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ORIGINAL ARTICLE

A brief, multidimensional measure of clients' therapy preferences: The Cooper-Norcross Inventory of Preferences (C-NIP)☆

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Abstract Addressing and accommodating client preferences in psychotherapy have been consistently associated with improved treatment outcomes; however, few clinically useful and psychometrically acceptable measures are available for this purpose. The aim of this study was to develop a brief, multidimensional clinical tool to help clients articulate the therapist style they desire in psychotherapy or counseling. An online survey composed of 40 therapy preference items was completed by 860 respondents, primarily female ($n = 699$), British ($n = 650$), White ($n = 761$), and mental health professionals themselves ($n = 615$). Principal components analysis resulted in four scales that accounted for 39% of the total variance: Therapist Directiveness vs. Client Directiveness, Emotional Intensity vs. Emotional Reserve, Past Orientation vs. Present Orientation, and Warm Support vs. Focused Challenge. These scales map well onto dimensions of therapist activity and cover most of the major preference dimensions identified in the research literature. Internal consistency coefficients ranged between .60 and .85 ($M = .71$). Tentative cutoff points for strong preferences on each dimension were established. The 18-item Cooper-Norcross Inventory of Preferences (C-NIP) is a multidimensional measure with clinical utility, but additional validity data are needed.

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PALABRAS CLAVE
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Una medida multidimensional breve de las preferencias de terapia de los clientes: el Inventario de Preferencias Cooper-Norcross

Resumen Abordar y acomodar las preferencias del cliente en psicoterapia se asoció consistentemente con mejoras en los resultados del tratamiento; sin embargo, pocas medidas clínicamente útiles y psicométricamente aceptables están disponibles para este propósito. El objetivo fue desarrollar una herramienta clínica multidimensional breve para ayudar a que los clientes articulen el estilo terapéutico que desean en la psicoterapia o consejería. Una encuesta online compuesta por 40 ítems de preferencias de terapia fue completada por 860 sujetos, principalmente mujeres ($n = 699$), británicos ($n = 650$), blancos ($n = 761$) y profesionales de la salud mental ($n = 615$). Un análisis de componentes principales aisló cuatro escalas que representan el 39% de la varianza total: Directividad del terapeuta vs. Directividad del cliente, Intensidad emocional vs. Reserva emocional, Orientación pasada vs. Orientación presente y Apoyo caluroso vs. Cambio focalizado. Estas escalas recogen las dimensiones de la actividad del terapeuta y cubren la mayoría de las principales dimensiones de preferencias identificadas en la literatura. Los coeficientes de consistencia interna oscilaron entre 0,60 y 0,85 ($M = 0,71$). Se establecieron puntos de corte provisionales para fuertes preferencias en cada dimensión. El Inventario de Preferencias Cooper-Norcross-18 ítems (C-NIP) es una medida multidimensional con utilidad clínica, pero se necesitan datos adicionales de validez.

In recent years, there has been an increasing emphasis on taking client preferences into account when determining a psychological or medical treatment (National Collaborating Centre for Mental Health, 2010; Straus, Richardson, Glasziou, & Haynes, 2005). Indeed, the international juggernaut of *evidence-based practice* (EBP) considers patient values as one of the three essential evidentiary sources, along with best reseach evidence and clinican expertise, that require consideration and integration. The American Psychological Association (2006) definition of EBP explicitly expanded ''patient values'' into ''patient characteristics, culture, and preferences''. In so doing, clients assume a more active, prominent position in EBPs in mental health and addictions. In all cases, the integration of client preferences is a defining feature of evidence-based practice in psychology (Norcross, Hogan, & Koocher, 2008).

Client preferences can be defined as ''the behaviors or attributes of the therapist or therapy that clients value or desire'' (Swift, Callahan, & Vollmer, 2011, p. 302). Three types of client preferences have been proposed in the literature (Swift et al., 2011). *Therapist preferences* refer to clients' desires that psychotherapists will have specific personal characteristics, such as being female. *Treatment preferences* refer to macro-level desires for a particular kind of therapy, such as cognitive-behavioral therapy over a person-centered approach. Finally, *role preferences* refer to micro-level preferences for particular behaviors, activities and styles of intervention within the therapeutic work, such as a nondirective therapist approach. Role preferences can be further subdivided into *therapist role preferences* (such as asking questions) and *client role preferences* (such as reflecting on childhood events) (Cooper & McLeod, 2011; Watsford & Rickwood, 2014).

Research on the relationship between client preferences and therapy outcomes provides strong support for the clinical assessment and empirical investigation of this factor. Meta-analytic findings indicated that clients who received a preferred therapy, as compared with clients who receive a non-preferred therapy, show significantly greater clinical outcomes and satisfaction, and significantly lower dropout rates at a ratio of almost one-to-two (Lindhiem, Bennett, Trentacosta, & McLear, 2014; Swift et al., 2011).

Despite these consistent research findings, there is little evidence that client preferences are routinely being assessed or accommodated in clinical practice. A key reason may be the small number of public tools for assessing client preferences, and those are primarily for research rather than clinical purposes.

Treatment preference vignettes

A standard research method for assessing clients' preferences has been to provide participants with written vignettes (e.g., King et al., 2000) or video recordings (e.g., Devine & Fernald, 1973) of different treatments. Clients are then asked to indicate which of these treatments they would prefer or to rate the strength of their preferences. A parallel in clinical practice is *decision aids* (The Health Foundation, 2014), which provide patients with information about the different treatments for their condition and support shared decision making. Although primarily available for physical health conditions, decision aids for depression have now been produced, both as a written pamphlet (BMJ Group, 2015b) and as a web-based resource (BMJ Group, 2015a).

The use of decision aids typically lead to greater self-efficacy and improved decision making (The Health Foundation, 2014). However, for clinical purposes, such approaches have several limitations. First, in many instances, they elicit only dichotomous answers (preference