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THE DEVELOPMENT OF THE CLIENT TREATMENT ORIENTATION SCALE

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THE DEVELOPMENT OF THE CLIENT TREATMENT ORIENTATION SCALE

A Thesis

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

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in

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ABSTRACT

According to the American Psychological Association (2006), three components should be equally considered in treatment decision-making: empirical research, clinical judgment, and the client's values and preference. Swift, Callahan, and Vollmer (2011) defined client preferences as specific attributes that are desired in a therapeutic setting and are divided into three categories: role, therapist, and treatment-type. Currently, there is no treatment orientation scale that measures treatment type and magnitude of the relationship. For this initial phase of development, 5 treatment orientations are being used as the basis of the Client Treatment Orientation Scale (CTOS): psychodynamic, existential, cognitive-behavioral therapy, acceptance and commitment therapy, and multicultural. The purpose of this study is to begin development of a treatment orientation scale with 5-7 questions per subscale domain. A total sample of 651 participants completed the survey, was English speaking, and aged 18 or over, with the majority being male (*n* = 334, 51.3%). The mean age of participants was 31.91 (*SD* = 8.23), with an equal distribution of degree type (e.g. psychiatrist, clinical psychology, counseling psychology, and school psychology) with psychiatry the most endorsed at 26.6% (*n* = 173). Overall, results did not support the use of the CTOS in applied or research settings. Reliability analyses for the 5 subscales were: psychodynamic (α = .52), existential (α = .32), cognitive-behavioral therapy (α = .64), acceptance and commitment therapy (α = .46), and multicultural (α = .63). There were various limitations of the study, such

as being self-report and the possibility of not being representative of the particular orientations being measured. Future research could re-examine items for latent variables or refine the current items for another factor analysis study.

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CHAPTER ONE

INTRODUCTION

The Development of the Client Treatment Orientation Scale

According to the American Psychological Association (2006), three components should be equally considered in treatment decision-making: empirical research, clinical judgment, and the client's values and preference. Swift, Callahan, and Vollmer (2011) defined client preferences as specific attributes that are desired in a therapeutic setting and are divided into three categories: role, therapist, and treatment-type. Specifically, role preferences refer to actions in therapy that the client desires (listening role, active or advice giving role, etc.). Furthermore, therapist preferences refer to characteristics that the client desires in a therapist (similar ethnic/cultural background, clinical expertise, etc.). Lastly, treatment preferences are specific types of treatment (psychotherapy, pharmacotherapy). Because client preferences can have vast, numerous combinations accommodating these preferences may not be possible or even difficult. However, attempting to adhere to a client's preferences should be encouraged. The three aforementioned client preferences cover a wide breadth of information that may perhaps provide insight for treatment and demonstrate therapist investment in the client.

Background

Accordingly, it is important to consider client's preferences when attempting to understand their continued involvement and progress in treatment. Cognitive dissonance theory, developed and formally proposed by Leon Festinger in 1957, can be used to understand the need for agreement between a client's preferences in treatment and adherence and participation in treatment. According to cognitive dissonance theory, when a person maintains two or more relevant pieces of information and those pieces compete or are inconsistent with each other, discomfort (or dissonance) is created. This dissonance then motivates the person to find a way to reduce the dissonance and maintain a form of consistency (Festinger, 1957). For instance, if a person is to choose between two psychotherapy orientations, whichever treatment orientation the person chooses, the person's view of their choice will be strengthened or seen more positively. Thus, cognitive dissonance theory may play a critical role in regards to client choices and preferences. Within the realm of cognitive dissonance theory, the free choice paradigm provides additional explanation of how dissonance changes after decision making. Brehm (1956) demonstrated that after participants had made a decision between two choices, participants would then view their choice as more desirable and view the other choices that were not chosen as less desirable, thus reducing dissonance through attitudinal changes. Considering the previous treatment orientation example, not only would the person view their choice of treatment more positively, but the person would also

view the other treatment (treatment not chosen) as less desirable. If clients are given a choice between particular psychological interventions, they may be more likely to adhere and commit to therapy; however, if a client is offered a choice and not given that choice, treatment adherence and commitment may be weaker. The development of a scale or procedure that presents clients with a choice about treatment could strengthen treatment.

Client Preferences

Swift and Callahan (2009) conducted a meta-analysis examining the effect of client treatment choice and outcomes. More specifically, the researchers utilized studies that evaluated client preferences to treatment and compared groups that received their preferred treatment to groups who did not receive their preferred treatment. The researcher's meta-analysis utilized 26 studies with a combined sample of 2,356 (1,240 clients received preferred treatment compared to 1,116 who did not receive their preferred treatment). Clients (combined throughout the 26 studies) were primarily Caucasian (77.39%), male (64.65%), and an approximate age of 42.51 years old. Treatments utilized throughout the studies varied from cognitive-behavioral, pharmacotherapy, and group therapy and involved working on a specific psychological problem (e.g., anger management, pain management, weight loss, substance use, etc.). Overall, researchers found a small weighted effect size ($r = .15$, $p < .001$). Additionally, the researchers indicated that clients who did receive their preferred treatment had a 58% chance of improvement, compared to clients who did not receive their

preferred treatment of which indicated a 42% chance of improvement ($p > .05$). Additionally, the researchers analyzed 10 studies that recorded drop-out rates and demonstrated that clients were half as likely to drop-out of a study if they received their preferred treatment.

A second meta-analysis evaluating client preferences was conducted by Lindhiem, Bennet, Trentacosta, and McLear (2014) and corroborated Swift and Callahan's (2009) findings. Lindhiem et al.'s meta-analysis primarily utilized different studies (only five articles were used from both meta-analyses) from Swift and Callahan's (2009) meta-analysis due to the differing inclusion/exclusion criteria (clinical outcome and treatment satisfaction), difference in preference effects of disorders (medical and psychological disorders), and additional moderation variables (psychoeducation provided vs. psychoeducation not provided, inpatient vs. outpatient). The researchers evaluated preferences in relation to treatment completion, clinical outcome, and treatment satisfaction. The researchers demonstrated that client preferences and treatment satisfaction resulted in a medium-large effect size ($d = .34$, $p < .001$, $n = 7347$) from 14 studies. The researchers also found that client preferences and treatment completion resulted in a small effect size ($d = .17$, $p < .001$, $n = 4{,}013$) from 15 studies. The researchers demonstrated that client preferences and clinical outcomes resulted in a small effect size ($d = .15$, $p < .001$, $n = 6{,}692$) from 26 studies, which was also consistent with Swift and Callahan's (2009) meta-analyses. Although client preferences appear to have only a small effect in

regards to therapeutic outcome, client preferences appear to play a meaningful role in regards to dropout rates (Lindheim et al., 2009; Swift & Callahan, 2009). This reiterates the importance of client preferences and choice, as well as how cognitive dissonance functions within client treatment choice.

Swift and Greenberg (2012) prefer the term premature discontinuation to dropout, because the term dropout may have other implications or assumptions of the term usage. Premature discontinuation occurs when a client starts a treatment or intervention and discontinues treatment prior to recovery from the problems that led the client to seek services (Garfield, 1994; Hatchett & Park, 2003; Swift, Callahan, & Levine, 2009, Swift & Greenberg, 2012). Additionally, Swift and Greenberg (2012) conducted an updated meta-analysis regarding premature discontinuation from 669 studies (n = 83,834), 19.7% (CI 18.7%, 20.7%) with a weighted mean average. The researchers indicated that younger (d = 0.16) clients and less educated (d = 0.29) clients moderated dropout rates. Also, eating disorders (dropout rates of 23.9%), personality disorders (dropout rates of 25.6%), trainee therapists (dropout rates of 26.6%), and clients treated in a university setting (dropout rates of 30.4%) were other variables that indicated higher rates of dropout. As showcased, there are a variety of indicators of client dropout, many of which are out of the therapist's control. However, there are some factors within the control of a therapist that could mitigate dropout rate such as client preference and/or therapeutic alliance.

Outside of client preference for treatment type, a client may also prefer a specific gender of their therapist. Pikus and Heavey (1996) examined the rates and relationship of client's preferences for a therapist's gender. The researchers' sample consisted of 116 participants (41 male, 75 female), primarily Caucasian (74%), with a mean age of 27.89 (18 to 69 years of age) and recruited from the community and students at a west coast university. The researchers found that the majority of males expressed no preference (*n* = 24, 58%) and the majority of females preferred a female therapist (*n* = 42, 56%). Of the female participants, 22 reported that they felt more comfortable talking with women and 13 wanted a therapist of the same gender in order to better understand them. In this study, gender was the important client preference factor and participants described logical reasons as to why these preferences are important. In general, clients can have innumerable reasons as to their preferences and by understanding those preferences, researchers and therapists can limit the dropout rates.

