Working with Client Preferences in Counselling and Psychotherapy

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Client preferences can be defined as the specific conditions and activities that clients want in their therapy. The literature suggests three main types of client preferences [1]. First are *treatment preferences*: the desires that clients have for specific types of intervention, like person-centred or psychodynamic. Second are *preferences about the therapist*. This is the kind of counsellor or psychotherapist that the client would like to work with; for instance, lesbian, Asian, or an older adult. Third are *activity preferences*: the specific actions that clients desire to engage in throughout the therapy process. This can include the frequency and format of therapy (for instance, online therapy), the methods and techniques to be used (for instance, two-chair work), the preferred topics to focus on (for instance, early childhood), and the therapist's particular style (for instance, focusing on emotions).

In preference work, we can also distinguish between *preference assessment*—the identification of clients' strong likes and dislikes—and *preference accommodation*—the therapist adjustment of their way of working to the client's expressed desires [2].

There are both ethical and empirical reasons why therapists should concern themselves with client preferences. Research shows that clients are as much as 50% less likely to drop out of therapy when the treatment matches their preferences, and also show somewhat better outcomes. So, for instance, a client who wants a warm, supportive, client-led therapy style may be particularly likely to drop out—or show relatively poor outcomes—if they are given a highly directive and therapist-led CBT [1]. Ethically, preference assessment and accommodation can convey a deep respect for our clients and their ways of seeing their worlds: a core requirement of any ethical framework [e.g., 3]. It also means respecting our clients' rights to be autonomous, self-governing agents; and recognising that they are not uniform, 'machine-made' products, but individualized beings with distinctive wants. Such honouring of difference is also important across cultures. A White male counsellor, for instance, who does not ask his female Pakistani client about her particular preferences may end up imposing European, 'male' assumptions on her. When we ask, therefore, we share power; we move away from a comparatively authoritarian, expert-led stance towards a more egalitarian and democratic one.

Addressing Common Concerns

Therapists, quite rightly, have a number of concerns about working with client preferences, and these are worth addressing up front.

'Most of my clients don't know what they want.'

It's certainly true that some clients don't have strong preferences, particularly if they have not been in counselling or psychotherapy before. But preference work is not an all-or-nothing thing: it's about gently and sensitively offering clients an opportunity to share their preferences, if and when they have them and would like to do so.

'What clients* want *isn't necessarily what they* need*.'

That can be true. A client, for instance, might want warmth and reassurance from their therapist when, actually, what would help them is to learn to tolerate anxieties and tensions in interpersonal relationships. But, as we have seen, research shows that, overall, clients succeed better in therapy when they get the approach they want. Moreover, when therapists think that what a client requests will not prove helpful, then can then raise that concern with them. It's

not about handing over responsibility to clients, but working collaboratively with them—'shared decision making', as they call it in the medical field—to work out, together, the best way forward.

'Clients preferences can change over the course of therapy'

Yes, some do and some don't (though our research shows that most client preferences are pretty stable over time). That means that assessing client preferences is not a 'set-and-forget' process. It's often more tentative and recursive: opening up the discussion, trying things, and being willing to change the way of working if clients are not finding it helpful or want something else.

'Does that mean I have to offer every therapeutic methods to every client I meet?'

No, we can only learn so many approaches, and we have to practice within our competencies. Thus, sometimes, working with client preferences means recognising that what they want is not what we can competently offer (and referral to another may be indicated). But, generally, it is much better that clients and therapists have that discussion early on, rather than discovering incompatibilities months into treatment.

'I already have an intuitive sense of what my clients want, so why bother asking?'

Intuition is a valuable skill; but research shows, again and again, that therapists' and clients' perceptions of what is going on in therapy are often mismatched. For instance, one study found that, in about two-thirds of cases, clients and therapists had somewhat different views about the goals for therapy [4]. Moreover, there is a risk that therapists' intuitive sense of what clients want are biased by the therapists' *own* therapy preferences. Our research shows that there are quite large and systematic differences between what therapists and laypeople want, as clients [5].

'I already work with clients' preferences. I don't need to do more.'

Interestingly, in the medical field, doctors tend to think there's more shared decision making going on than patients [6]. The difference may come down to power. If a doctor says, 'Why don't we try treatment X', and a patient nods their head, the doctor may feel it's a shared decision; but, for the patient, it may be more a case of compliance for fear of appearing ignorant or rude. Given that a similar power dynamic can exist in therapy—with research showing that client deference frequently occurs, even in person-centred approaches [7]—it behoves all therapists to reflect on their practice and think about how frequently they provide clients with opportunities to express their preferences. It may be less than we think.

Assessing Client Preferences

So how should you go about assessing client preferences?

Almost certainly, the first step is a reflexive one: asking yourself, *What is my scope of practice*? That is, what are you (a) competent and (b) willing to offer to your clients? For instance, are you able and willing to offer transference interpretations, anxiety-management skills, or methods to discover meaning in life? What about individual, couple, group, or family therapy? