, Tracey et al. (2014) argue that psychotherapists often do not engage in deliberate practice (i.e., repetition and refinement with individualized training goals), do not receive accurate feedback or display bias towards positive self-appraisals that are not justified by actual performance. Therefore, older participants might set their bar too high for effective therapists by searching for experienced therapists. Given that older people are less likely to undergo psychotherapeutic treatment even if they are in need of help (Gellert et al., 2021), they are might have less opportunity to revise potential misconceptions about therapy.

Fourth, anxious participants preferred male psychotherapists as well as therapists with the highest academic degree (in Germany: “Habilitation” – higher doctorate). These results could represent stereotypes of psychotherapists, as described in a review investigating the image and representation of psychotherapists in the late 1990s to early 2000s (von Sydow, 2007). Typically, psychotherapists were depicted as looking “Freudian”, i.e. an elderly man with gray hair and beard. Furthermore, female therapists were mostly depicted as being more incompetent or with an unfulfilled personal life (von Sydow, 2007). In another study, the academic degree held by a psychotherapist was rated least important for the evaluation of competency (Kühne et al., 2021). Likely, trait anxiety leads to more conservative choices

(Peng et al., 2014) and thus, people resort to stereotypical characteristics and depictions of expert status, rather than being open-minded towards gender or academic degree of psychotherapists.

Practical Implications

Given that preference accommodating is associated with positive therapy outcomes (Lindhiem et al., 2014; Swift et al., 2018), and given the heterogeneity of the reported preferences, it seems beneficial for the psychotherapeutic workforce to reflect patients' preferences. For example, a male refugee may prefer speaking to a male psychotherapist with a similar ethnic background, but will have a difficult time finding a suitable fit, since, overall, in the field of psychology, the workforce is far from heterogeneous. In Germany, 75.2 per cent of all psychotherapists were female in 2019 (Kassenärztliche Bundesvereinigung, 2021). In 2016, the American Psychological Association (2018) reported that, of all psychologists in the USA, 65 percent were female, their median age was 49 years, and 84 percent were white. In their sample of 268 psychotherapists in the USA, Solomonov and Barber (2019) reported that 62 percent identified themselves as Democrats, 23 percent as independent, and 7 percent as Republican. Given this lack of diversity, preference accommodation may be difficult to establish. If there are no suitable fits available, patients may refrain from seeking psychotherapeutic help in the first place. On the one hand, with more diverse psychotherapists, it should be possible to accommodate more preferences and offer more diverse options for people seeking treatment. Furthermore, training such as on intercultural competence for psychotherapists could help to close any preference gaps (von Lersner et al., 2016). On the other hand, for almost all characteristics, more than half of our sample did not have any specific preference, and thus seem to be open to different psychotherapists. Moreover, psychotherapists should be able to build successful empathic therapeutic relationships, irrespective of their patients' characteristics (Nienhuis et al., 2018), which is a matter of competence-based training and supervision.

Methodologically, we recommend to measure preference regarding therapists with exhaustive or open options (even though adaptation or adjustment might not be possible) and to implement “no preference”-options in order to capture even unexpected or rare preference rather than having patients choose the lesser of two evils. Some studies further suggest to differentiate between preferences for different topics or types of problems such as sexual or social problems (e.g., Bernstein et al., 1987; Landes et al., 2013). We argue that such responses allow more individualized approaches to accommodate or manage patients’ preferences. Moreover, implementing standardized preference questionnaires like the Cooper-Norcross Inventory of Preferences (Cooper et al., 2016; Heinze et al., 2022) in order to assess patient preferences towards therapist characteristics and psychotherapy activities, can help psychotherapists to track individual preferences. After becoming aware of them, Norcross and Cooper (2021) recommend either adopting psychotherapy preferences, adapting to preferences by adjusting them to therapy circumstances, proposing alternatives or referring patients to other therapists. However, in cases of sociodemographic characteristics of psychotherapy, adjustments are barely practical, which is why, if preferences cannot be met, we recommend talking about preferences to help patients, so that therapists can manage their expectations and prevent alliance ruptures.