Race/ethnicity is another preference that may be considered by some clients. Cabral and Smith (2011) conducted multiple meta-analyses addressing preferences of race/ethnicity (52 studies), perceptions of race/ethnicity (81 studies), and client outcomes of receiving preference therapist vs. not receiving preference therapist (53 studies). The researchers reported a moderate to large effect size (*d* = 0.63, CI [0.48, 0.78]) of participants that indicated a preferred therapist of the same race/ethnicity (52 study sample). The researchers also found that participants perceived that matched therapists (therapist and client are

of the same race/ethnicity) would be more successful (81 studies), which produced an average effect size of .32 (CI 0.19, 0.45). Finally, the researchers demonstrated that matched vs. unmatched conditions (clients actually matched to their preferred therapist race/ethnicity) had small differences (53 studies), which produced an effect size of 0.09 (CI 0.05, 0.13). The researchers have shown that therapist preferred race/ethnicity affected clinical outcome; however, an important concept not measured was the initial and early stage therapeutic alliance between therapists of the clients' preferred race/ethnicity. In fact, Swift and Callahan (2009) have shown that client preferences may reduce premature discontinuation. Accommodation of preferences (when possible) may also help maintain client treatment adherence.

Therapeutic Alliance

Therapeutic alliance, or working alliance, has been shown to be an important factor in the client-therapist relationship and outcomes (Horvath, Del Re, Fluckiger, & Symonds, 2011). The therapeutic alliance is defined as a positive emotional bond between the therapist and client, the ability for the client and therapist to agree on goals, and their general agreement on tasks (Bordin, 1994). Horvath et al. (2011) conducted a meta-analysis that included 190 independent studies (including international studies) and at least 30 different validated measures of the therapeutic alliance. The researchers found that the therapeutic alliance and outcome yielded a significant moderate effect size, r = .28 (95% CI: .249, .301), $p \leq .001$. An important limitation with this study is that

sample size was not mentioned, and only number of studies was mentioned. With the therapeutic alliance being such an important predictor of successful clinical outcomes, it is equally as important to identify ways to improve alliance as early as possible.

Consideration of client preferences may increase therapeutic alliance, thus impacting continued treatment and adherence. Iacoviello, McCarthy, Barrett, Rynn, Gallop, and Barber (2007) examined the relationship between the therapeutic alliance and psychotherapy preferences. The researchers conducted a randomized controlled trial between, psychotherapy, medication, and a placebo group (control), among a sample of 75 patients. All patients reported their treatment preference (psychotherapy or medication) prior to the start of the study and were randomly assigned to one of three treatment conditions. Patients were given California Psychotherapy Alliance Scale to measure their therapeutic alliance and a measure of depression at intake and the 3rd, 5th, and 9th weeks. The researchers demonstrated that patients who preferred psychotherapy and were assigned to the psychotherapy condition reported continuous increases in therapeutic alliance over time ($r = .23$, $p < .01$). Overall, the researchers found that patients who preferred psychotherapy but were assigned to other conditions (medication or placebo) reported a steady decrease in therapeutic alliance throughout treatment. These findings shed light on the importance of client preference and how it can impact therapeutic alliance, treatment adherence, treatment completion, and treatment outcomes.

Treatment adherence can present challenges that many from the behavioral health and the medical fields have to contend with. Kwan, Dimidjian, and Rizvi (2010) conducted an experiment that assessed clients for their preference (or no preference) for pharmacotherapy or psychotherapy in relation to working alliance, attrition, attendance, and clinical improvement. The majority of the sample consisted of females (64.2%), white (79.2%), never married (43.4%), had a college degree (47.2%), an income level greater than $50,000, with a mean age of 38.4 (*SD* = 11.7), and all participants met criteria for major depressive disorder. Additionally, the sample consisted of 51 participants who preferred psychotherapy, 19 antidepressant medications, and 36 no preference (*n* = 106). The researcher's initial findings showed that clients were 50% less likely to complete treatment if the client was a part of the pharmacotherapy condition. In regards to attendance, clients who were matched to their preferred treatment attended 89.1% of their expected visits, compared to those who were not matched to their preferred treatment (70.4%). Furthermore, clients matched to their preferred treatment scored significantly higher on the Working Alliance Inventory (measuring the therapeutic alliance; *M* = 5.76, *SD* = .80) compared to clients who were in a non-preferred treatment (*M* = 4.96, *SD* = 1.12). There was little direct effect on preference and outcome; however, there was a significant indirect effect for clients in their preferred treatment compared to those who were not; 16% of variance was explained in regards to reduction in depressive scores.

Once again, client preferences have a standout as an important factor for researchers and therapists to consider for treatment and dropout rate reduction.

Current Preferences Scales

Client preference appears to be important, however, there has only been limited work to create measures that can be used by practitioners to assess client preferences. Currently there are two scales and one interview that address client's preference in regards to psychotherapy treatment. One preference scale is the Psychotherapy Expectancy Inventory – Revised (PEI-R), which client preferences across four factors: approval-seeking, advice-seeking, audience-seeking, and relationship-seeking (Rickers-Ovsiankina, Berzins, Geller, & Rogers, 1971). The PEI-R contains 30-items (6 items are filler) on a 7-point Likert scale (answers range from 1 = not at all to 7 = very strongly). More recently, Bleyen, Vertommen, Steene, and Audenhove (2001) conducted a confirmatory factor analysis in order to reassess the reliability of the PEI-R . Results revealed that the PEI-R still maintains reliability as a four-factor measure (λ_2 = 0.78 approval, 0.85 advice, 0.89 audience, 0.89 relationship). However, Bleyen et al. (2001) also found that the PEI-R also fits as a five-factor model; thus, more research should be conducted for further use of this measure. Although this measures four areas of client preferences, it does not measure any preferences toward client treatment or orientation.

Another scale that addresses client preferences in relation to psychotherapy is the Treatment Preferences and Experience (TPEX)

questionnaire developed by Berg, Sandahl, and Clinton (2008). The TPEX questionnaire measures client preferences across four factors: inward-oriented treatment (e.g. interventions that utilize reflection and inner mental processes; psychodynamic) versus outward-oriented treatment (e.g. interventions that utilize direct problem solving; cognitive behavioral therapy), support (e.g. focus of active advice, encouragement, or sympathy from the therapist), and catharsis (e.g. focuses on expression and affect). However, there may be some concerns with this scale, such as understanding whether internal experiences refer specifically to unconscious-based theoretical orientations or if thoughts are included. Additionally, this scale was originally developed in Sweden and has shown psychometric stability with a sample involving clients diagnosed with generalized anxiety disorder; however, additional psychometric reliability and validation is needed for an American population. Although there are currently two scales that measure preferences in different ways, there is also an interview method that attempts to ascertain client preferences and treatment type.

Finally, the Treatment Preferences Interview (TPI) was developed to assess preferences and type of therapy with the client (Vollmer, Grote, Lange, & Walker, 2011). The TPI authors aim to use the client's preferences in congruence with working alliance factors (relational bond, collaboration, and goals). For example, an interview question may inquire as to the client's previous therapy experiences, preference in type of therapy approach (therapist directive/nondirective, therapist being talkative or more reserved), and/or

therapist characteristic preference (gender, sexual orientation, ethnicity, and other demographic related information). Currently, there is limited research on use of the TPI; however, the researchers have some preliminary findings that indicate that 84.2% (*n* = 48) of clients reported a positive experience when given a voice in choosing a therapy approach. The researchers also indicated that the majority of clients preferred the therapist to make a choice about therapy type but liked being offered a choice about therapy type. Although this interview method does address client preferences, it can be time consuming and may not be ideal for therapist or treatment selection.

There are some limitations involving the use of the aforementioned scales. The TPEX and PEI-R measure client preferences, however, treatment type/orientation are not directly measured. The TPEX authors mention that the scale can be used to determine treatment orientation; however, more research is needed with an American population. Usage of the TPI should be done with caution as it lacks research and provides other psychotherapy orientations that the client may not know or understand, even though treatment type/orientation is considered. In order to determine a particular treatment type/orientation that may fit a client's preference, understanding psychotherapeutic orientations is necessary.

Psychotherapy Theoretical Orientations

Although there are various psychotherapy orientations, there are also commonalities that are believed to be important across any/all psychotherapies.

Therapeutic common factors are elements that should be utilized regardless of therapeutic orientation. Rogers (1957) stated that necessary and sufficient conditions for client change were encapsulated in six components: psychological contact (two people impacting each other's lives), incongruence (client in a state of vulnerability), congruence and genuiness (therapist factors), unconditional positive regard or acceptance (therapist must accept and appreciate the client as is), empathy (enter into the client's "shoes"), and perception of empathy and acceptance (client must perceive that he/she is being accepted and understood). Although more recent research has shown that these conditions are important and necessary, these conditions are not sufficient for client change and growth. Although common factors are necessary, other psychotherapies such as psychodynamic seek to fill in the "sufficient" condition for client growth and treatment.

There are wide varieties of psychotherapeutic orientations available for mental health workers to learn and be trained in, such as: psychodynamic, existential, cognitive behavioral therapy, acceptance and commitment therapy, dialectical behavior therapy, supportive, interpersonal, solution focused, narrative, and the list goes on. Prochaska and Norcross (2010) combined three other studies in order to compile primary theoretical orientations of psychotherapists in the United States and found that eclectic/integrative therapist were the rated as the most used orientation at 29% by clinical psychologists. Across various professions (e.g. clinical psychologists, social workers,

counseling psychologists, and counselors) there were orientations that were favored; however, in general, eclectic/integrative (23-29%), cognitive (19-29%), behavioral (8-11%), psychodynamic (5-12%) were amongst the most used therapeutic orientations (Prochaska &Norcross, 2010). For this study, initial therapy orientations were decided upon to build in this first phase were based on various criteria: individual-based therapies (e.g. systems/family oriented therapies were decided against in this first phase), popularity of an orientation (e.g. cognitive behavioral appears to have a large practitioner base in the United States), and accessibility of training (e.g. cognitive behavioral and psychodynamic appear to be instructed in many programs; however, dialectical behavior therapy requires additional training and may not be assessable to many mental health providers). With these criteria in mind, 5 psychotherapeutic approaches were decided to be a part of the initial phase of development of a client preference orientation scale, of which, are psychodynamic, existential, cognitive behavioral, acceptance and commitment, and multicultural.

Psychodynamic psychotherapy is one of the oldest treatment orientations and is still used in modern psychotherapy. Some of the basic principles of psychodynamic psychotherapy are: most of mental life is unconscious, childhood experiences and genetic factors shape us as adults, patient/client's transference is a primary source of understanding, therapist's countertransference provides understanding of how the client makes others feel, patient/client resistance is a primary focus, symptoms and behaviors are determined by complex unconscious

forces, and psychodynamic therapists help patients/clients achieve authenticity and uniqueness (Gabbard, 2004). Additionally, there are seven techniques that stand out and help therapists reach these underlying principles. The seven techniques are: focus of affect and expression of emotion, exploration of attempts to avoid distressing thoughts and feelings, identification of recurring themes and patterns, discussion of past experiences, focus on interpersonal relations, emphasis on the therapeutic relationship, and exploration of fantasy life (Gabbard, 2004; Shedler, 2010). There are other treatment variations that psychodynamic psychotherapy can offer (Core Conflictual Relationship Theme, object relations, etc.); however, these techniques and principles cover the basic and broadness that psychodynamic psychotherapy can cover. Another psychotherapy that emphasizes different elements is existential psychotherapy.

Existential psychotherapy is an orientation with much of its origins rooted in philosophy. Existential psychotherapy emphasizes four ultimate concerns: inevitable death, freedom, isolation, and meaninglessness (Yalom, 1980). It is these four concerns, that when confronted (consciously or unconsciously) bring about dread and anxiety, thus triggering defense mechanisms, and consequently are focused and treated in the present tense. The death concern perpetuates the thought that while we exist now, we will not always exist. Freedom is typically thought of as being positive; however, existentially it means we must also be responsible for our choices, thus in charge of our own design/fate. Existential isolation refers to the understanding that no matter how close we become with

others we are existentially alone; and it is that awareness that makes our need for contact all the more important. Finally, meaninglessness is only confronted when the other three concerns (isolation, freedom, and death) have become understood; we must all make and create our own meaning for our existence. Additionally, Viktor Frankl's logotherapy (1945) expounds on the meaninglessness component and postulates that life has meaning under any and all circumstances. Although existential psychotherapy conceptualizes clients through broad universal truths/concerns, another psychotherapy orientation focuses more on specific, individual problems and the behaviors, thoughts, and emotions attached to them.

Cognitive-Behavioral Therapy (CBT) has been shown to be efficacious and a widely used therapeutic approach. CBT conceptualization often considers three components: emotional (client's subjective feelings), behavioral (client's overt responses), and cognitive (client's thoughts, interpretations, beliefs, and mental coping strategies; Tolin, 2016). Furthermore, CBT treatment attempts to impact two areas (primarily behaviors and cognitions) in order to affect the emotional difficulties that a client may display (Tolin, 2016). For instance, treating a client for depression may involve behavioral activation and reframing client interpretations in order to treat the client's mood. In addition, Tolin (2016) states that specific elements of CBT are: focus on clients target problem, time-limited, present-focused, therapist directive, active, measures and tests hypotheses. CBT

is not the only behavioral psychotherapy being used, but Acceptance and Commitment Therapy (ACT) has grown in popularity.

ACT is part of a “third generation” of behavioral therapies. ACT has six core therapeutic processes: acceptance, contact with the present moment, values, defusion, self-as-context, and committed to action (Harris, 2009). The six core processes can be separated into three categories that form the ACT model, which is acceptance of thoughts and feelings, choosing a valued direction, and taking action (Harris, 2009). By attenuating to the core processes, the ACT model is meant to help clients achieve psychological flexibility. Whereas different psychotherapies emphasize aspects that are believed to be important for client growth and outcomes; modern psychotherapy must also have considerations relevant to a client’s culture.

Multicultural considerations have started to be important factors during the application of therapeutic treatment. Because many theoretical orientations have differing philosophical origins, treatment may act against particular cultural values (Hill, 2014). For instance, emotional expression may be frowned upon by some cultures, thus utilizing treatment that emphasizes emotions may be difficult, if not detrimental to treatment. Because there are many cultures that live in America, not everyone adheres to their traditional cultural values. Skovholt and Rivers (2003) outlined three areas that therapists should consider: general experiences and characteristics of the client’s cultural group; the client’s individual experiences and characteristics; and basic human needs. Although there are

many other considerations and theoretical orientations that are not covered, these are believed to be the most foundational or most utilized therapies (excluding the more modern multicultural considerations).

Summary

In a variety of ways, client preferences for therapist qualities and treatment modality stand out as an important factors to assess and accommodate when possible. The research has shown that clients who do not receive their treatment preference are 50% more likely to drop out (Swift and Callahan, 2009). The research has also shown that client preferences and clinical outcome produce only a small effect (Swift and Callahan, 2009; Lindhiem et al., 2014). However, accommodation of client preferences can increase the therapeutic alliance, thus indirectly increasing treatment adherence and treatment completion (Iacoviello et al., 2007; Kwan, Dimidjian, and Rizvi 2010). Clients may also have strong preferences for a specific gendered therapist (Pikus and Heavey, 1996) or race/ethnicity (Cabral and Smith, 2011) which may be important preferences. Additionally, some preferences are unable to be accommodated, thus a conversation should occur with the client in order to mitigate potential adverse effects of client nonmatching (Vollmer et al., 2011). Finally, areas of importance for increasing clinical success is addressing, understanding, and measuring client preferences (roles, therapist, and treatment type).

Purpose

The purpose of this study is to begin development of a treatment orientation scale. Currently, there is a lack of research regarding the use of client preference scales, as well as, both scales do not measure client treatment orientation and magnitude of the relationship. The only other measurement method for client preferences was an interview, which can be time consuming, but also does not clearly show strength for a preferred treatment type. The intended goal for this scale is to measure both treatment type/orientation and the magnitude of the relationship. Thus, an initial sample pool of questions are to be created and an exploratory factor analyses will reduce the items within the scale to 5-7 items per factor (i.e. total items range from 25-35). This scale may help in deciding on therapeutic orientations for the individual client's treatment. Additionally, this scale may also bring about information that can be foci in the therapy session. Utilization of this scale may also foster greater therapeutic alliance earlier in therapy by addressing the client's preference treatment orientation during or throughout therapy. Finally, if the client does prefer a treatment that is less efficacious for a specific problem, it can be addressed earlier in treatment.

CHAPTER TWO

METHODS

Participants

A total sample of 651 participants completed the survey, was English speaking, and aged 18 or over, with the majority being male (*n* = 334, 51.3%). The mean age of participants was 31.91 (*SD* = 8.23), with an equal distribution of degree type (e.g. psychiatrist, clinical psychology, counseling psychology, and school psychology) with psychiatry the most endorsed at 26.6% (*n* = 173). The majority of participants were professionally licensed (*n* = 635, 97.5%), with a distributed type of license (i.e. LMFT, LPCC, psychologist, etc.) with LMFT endorsed the most at 26.3%. The majority of participants reported currently practicing in a school setting (*n* = 177, 27.2%), with the most used psychotherapeutic orientation being CBT (*n* = 151, 23.2%). Participants were recruited through various listservs (e.g. California Association of Marriage and Family Therapists) and social media (e.g. Facebook, Reddit, etc.). All participants were provided with an Informed Consent Form (Appendix A) and a Post-Study Information Form (Appendix E) as well. All participants were treated in accordance with the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2002). Refer to Table 1 for a full table of demographic information.