Strengths, Limitations and Outlook

Our study has an adequately sized sample for identifying small effects of predictors on preferences that, to the best of our knowledge, are underrepresented in preference research so far. Furthermore, we recruited laypersons rather than patients, since preferences of those who may become first-time patients should also be considered, e.g., in order to reduce entry barriers. Nevertheless, two-thirds of our sample indicated having prior psychotherapeutic experience on different levels like former patients or relatives of patients, i.e., we included a large number of people for whom the topic was individually relevant. We add to the mainly Anglo-American literature by introducing preferences of a German-speaking sample, which,

on the other hand, might be associated with specific cultural and political attitudes that does not allow generalizing to other cultures or ethnic minorities. However, we replicated most findings of US-samples despite a lesser emphasis on ethnic diversity and religiosity in the population, and a more clear-cut conception of psychotherapy as the treatment of choice for mental disorders in Germany, possibly since lay conceptions of psychotherapy are based on pop-cultural representations in movies or TV shows that are shared in Western countries (von Sydow, 2007). Moreover, we used a non-probability sample that was not representative, and yielded low response rates that are, however, comparable to other probability sample studies. The respondent pool consists of volunteers interested in psychological and social research, which might have excluded other people, e.g. older people with less experience in online applications. Furthermore, the rather low response rate might be due to non-active members of the respondent pool. Moreover, the current study joins other cross-sectional studies conducted on preferences. Since there is no comprehensive theory on preferences, on how they arise and how they impact the psychotherapeutic process, we based our hypotheses on previous empirical studies. Furthermore, despite controlling for exploratory analyses, future studies should replicate our findings with independent samples. Moreover, there are multiple factors influencing the decision to select a preference or not that we did not control for and could be accounted for by selection models (Heckman, 1979). Last, the reliability of the Big-Five preference ratings was low. Possibly, some items were less suitable for preference ratings, as the behaviors described in the items focused on private aspects with only a minor impact on psychotherapy settings. Despite previous studies reporting congruency effects (Anestis et al., 2021; Cabral & Smith, 2011; Furnham & Swami, 2008), it is unknown why patients prefer specific therapist characteristics. We thus suggest longitudinal studies to investigate whether and how preferences change over the course of psychotherapeutic treatment. It seems plausible that patients prefer aspects that are perceived as beneficial in the therapy process, even though some people may be willing to forfeit treatment efficacy to

receive their preferred therapist (Swift et al., 2015). Consequentially, experimental case vignette studies could vary the anticipated extent of benefits as a predictor of preference choices.

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Table 1

Sample Characteristics and Comparison of Subsamples

	Respondent							
	Full Sample (*N* = 969)		Pool Sample (*n* = 733)		Student Sample (*n* = 236)			
	n	*%*	*n*	*%*	*n*	*%*	*X*	*ES*
Gender							23.10***	.15
Female	649	66.98	461	62.89	188	79.67		
Male	301	31.06	257	35.06	44	18.64		
Non-binary	19	0.02	15	0.02	4	0.02		
Prior Psychological								.22
Knowledge[a]	430	44.74	282	38.63	148	64.07	47.49***	
Prior Psychotherapeutic								
Experience[a]	627	65.10	468	64.29	159	67.66	0.75	.03
Highest Educational Level							103.82***	.37
in school	3	0.31	2	0.27	1	0.42		
no degree	1	0.10	1	0.14	0	0.00		
middle school	85	8.77	71	9.69	14	5.93		
high school diploma	344	35.50	200	27.29	144	61.02		
bachelor's degree	146	15.07	110	15.00	36	15.25		
master's degree	309	31.89	271	36.97	38	16.10		
PhD or higher	66	6.81	63	8.59	3	1.27		
Other	15	2.16	15	2.05	0	0.00		
Employment							219.04***	.48
Unemployed	38	3.92	32	4.37	6	2.54		
Student	263	27.14	113	15.42	150	63.56		
Employed	426	43.96	372	50.75	54	22.88		
Self-Employed	68	7.02	60	8.19	8	3.39		
Retired	101	10.42	99	13.51	2	0.85		
Other	73	7.53	57	7.78	16	6.78		
Religion	402	41.53	324	44.26	78	33.05	8.78**	.10
Marginalized Group	24	2.48	16	2.18	8	3.39	0.64	.03

Note. $N = 969$. [a] $n = 961$ (prior psychological knowledge) and $n = 963$ (prior psychotherapeutic experience) due to incorrect answers. ES = Effect size (φ for 2 x 2-contigency tables, Cramer's *V* for k x 2-contigency tables (.10 = small, .30 = medium, .50 = large)).

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 2

Descriptive Statistics for Preferred Therapist Characteristics

Preference	% (*n*) Indicating a Preference	*M(SD)*	Most preferred (*n*)	Least preferred (*n*)
Political Attitude[a]	81.11 (786)	4.37 (1.56)		
Practical Experience in Years	62.23 (603)	5.96 (4.14)		
Age	35.71 (346)	42.24 (7.25)		
Number of Patients Treated	35.50 (344)	77.87 (138.94)		
Research Experience in Years	24.87 (241)	3.81 (4.94)		
Religiosity	47.37 (459)		Nonreligious (381)	Religious (78)
Academic Degree	45.10 (437)		Master's Degree (312)	Post-Doctorate Degree (22)
Gender	38.91 (377)		Female (275)	Non-binary (19)
Ethnicity	22.08 (214)		No Ethnic Minority (203)	Any Ethnic Minority (11)
Extraversion		3.67 (0.56)		
Agreeableness		3.97 (0.62)		
Conscientiousness		4.10 (0.56)		
Neuroticism		1.63 (0.54)		
Openness		3.97 (0.54)		

Note. *M(SD)* shows the mean (standard deviation) of preferred therapist characteristic of participants who had indicated any preference. There was no "no preference"-option for preferred Big-Five items.