Measures

Client Treatment Orientation Scale

The CTOS is currently constructed of 67 items on a 7-point likert scale (1 = strongly disagree and 7 = strongly agree) across 5 factors. The 5 factors are: psychodynamic (e.g., I would like to examine my childhood for relevance to my symptoms or therapy goals), existential (e.g., I would like help finding meaning in my life), cognitive-behavioral (e.g., I want to change my negative thoughts), acceptance and commitment (e.g., It's important for me to act in accordance of my values), and multicultural considerations (e.g., My culture differs from the majority of people around me). Each factor is meant to measure the client's disposition towards a treatment orientation. Each item within a factor asks clients questions that refer to principles or fundamentals of that treatment orientation. For this study, participants were asked how strongly each item adheres to the principle/fundamentals of a treatment orientation and if their particular client demographic would understand the question/statement that is being asked.

Demographics Form

Participants were asked basic demographic information regarding their age, gender, race, and ethnicity. Additionally, participants were asked what degree they have, the field their degree is in, length of time they have been graduated, the type of license that they have, the setting that the therapist works in, and which theoretical orientation they utilizes. Refer to Table 1 for participant demographics.

Procedure

Invitations (Appendix B) were placed on various social media outlets (e.g. Facebook, Reddit, CAMFT forum Board, listservs) to participate in this study. A link to Qualtrics will allow participants to complete the survey. Participants were given a consent form notifying him/her the nature of the study and that it is completely voluntary. Participants will be also notified that upon completion of the survey and submission of a contact email, those participants will be offered an opportunity to win one of 18, $50 gift cards through an equal opportunity drawing. Upon completion of measures, participants were provided with a post study information form, notifying the participant contact information for study results.

Design and Analysis

Multiple exploratory factor analyses were conducted using SPSS. The initial principal factor analysis with varimax rotation was conducted on all the items with 5 factors forced. Additional principal factor analyses were conducted by matching participants to the orientation that they currently use in their setting.

CHAPTER THREE

RESULTS

A principal axis factor analysis with a varimax rotation, using SPSS version 23 was utilized to assess the dimensionality of 67 items with the criterion of keeping 5-7 questions for each of the 5 factors. The factors consisted of self-reported ratings of preferences for psychotherapeutic orientations of the following: psychodynamic (14 items), existential (13 items), CBT (12 items), ACT (14 items), and MCT (14 items). Each item was rated on a 7-point likert scale that ranged from 1 (strongly disagree) to 7 (strongly agree).

General

There were 651 participants for our initial exploratory factor analysis (EFA), with varimax rotation. Univariate outliers were not found for the 67 items; thus no participants were removed. Multivariate outliers were checked using Mahalanobis analysis; no outliers were removed according to the criterion of discontinuity. KMO and Bartlett's test met minimum satisfactory requirements, KMO = .59. Bartlett's Test of Sphericity was also adequate, < .05. After listwise deletion, our sample for the full EFA resulted in *n* = 579. When 5 factors were forced through varimax rotation, only four items were above the minimum statistic of .30. Reliability analysis revealed Cronbach's Alphas for Psychodynamic (α =

.28), Existential (α = .22), Cognitive-Behavioral (α = .44), Acceptance and Commitment Therapy (α = .32), and Multicultural (α = .43). Refer to Table 2 for means, SDs, rotated factor loadings for the full EFA, Eigenvalues, percent of variance explained, and reliability for each of the five subscales.

Psychodynamic

Participants were split from full sample to those participants who endorsed that they used Psychodynamic psychotherapy, *n* = 137. Univariate outliers were not found; thus no participants were removed. Multivariate outliers were checked using Mahalanobis analysis; no outliers were removed according to the criterion of discontinuity. KMO and Bartlett's test met minimum satisfactory requirements, KMO = .62. Bartlett's Test of Sphericity was also adequate, < .05. After listwise deletion, our sample remained at *n* = 137. When the EFA was utilized with varimax rotation, 5 factors were initially produced and after rotation only one factor remained. After the rotation, 10 items remained above a .30 factor score. From those 10 items, reliability analysis revealed a Cronbach's Alpha = .52, which is not an adequate reliability for scale usage. Refer to Table 3 for rotated factor loadings for the psychodynamic items, Eigenvalues, and percent of variance explained.

Existential

Participants were split from full sample to those participants who endorsed that they used Existential psychotherapy, *n* = 129. Univariate outliers were not found; thus no participants were removed. Multivariate outliers were checked using Mahalanobis analysis; no outliers were removed according to the criterion of discontinuity. KMO and Bartlett's test did not meet minimum satisfactory requirements, KMO = .49; which may indicate that more participants are needed for this subscale. Bartlett's Test of Sphericity was not adequate, > .05. After listwise deletion, our sample remained at *n* = 129. When the EFA was utilized with varimax rotation 6 factors were initially produced and after rotation zero factors possessed an Eigenvalue over one. After the rotation, 10 items remained above a .30 factor score. From those 10 items, reliability analysis revealed a Cronbach's Alpha = .32, which is not an adequate reliability for scale usage. Refer to Table 4 for means and SDs of psychodynamic items. Refer to Table 4 for rotated factor loadings for the existential items, Eigenvalues, and percent of variance explained.

Cognitive-Behavioral

Participants were split from full sample to those participants who endorsed that they used CBT, *n* = 146. Univariate outliers were not found; thus no participants were removed. Multivariate outliers were checked using Mahalanobis

analysis; no outliers were removed according to the criterion of discontinuity. KMO and Bartlett's test met minimum satisfactory requirements, KMO = .76. Bartlett's Test of Sphericity was also adequate, < .05. After listwise deletion, our sample remained at *n* = 146. When the EFA was utilized with varimax rotation, 4 factors were initially produced and after rotation only one factor remained. After the rotation, 11 items remained above a .30 factor score. From those 11 items, reliability analysis revealed a Cronbach's Alpha = .64, which is not an adequate reliability for scale usage. Refer to Table 5 for rotated factor loadings for the CBT items, Eigenvalues, percent of variance explained.

Acceptance and Commitment

Participants were split from full sample to those participants who endorsed that they used ACT, *n* = 115. Univariate outliers were not found; thus no participants were removed. Multivariate outliers were checked using Mahalanobis analysis; no outliers were removed according to the criterion of discontinuity. KMO and Bartlett's test met minimum satisfactory requirements, KMO = .56. Bartlett's Test of Sphericity was not adequate, > .05. After listwise deletion, our sample remained at *n* = 115. When the EFA was utilized with varimax rotation, 6 factors were initially produced and after rotation zero factors remained. After the rotation, 10 items remained above a .30 factor score. From those 10 items, reliability analysis revealed a Cronbach's Alpha = .46, which is not an adequate

reliability for scale usage. Refer to Table 6 for rotated factor loadings for the ACT items, Eigenvalues, percent of variance explained.

Multicultural

Participants were split from full sample to those participants who endorsed that they used MCT, *n* = 120. Univariate outliers were not found; thus no participants were removed. Multivariate outliers were checked using Mahalanobis analysis; no outliers were removed according to the criterion of discontinuity. KMO and Bartlett's test met minimum satisfactory requirements, KMO = .63. Bartlett's Test of Sphericity was not adequate, < .05. After listwise deletion, our sample remained at *n* = 120. When the EFA was utilized with varimax rotation, 6 factors were initially produced and after rotation one factors remained. After the rotation, 13 items remained above a .30 factor score. From those 13 items, reliability analysis revealed a Cronbach's Alpha = .63, which is not an adequate reliability for scale usage. Refer to Table 7 for rotated factor loadings for the MCT items, Eigenvalues, percent of variance explained.

CHAPTER FOUR

DISCUSSION

Discussion of Findings

The purpose of the present study was to begin initial development of a client treatment orientation scale, identify strong items, reduce the amount of items used in this scale, and determine reliability for each of the 5 factors. Overall, there were some consistency issues with the 5 factors. Two of the 5 factors did not meet assumptions (i.e. existential and ACT); thus information from these two subscales should be considered cautiously. Additionally, reliability of each of the 5 subscales indicates that the scales are below recommended usage and consistency is weak. After rotation, there were enough items to reduce within each subscale; however, reduction from 10 items to 5 items made little difference in increasing reliability.

The poor reliability for each subscale may have been the result of a high degree of overlap between the proposed factors (e.g. behavioral components within psychodynamic psychotherapy, cognitive components within existential, etc.). Thus, there additional constructs may need to be considered within each subscale, and alternative ways of conceptualizing what approaches are unique to each orientation may need to be clarified.

Another potential reason that the subscales were not easily defined could have been due to diverse level of training among the licensed professionals that

participated. There are various masters and doctoral levels programs across the United States; however, the APA only accredits doctoral programs. There are other governing bodies within each state to certify master's level programs, however there may not be a strong emphasis or measurement of treatment orientations. For instance, some programs tend to emphasize one overarching orientation while others tend to be more integrative, possibly making it difficult for some individuals to differentiate techniques belonging to specific orientations. In addition, the amount of focus on clinical interventions varies depending on the program's focus and duration. Accordingly, including only at MFTs and/or psychologists, who's programs tend to provide more clinical training than psychiatry or social work programs, as experts may have yielded different results. Further, LCSWs are not allowed to accrue therapy hours until after graduating, while MFTs conduct therapy on clients during their program; at least within California, which can result in considerable differences in level of training and experience.

Because participants were recruited through social media and were from varied professional backgrounds (e.g., MFT, LCSW, psychologist, etc.), geographic locations, and training programs, there could have been varying degrees of emphasis on having a specific overarching treatment orientation. Additionally, as a therapist continues their work, they may become more integrative over time and incorporate techniques from varied treatment orientations making it difficult to differentiate treatment approaches. In addition,

certain therapeutic orientations have various backgrounds and origins that make it difficult for clinicians to collectively agree upon (e.g. existential psychotherapy has various roots and offshoots). Because clinician training may have had an impact on this study, clinician judgment may have also played a role. For example, some of the items were about client behaviors, feelings, or thoughts of particular to a therapeutic orientation.

Another reason that scale stability was problematic could be due to the discrepancy between clinicians and statistics. Grove et al. (2000) conducted a meta-analysis that viewed 136 studies in which a clinician made a decision vs. a mechanical decision (i.e. decision based on algorithms and/or statistics). The researchers found that mechanical decision-making was far more accurate compared to clinician-based decisions, 33-47%. With this in mind, clinician error may also present in their evaluation of the treatment orientation items as well. Although there are a couple possible reasons for the outcome of the factor analyses there are also a variety of limitations that could have increased the error in this study.

Limitations

Some limitations of this study are the sample collection method and treatment orientations decided upon. Various social media outlets and word-of-mouth networking were used to recruit participants, thus the study sample may not be representative of the larger clinician field as a whole. Additionally, there are a variety of treatment orientations being utilized by therapists and this study

only utilized 5 orientations. These 5 orientations may not be representative enough for the clinician population. Another limitation is the format of the study, in that it is self-report. In addition, the mean age of experience was 4.85 years for study participants. It is possible that results would be different if the participant experts had more experience.

Implications and Future Research

In the current state of the scale, more research and item development is needed. Our findings may indicate the difficulty in developing a scale from complex constructs. Additionally, our findings can provide various considerations for researchers to consider in developments of client preference scales. Due to the factor structure and loading, it may be necessary to develop items from a technique basis (i.e., utilizing items that only are a specific behavior that can occur in the therapy room); although with this method, it may be more challenging to identify specific items for certain theoretical orientations. With the completion of this study, there has yet to be a treatment orientation scale or format to be published; of which, this study could be a basis for other researchers to build from.

Future research could branch in various directions. One direction could be to conduct another initial development of the CTOS, in which, the researchers identify strong items and collect another sample of mental health professionals (e.g. therapists, psychiatrists, social workers, etc.), and conduct another exploratory factor analysis with the strong items. Additional analyses

could also be conducted in order to explore potential latent variables. Another potential direction could be to take a qualitative or quantitative approach in potential client reactions to the items. Finally, the measure could be modified from item-based scale and instead include a paragraph-based scale design (e.g. a paragraph describing the therapeutic orientation), similar to the TPI. It may also be important to explore differences in clinician sample with more specific theoretical training (e.g. psychologists). While the results were not as strong as desired, this study provides a wide breadth of information to build upon.

Table 1. Participant Demographics

Variable	*n*	Percent
Mean age (years)	31.91	50.8 (cumulative percent)
Gender		
Male	334	51.5
Female	314	48.5
Racial Background		
Caucasian	166	25.5
Asian	160	24.6
African American	149	22.9
American Indian or Alaskan Native	167	25.7
Native Hawaiian	0	0
Two or more races	2	.3
Other	5	.8
Choose not to disclose	1	.2
Degree Type		
Masters of Science	145	22.3
Masters of Arts	134	20.6
PhD	128	19.7
PsyD	108	16.6
MD	130	20.0
Other	10	1.5
Degree Field		
Clinical Psychology	158	24.3
Counseling Psychology	154	23.7
School Psychology	162	24.9
Psychiatry	173	26.6
Other	9	1.4
Professionally Licensed		
Yes	635	97.5
No	16	2.5
Type of License		
LMFT	171	26.3
LPCC	167	25.7
LCSW	142	21.8
Psychologist	152	23.3
Other	20	3.1
Practice Setting		
School	177	27.2
Private Practice	163	25.0
Hospital	154	23.7
Researcher	147	22.6

Other	17	2.6
Therapeutic Orientation		
Psychodynamic	140	21.5
Existential	141	21.7
CBT	151	23.2
ACT	124	19.5
MCT	127	19.5
More than one orientation (from the five displayed)	17	2.6

Note. n = 651.

Table 2. Summary of Exploratory Factor Analysis Results

Item	Mean	*SD*	Rotated Factor Loadings				
			1	2	3	4	5
(c4)My mood and thoughts affect my behavior.	4.03	2.04	**.33**	.04	.06	-.04	.13
(m10)I would like my therapist to acknowledge my cultural background.	4.03	2.03	**.31**	.14	-.00	.09	.06
(c1)I want to change my negative thoughts.	4.04	2.08	.29	.07	.07	.14	-.00
(a9)I would like to be aware of my thoughts without them controlling me.	3.99	2.02	.23	.15	.03	.02	-.17
(a10)I would like to be aware of my emotions without them controlling me.	4.11	2.05	.22	.02	.06	.01	-.08
(c9)Whenever my symptoms occur, I want a technique/skill to help control or reduce the severity.	4.13	2.00	.20	.09	.18	-.04	.04
(a4)I need help being more aware of the present moment.	3.87	2.01	.19	.10	.08	-.15	.06
(c10)I would like my therapist to collaborate with me on my goals.	4.11	1.97	.19	.08	.19	.04	-.12
(m5)My gender role conflicts with what I want to do.	4.18	1.96	.19	.07	.09	-.02	.01
(m11)I have to explain my identity to others (ethnicity, culture, religion, gender).	4.10	2.07	.18	.02	.09	.11	.02
(e12)I want to explore my existence of life.	4.12	2.05	.18	.15	.06	.02	.08
(p10)I want to explore my emotions.	4.06	1.99	.17	.12	.03	-.01	.04
(m7)I want to have deeper relationships with	4.14	2.02	.17	.01	-.04	.02	.01

people.							
(e3)It is important for my therapist to be authentic with me.	3.99	2.03	.16	.09	.12	.01	.06
(e6)I want to connect with other people.	4.16	2.01	.16	.07	.03	.10	-.14
(m13)I have to deal with a language barrier.	4.12	2.07	.16	.10	.11	-.03	.014
(p7)I'd prefer the therapist to give me insight into my problems or situation.	3.98	1.99	.15	-.13	.02	.04	-.11
(a11)I want to own my thoughts, and not let my thoughts own me.	4.11	1.99	.15	-.01	.08	.06	.07
(m12)I feel like an outsider.	4.02	2.00	.13	.10	.02	.04	.04
(p11)I want help to understand some of my emotions.	4.16	2.06	.13	-.01	.02	.10	.01
(e7)I would prefer to focus on my present situation.	3.93	2.00	.13	.02	.10	.03	-.10
(a3)I want to accept my negative thoughts.	4.01	2.00	.10	-.06	.10	.03	.08
(e5)I feel that no one understands me.	4.19	1.99	.07	.29	.02	-.08	-.04
(m1)My culture is important to my identity.	4.18	2.02	.15	.28	-.00	.04	.07
(p4)My early life experiences explain a lot of what I do.	4.04	2.05	.15	.28	.09	.07	-.05
(m3)Societal issues are a big concern of mine (immigration, racism, etc.).	4.23	2.06	.06	.27	.07	-.03	.03
(p3)I believe that I do some things unconsciously.	4.09	2.01	.08	.27	-.02	.07	.05
(m6)I have to deal with discrimination too often.	3.91	2.00	.17	.23	.04	.10	.12
(p1)I would like to examine my dreams for relevance to my	4.13	1.93	-.06	.22	.09	.03	-.03

symptoms or therapy goals.							
(c7)I want techniques/skills to help with my symptoms or situation.	4.07	1.95	.08	.22	.18	.10	-.09
(p8)I have some unresolved issues with people from my past.	3.94	1.98	.16	.21	-.06	.03	.20
(c12)I would like some help learning problem solving skills.	4.19	2.03	.03	.20	.02	.11	.12
(c2)I want to change my negative behaviors.	3.98	2.02	.07	.19	.18	.09	-.03
(e4)I feel isolated from others.	3.98	2.02	-.08	.17	.14	.12	.14
(m8)I am bullied because of who I am.	4.16	2.02	.070	.16	.11	.05	-.02
(a8)My values differ from my thoughts.	4.16	2.00	.12	.14	-.01	.06	-.12
(c5)I would like assignments for me to complete on my own, outside of therapy.	4.10	2.12	-.02	.11	**.48**	-.15	.06
(e1)I would like help finding meaning in my life.	4.07	2.01	.13	-.07	.33	-.04	.09
(m2)My culture is important to my identity.	4.11	1.99	.18	.11	.26	.04	.07
(m4)My culture of origin dictates that I should act in one way, but I want to act in another.	4.01	2.06	.09	.07	.25	.07	.05
(c6)I would prefer a structured format to therapy.	4.03	2.04	.00	.11	.24	.14	-.01
(p2)I would like to examine my childhood for relevance to my symptoms or therapy goals.	4.15	2.03	.03	.12	.24	.15	-.01
(c3)My negative thoughts affect my mood.	4.15	2.01	-.02	.19	.22	.13	.11