[a] Ten-point differential (1 = *left*, 10 = *right*)

Table 3

Predictors and Preferred Characteristics

Predictor	Preferred Therapist Characteristic
Sociodemographic	
Female participants preferred	older therapists.
	less preference for research experience.
Older participants preferred	therapists with no ethnic minority background.
	older therapists.
	therapists with more therapeutic experience (in years and number of patients treated).
Participants with prior psychotherapeutic experience preferred	female therapists.
Religious participants preferred	religious therapists.
Non-religious participants preferred	non-religious therapists.
Participants with ethnic minority background preferred	therapists with ethnic minority background.
Liberal participants preferred	liberal therapists.
Personality	
More anxious participants preferred	male therapists.
	therapists with postgraduate degree (in German "Habilitation").
	therapists with more years of therapeutic experience.
More conscientious participants preferred	more conservative therapists.
More open participants preferred	liberal therapists.

Note. Table includes significant results ($p < .0037$, Šidák-correction) in multinomial logistic regression (categorial preferences; reference category: no preference), or linear regression models (interval-scaled preferences), respectively.

Table 4

Linear Regression Models for Preferences regarding Big-Five Facets

	Therapist Extraversion		Therapist Agreeableness		Therapist Conscientiousness		Therapist Neuroticism		Therapist Openness	
Predictor	*B (SE)*	*t*	*B (SE)*	*t*	*B (SE)*	*t*	*B (SE)*	*t*	*B (SE)*	*t*
Model 1: Socio-demography										
Intercept	3.70 (0.06)	58.39**	3.68 (0.07)	53.05**	4.03 (0.06)	63.03**	1.76 (0.06)	28.61**	3.72 (0.06)	60.71**
Gender	0.08 (0.03)	2.52*	0.19 (0.03)	5.63**	0.01 (0.03)	0.31	-0.07 (0.03)	-2.06*	0.03 (0.03)	1.03
Age	-0.08 (0.03)	-2.42*	0.06 (0.03)	1.79	0.07 (0.03)	2.02*	-0.03 (0.03)	-1.05	0.10 (0.03)	3.00**
Psychotherapy Experience	0.02 (0.03)	0.50	0.04 (0.03)	1.28	-0.03 (0.03)	-0.79	-0.05 (0.03)	-1.48	0.13 (0.03)	3.85**
R^2		0.01		0.03		0.00		0.01		0.02
Model 2: Personality										
Intercept	2.47 (0.18)	13.26**	2.94 (0.21)	14.17**	3.27 (0.19)	17.57**	1.66 (0.18)	9.05**	2.33 (0.16)	14.29**
Anxiety	0.12 (0.05)	2.30*	-0.01 (0.05)	-0.22	0.02 (0.05)	0.30	0.12 (0.05)	2.27*	0.06 (0.05)	1.31
Extraversion	0.21 (0.04)	5.74**	0.01 (0.04)	0.31	0.00 (0.04)	0.10	-0.01 (0.04)	-0.15	-0.06 (0.03)	-1.90
Agreeableness	0.04 (0.03)	1.25	0.18 (0.03)	5.53**	-0.05 (0.03)	-1.49	0.04 (0.03)	1.12	0.06 (0.03)	1.99*
Conscient-iousness	0.12 (0.03)	3.65**	0.10 (0.03)	2.94**	0.28 (0.03)	8.51**	-0.05 (0.03)	-1.33	0.05 (0.03)	1.60
Neuroticism	0.07 (0.05)	1.37	0.10 (0.05)	2.03*	0.02 (0.05)	0.32	0.02 (0.05)	0.48	-0.08 (0.04)	-1.70
Openness	0.01 (0.03)	0.21	0.02 (0.03)	0.61	0.02 (0.03)	0.74	-0.08 (0.03)	-2.31*	0.48 (0.03)	16.40**
R^2		0.05		0.04		0.07		0.03		0.23

Note. Model 1 and 2 were conducted independently.

* $p < .05$. ** $p < .0037$ (Šidák-correction).

Eigenständigkeitserklärung

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