(c8)I would like help becoming aware of the triggers or situations that relate to my problems or symptoms.	4.07	1.99	.16	.04	.20	.16	.03
(p5)I give symbolic meaning on events in my life.	3.98	2.04	.13	.01	.15	.03	.04
(e11)I feel I have no control of my life.	4.00	2.01	.12	.12	-.05	**.35**	.02
(p9)I would like the therapist to analyze my experiences.	3.96	2.01	-.06	.06	.02	**.32**	.03
(c11)I am having difficulty solving my problems.	4.10	2.01	.00	.04	.15	.27	.03
(a7)My values differ from what I do.	4.22	2.00	.13	-.17	.20	.22	-.04
(p6)I'd like the opportunity to speak whatever comes to mind.	4.13	2.01	.15	.17	.12	-.21	.01
(p13)I have some trouble with relationships (romantic, and/or non-romantic).	3.89	1.92	.04	.03	-.04	.19	.09
(a1)I am having trouble accepting certain thoughts.	4.00	1.88	.10	.08	.07	.17	-.07
(p14)I feel as if my life continues to repeat the same events over and over again (multiple divorces, failed relationships, etc.).	4.16	2.04	.06	.17	.10	.17	.06
(a12)My values direct my life.	4.15	2.00	-.02	.11	.06	.16	-.01
(m9)I am having difficulty with different groups in my life (school, social, home, work).	4.03	1.95	.13	-.00	.11	.15	.04
(e10)I'd prefer the therapist to give me insight into my problems or situation.	3.96	1.99	.07	-.04	.02	.14	-.02

(a13)It’s important to set goals that align with my values in therapy.	3.90	1.98	.03	.12	.06	.13	.11
(a5)I would prefer assignments for me to complete on my own, outside of therapy.	4.03	2.03	.01	.08	.04	.10	.08
(e8)I have tough choices that I need to make.	4.06	2.04	.05	.09	.05	-.06	.29
(a14)I struggle making decisions based on my values.	3.99	2.02	.03	.03	.05	.05	.26
(p12)I want help with my relationships (romantic, and/or non-romantic).	4.10	2.03	.05	.00	.00	.09	.24
(a2)My negative thoughts sometimes determine my reality.	4.12	2.06	.19	.05	-.14	.02	.22
(e13)I would like to know that my therapist has similar experiences to me.	4.00	1.92	-.01	.00	.07	-.02	.20
(a6)It's important for me to act in accordance with my values.	4.09	1.95	.15	-.16	.10	.16	.18
(m14)My culture differs from the majority of people around me.	4.05	2.04	.13	.09	.13	.04	.15
(e2)My life has little or no purpose.	4.13	2.13	.13	.03	.11	.09	.14
(e9)I need help fully experiencing some of my emotions.	4.14	1.97	.10	.12	.07	-.04	-.13

Note. n = 579, bolded numbers indicate values > .30, values rounded two decimal places, items of .00 are < .01.

Table 3. Rotated Factor Loadings for Psychodynamic Items

Item	Mean	*SD*	Rotated Factor Loadings				
			1	2	3	4	5
(p14)I feel as if my life continues to repeat the same events over and over again (multiple divorces, failed relationships, etc.).	4.43	2.09	**.57**	-.05	.13	.09	.02
(p4)My early life experiences explain a lot of what I do.	3.83	2.12	**.47**	.12	-.03	.10	.10
(p1)I would like to examine my dreams for relevance to my symptoms or therapy goals.	4.15	1.80	**.38**	.13	.01	-.13	.03
(p11)I want help to understand some of my emotions.	4.07	2.10	**.37**	-.10	.18	-.03	.14
(p7)I'd prefer the therapist to give me insight into my problems or situation.	4.19	1.98	**.30**	-.21	.04	.04	.13
(p8)I have some unresolved issues with people from my past.	4.16	2.14	.28	.15	.17	.23	.04
(p5)I give symbolic meaning on events in my life.	3.91	1.98	.25	.04	.06	-.00	.17
(p3)I believe that I do some things unconsciously.	4.63	2.00	.13	**.84**	.10	-.07	.10
(p10)I want to explore my emotions.	4.23	1.96	.39	-.02	**.58**	**-.36**	-.16
(p13)I have some trouble with relationships	4.08	1.96	.08	-.10	**.46**	.05	.20

(romantic, and/or non-romantic).							
(p12)I want help with my relationships (romantic, and/or non-romantic).	4.34	2.02	.01	.12	.28	.03	.02
(p9)I would like the therapist to analyze my experiences.	4.26	1.95	.04	-.06	-.00	**.52**	-.02
(p2)I would like to examine my childhood for relevance to my symptoms or therapy goals.	4.16	2.07	.14	.01	.18	.19	**.48**
(p6)I'd like the opportunity to speak whatever comes to mind.	4.58	1.96	.10	.04	-.01	-.17	**.31**
Eigenvalues			1.26	.84	.75	.56	.47
% of Variance			8.97	6.01	5.36	4.00	3.37

Note. n = 137, bolded numbers indicate values > .30, values rounded two decimal places, items of .00 are < .01.

Table 4. Rotated Factor Loadings for Existential Items

Item	Mean	*SD*	Rotated Factor Loadings					
			1	2	3	4	5	6
(e4)I feel isolated from others.	3.82	2.10	**.90**	.07	.05	.14	-.04	-.11
(e11)I feel I have no control of my life.	4.25	2.10	.14	**.70**	.04	.12	.06	-.08
(e6)I want to connect with other people.	4.19	1.98	-.06	.37	.06	-.03	-.08	.09
(e10)I'd prefer the therapist to give me insight into my problems or situation.	3.60	1.81	.03	.22	-.02	-.06	.17	.17
(e9)I need help fully experiencing some of my emotions.	4.14	2.03	-.08	.05	**.49**	-.02	-.02	-.03
(e5)I feel that no one understands me.	3.98	2.02	.12	.02	**.47**	**.37**	.13	-.12
(e12)I want to explore my existence of life.	4.29	2.10	.05	.01	**.38**	-.02	.01	.15
(e3)It is important for my therapist to be authentic with me.	4.04	1.99	.08	.08	.03	.46	.04	-.01
(e7)I would prefer to focus on my present situation.	4.15	1.99	-.08	.10	.22	**-.35**	.15	.16
(e13)I would like to know that my therapist has similar experiences to me.	4.08	1.86	-.12	-.06	.08	**.33**	.06	.28
(e8)I have tough choices that I need to make.	3.79	2.02	-.08	.00	.10	.06	**.57**	-.06
(e1)I would like help finding meaning in my	4.16	2.14	.24	-.03	-.07	-.02	**.30**	.06

life.								
(e2)My life has little or no purpose.	4.26	2.16	-.03	.07	.04	-.04	-.03	**.47**
Eigenvalues			.94	.71	.68	.63	.50	.43
% of Variance			7.25	5.43	5.25	4.85	3.82	3.27

Note. n = 129, bolded numbers indicate values > .30, values rounded two decimal places, items of .00 are < .01.

Table 5 Rotated Loadings for Cognitive-Behavioral Items

Item	Mean	*SD*	Rotated Factor Loadings			
			1	2	3	4
(c5)I would like assignments for me to complete on my own, outside of therapy.	4.37	2.24	**.77**	.10	.02	.02
(c2)I want to change my negative behaviors.	4.10	2.11	**.44**	-.02	.29	.27
(c6)I would prefer a structured format to therapy.	4.08	2.11	-.01	**.48**	.05	.16
(c4)My mood and thoughts affect my behavior.	4.24	2.21	.01	**.42**	.10	.15
(c12)I would like some help learning problem solving skills.	4.29	2.03	.10	**.35**	.15	-.02
(c7)I want techniques/skills to help with my symptoms or situation.	4.12	2.06	.14	**.33**	.08	.32
(c10)I would like my therapist to collaborate with me on my goals.	4.39	1.95	.29	**.31**	.08	.16
(c3)My negative thoughts affect my mood.	4.36	2.00	.04	.15	**.76**	.17
(c11)I am having difficulty solving my problems.	4.38	2.00	.13	.26	**.31**	.06
(c1)I want to change my negative thoughts.	4.16	2.21	.21	.21	.28	.27
(c9)Whenever my symptoms occur, I want a technique/skill to help control or reduce the severity.	4.38	2.03	.04	.12	.11	**.56**
(c8)I would like help becoming aware of the triggers or situations that relate to my problems or symptoms.	4.23	1.98	.24	**.30**	.16	**.35**
Eigenvalues			1.03	.98	.91	.79
% of Variance			8.55	8.18	7.61	6.6

Note. n = 14, bolded numbers indicate values > .30, values rounded two decimal places, items of .00 are < .01.

Table 6 Rotated Factor Loadings for Acceptance and Commitment Items

Item	Mean	*SD*	Rotated Factor Loadings					
			1	2	3	4	5	6
(a13)It's important to set goals that align with my values in therapy.	3.89	1.96	**.45**	.10	.11	-.11	.05	.05
(a9)I would like to be aware of my thoughts without them controlling me.	4.09	1.99	**.41**	.03	.13	.06	-.10	.01
(a3)I want to accept my negative thoughts.	3.77	1.95	**.36**	.09	.02	.23	-.08	-.05
(a6)It's important for me to act in accordance with my values.	4.37	1.93	.10	**.66**	.19	.13	.02	-.04
(a5)I would prefer assignments for me to complete on my own, outside of therapy.	3.97	2.04	**.38**	**.53**	**-.30**	.02	-.03	.20
(a11)I want to own my thoughts, and not let my thoughts own me.	4.37	1.99	-.02	.01	**.54**	-.24	-.06	.02
(a14)I struggle making decisions based on my values.	4.08	2.05	.20	.05	**.49**	.17	-.04	-.00
(a4)I need help being more aware of the present moment.	3.89	1.98	.12	.03	.19	.11	.04	.05
(a1)I am having trouble accepting certain thoughts.	4.05	1.98	.10	.04	.07	**.57**	.01	-.06
(a8)My values differ from my thoughts.	4.20	2.04	-.09	.13	-.08	**.43**	.01	.30

(a7)My values differ from what I do.	4.14	1.93	-.17	.05	.05	.08	.71	.04
(a12)My values direct my life.	4.19	2.02	.27	.02	-.04	.03	.29	.15
(a2)My negative thoughts sometimes determine my reality.	4.18	2.09	-.01	.06	.09	.11	-.23	.17
(a10)I would like to be aware of my emotions without them controlling me.	4.43	2.13	.06	-.01	.04	-.01	.02	**.55**
Eigenvalues			.84	.76	.75	.71	.66	.50
% of Variance			5.97	5.42	5.38	5.10	4.74	3.54

Note. n = 115, bolded numbers indicate values > .30, values rounded two decimal places, items of .00 are < .01.

Table 7 Rotated Factor Loadings for Multicultural Items

Item	Mean	*SD*	Rotated Factor Loadings					
			1	2	3	4	5	6
(m13)I have to deal with a language barrier.	4.22	2.03	**.78**	-.09	.26	.01	-.00	.05
(m8)I am bullied because of who I am.	4.15	2.05	**.46**	-.04	-.07	.22	.23	.02
(m3)Societal issues are a big concern of mine (immigration, racism, etc.).	4.25	2.10	.24	.15	.15	.01	.08	.20
(m7)I want to have deeper relationships with people.	4.25	1.90	-.08	**.66**	-.12	-.03	.11	-.18
(m4)My culture of origin dictates that I should act in one way, but I want to act in another.	4.08	2.08	.01	**.50**	.20	.17	-.08	.15
(m1)My culture is important to my identity.	4.05	2.19	.17	**.42**	.09	**.36**	.22	.02
(m2)My culture is important to my identity.	4.18	2.00	.10	.05	**.60**	.25	.11	-.10
(m11)I have to explain my identity to others (ethnicity, culture, religion, gender).	4.23	2.07	.29	.13	**.33**	-.11	.12	.12
(m9)I am having difficulty with different groups in my life (school, social, home, work).	4.46	1.88	.04	-.02	**.31**	-.03	.06	.05

(m5)My gender role conflicts with what I want to do.	4.36	1.90	.21	.14	.28	.03	.20	.11
(m14)My culture differs from the majority of people around me.	4.30	2.01	.05	.11	.04	**.72**	.04	.05
(m6)I have to deal with discrimination too often.	3.95	2.08	.25	.06	.11	-.04	**.56**	.08
(m10)I would like my therapist to acknowledge my cultural background.	4.07	2.03	-.04	.06	**.31**	.21	**.54**	.05
(m12)I feel like an outsider.	4.08	2.09	.08	-.06	.03	.05	.08	**.73**
Eigenvalues			1.12	.95	.91	.85	.80	.67
% of Variance			7.96	6.76	6.47	6.08	5.74	4.81

Note. n = 120, bolded numbers indicate values > .30, values rounded two decimal places, items of .00 are < .01.

APPENDIX A

INFORMED CONSENT FORM

PROJECT TITLE: The Development of the Client Treatment Orientation Scale

INVESTIGATOR:
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APPROVAL STATEMENT:

This study has been approved by the Department of Psychology Institutional Review Board Sub-Committee of the California State University, San Bernardino, and a copy of the official Psychology IRB stamp of approval should appear on this consent form. The University requires that you give your consent before participating in this study.

DESCRIPTION:

Adhering to client preferences, at least to some degree, may strengthen the therapeutic alliance earlier, thus increasing client retention. The purpose of your participation in this study was to investigate certain client preference information and to sort out theoretical orientation questions. Participation in this study will require no more than 45 minutes. Please alott enough time to fully complete the study in one sitting. Please note that there is no deception in this study, and we could not make this statement if there were any deception.

RISKS AND BENEFITS:

The benefits of participation include the gratifying experience of assisting in research which might have implications for the understanding of theoretical orientations from a client's perspective. It is very unlikely that any psychological harm will result from participation in this study. However, if you would like to discuss any distress you have experienced, do not hesitate to contact the CSUSB Psychological Counseling Center (909 537-5040).

Appendix B cont'd

VOLUNTARY PARTICIPATION:

Your participation in this study is entirely voluntary. You are free to withdraw your participation at any time during the study, or refuse to answer any specific question, without penalty or withdrawal of benefit to which you are otherwise entitled (however, you will not be included in the prize drawing).

CONFIDENTIALITY STATEMENT:

As no identifying information will be collected, your name cannot be connected with your responses and hence your data will remain completely anonymous. All information gained from this research will be kept confidential. The results from this study will be submitted for professional research presentations and/or publication to a scientific journal. When the study results are presented or published, they will be in the form of group averages as opposed to individual responses so again, your responses will not be identifiable. Results from this study will be available from Dr. Christina Hassija, after August 2018. Your anonymous data will be sent to the researcher in an electronic data file and stored for a period of 5 years on a password protected computer in a locked office and may only be accessed by researchers associated with this project.

RIGHT TO WITHDRAW:

You are free to refuse to participate in this study or to withdraw at any time. Your decision to withdraw will not result in any penalty or loss of benefits to which you are entitled. You may withdraw your participation by simply clicking the appropriate button to exit the study. If you choose to withdraw from the study you will not receive credit for your participation. Alternatively, you may also choose to leave objectionable items or inventories blank.

QUESTIONS OR CONCERNS:

If you have any questions or concerns regarding this study, please feel free to contact the Department of Psychology IRB Subcommittee at Psych.irb@csusb.edu. You may also contact the Human Subjects office at California State University, San Bernardino (909) 537-7588 if you have any further questions or concerns about this study.

I acknowledge that I have been informed of, and understand the true nature and purpose of this study, and I freely consent to participate. I acknowledge that I am at least 18 years of age. Please indicate your desire to participate by placing and "X" on the line below.

_____ _____

Participant's X Date

California State University Psychology Institutional Review Board Sub-Committee			
Approved	10/16/17	**Void After**	10/16/18
IRB #	H-17FA-02	**Committee Member**	

APPENDIX B

RECRUITMENT ADVERTISEMENT

Sam D. Worrall and Dr. Christina M. Hassija from California State University, San Bernardino is conducting this research.

Recruitment Ad: Development of the Client Treatment Orientation Scale

All qualified participants may be entered to win 1 of 18 $50 dollar Amazon E-gift cards. We are looking for English speaking therapists (to include: MFTs, LPCCs, LCSWs, Psychiatrists, etc.). You will be asked demographic questions, as well as, information pertaining to your education and therapeutic work.

The purpose of your participation in this study is to investigate certain client preference information and to sort out theoretical orientation questions. Participation in this study should require no more than 45 minutes and must be completed in one sitting.

If interested, click on the link below for more information.
http://csusb.az1.qualtrics.com/jfe/form/SV_bjhkCf68Jj7Wzzf
If you have any questions concerning this research, please contact:
Sam D. Worrall at samd.worrall@gmail.com

APPENDIX C

DEMOGRAPHICS QUESTIONNAIRE

Demographic Questionnaire

Please answer each question to the best of your knowledge.

1. Age:_____

2. Gender: M ___ F ___ Transgender ___ Other____(please check only one)

3. What is your racial background?

Caucasian (White)____ Asian (Asian American) ____ African American (Black) ____

American Indian or Alaskan Native ____ Native Hawaiian/other Pacific Islander _____

Other _____

4. What is your degree? (mark all that apply)

MS____ MA____ Ph.D.____ Psy D.____ M.D.____

Other (please specify) _____

5. What field is your degree from? (Mark all that apply)

ClinicalPsychology____CounselingPsychology____School_____Psychology____

Psychiatry_____

Other (please specify)_____

6. How long have you been graduated from your program?

_____years _____months

7. Are you professionally licensed?

Yes___ No____

8. What type of license do you possess (i.e. LMFT, LPCC, LSCW, etc)?

(Please specify)_____

9. What setting do you currently practice in?

School___ Private Practice____ Hospital____ Researcher____

Other Setting_____

10. What are the populations that you primarily work with?

_____

11. Which theoretical orientation do you use? (Mark all that apply)

Psychodynamic_____ Existential_____ Multicultural_____

Acceptance and Commitment Therapy (ACT) _____

Cognitive Behavioral Therapy (CBT) _____

APPENDIX D

CLIENT TREATMENT ORIENTATION SCALE

The following sets of questions are meant for clients to answer, in order to rate which theoretical orientation may fit him/her.

Please be aware the wording is meant for clients who may not have the strongest vocabulary or understanding of specific therapeutic theories. Hence, some terminology may not be the most accurate. If you do not regularly utilize a theory or are uncomfortable rating the statements, please select NA (Not Applicable)

As Subject Matter Experts, you are being asked to evaluate each item in regards to how strongly each statement encapsulates each theory.

On a Scale from 1-7, Please rate each item. 1=Strongly disagree, 2=Disagree, 3=Somewhat Disagree, 4=Neutral/Not Applicable, 5=Somewhat Agree, 6=agree, 7=Strongly Agree.

Psychodynamic:

1. ____I would like to examine my dreams for relevance to my symptoms or therapy goals.
2. ____I would like to examine my childhood for relevance to my symptoms or therapy goals.
3. ____I believe that I do some things unconsciously.
4. ____My early life experiences explain a lot of what I do.
5. ____I give symbolic meaning on events in my life.
6. ____I'd like the opportunity to speak whatever comes to mind.
7. ____I'd prefer the therapist to give me insight into my problems or situation.
8. ____I have some unresolved issues with people from my past.
9. ____I would like the therapist to analyze my experiences.
10. ____I want to explore my emotions.
11. ____I want help to understand some of my emotions.
12. ____I want help with my relationships (romantic, and/or non-romantic).
13. ____I have some trouble with relationships (romantic, and/or non-romantic).
14. ____I feel as if my life continues to repeat the same events over and over again (multiple divorces, failed relationships, etc).

Existential

1. ____I would like help finding meaning in my life.
2. ____My life has little or no purpose.
3. ____It is important for my therapist to be authentic with me.
4. ____I feel isolated from others.
5. ____I feel that no one understands me.
6. ____I want to connect with other people.
7. ____I would prefer to focus on my present situation.
8. ____I have tough choices that I need to make.
9. ____I need help fully experiencing some of my emotions.
10. ____I'd prefer the therapist to give me insight into my problems or situation.
11. ____I feel I have no control of my life.
12. ____I want to explore my existence of life.
13. ____I would like to know that my therapist has similar experiences to me.

CBT

1. ____I want to change my negative thoughts.
2. ____I want to change my negative behaviors.

3. ____My negative thoughts affect my mood.
4. ____My behaviors prevent me from
5. ____I would like assignments for me to complete on my own, outside of therapy.
6. ____I would prefer a structured format to therapy.
7. ____I want techniques/skills to help with my symptoms or situation.
8. ____I would like help becoming aware of the triggers or situations that relate to my problems or symptoms.
9. ____Whenever my symptoms occur, I want a technique/skill to help control or reduce the severity.
10. ____I would like my therapist to collaborate with me on my goals.
11. ____I am having difficulty solving my problems.
12. ____I would like some help learning problem solving skills.

ACT

1. ____I am having trouble accepting certain thoughts.
2. ____My negative thoughts sometimes determine my reality.
3. ____I want to accept my negative thoughts.
4. ____I need help being more aware of the present moment.
5. ____I would prefer assignments for me to complete on my own, outside of therapy.
6. ____It's important for me to act in accordance with my values.
7. ____My true self is different from some of the things I do.
8. ____My true self is different from some of the things I think.
9. ____I would like to be aware of my thoughts without them controlling me.
10. ____I would like to be aware of my emotions without them controlling me.
11. ____I want to own my thoughts, and not let my thoughts own me.
12. ____My values direct my life.
13. ____It’s important to set goals that align with my values in therapy.
14. ____I struggle making decisions based on my values.

Multicultural

1. ____My culture is important to my identity.
2. ____My religion is important to my identity.
3. ____Societal issues are a big concern of mine.
4. ____My problem stems from what I want to do compare to what society believes I should do.
5. ____My gender role conflicts with what I want to do.
6. ____I have to deal with discrimination too often.
7. ____I want to have deeper relationships with people.
8. ____I am bullied because of who I am.
9. ____I am having difficulty with different groups in my life (school, social, home, work).
10. ____I would like my therapist to acknowledge my cultural background.
11. ____I have to explain my identity to others.
12. ____I feel like an outsider.
13. ____I have to deal with a language barrier.
14. ____My culture differs from the majority of people around me.

APPENDIX E

POST STUDY INFORMATION

POST-STUDY INFORMATION FORM

ADHERING TO CLIENT PREFERENCES, AT LEAST TO SOME DEGREE, MAY STRENGTHEN THE THERAPEUTIC ALLIANCE EARLIER, THUS INCREASING CLIENT RETENTION. THE PURPOSE OF YOUR PARTICIPATION IN THIS STUDY WAS TO INVESTIGATE CERTAIN CLIENT PREFERENCE INFORMATION AND TO SORT OUT THEORETICAL ORIENTATION QUESTIONS.

THERE WAS NO DECEPTION IN THIS STUDY, AND WE COULD NOT MAKE THIS STATEMENT IF THERE WERE ANY DECEPTION. THE BENEFITS OF PARTICIPATION INCLUDE THE GRATIFYING EXPERIENCE OF ASSISTING IN RESEARCH WHICH MIGHT HAVE IMPLICATIONS FOR THE TREATMENT OF CLIENTS SEEKING THERAPY. MINIMAL RISKS ARE POSSIBLE WITH YOUR PARTICIPATION IN THIS STUDY. IF YOU WOULD LIKE TO DISCUSS ANY DISTRESS YOU HAVE EXPERIENCED, DO NOT HESITATE TO CONTACT THE CSUSB PSYCHOLOGICAL COUNSELING CENTER (909 537-5040).

RESULTS FROM THIS STUDY WILL BE AVAILABLE FROM DR. CHRISTINA HASSIJA, AFTER AUGUST 2018. ANY FURTHER QUESTIONS CONCERNING THIS STUDY MAY BE ANSWERED BY DR. HASSIJA AT CHASSIJA@CSUSB.EDU OR 909-537-5481, OR THE DEPARTMENT OF PSYCHOLOGY IRB SUBCOMMITTEE AT PSYCH.IRB@CSUSB.EDU. YOU MAY ALSO CONTACT THE HUMAN SUBJECTS OFFICE AT CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO (909) 537-7588.

APPENDIX F

DISPOSITION FORM

Human Subjects Review Board
Department of Psychology
California State University,
San Bernardino

PI:	Sam Worrall and Christina Hassija
From:	Ismael Diaz
Project Title:	Development of the Client Treatment Orientation Scale.
Project ID:	Worrall H-17FA-02
Date:	10-16-17

Disposition: Administrative Review

Your IRB proposal is approved. Your protocol (Development of the Client Treatment Orientation Scale, Worrall H-17FA-02) is approved for collecting responses from 400 participants (outside of the SONA pool). This approval is valid from 10-17-17 until 10-17-18.

Good luck with your research!

Ismael Diaz, Committee Member
Psychology IRB Sub-Committee

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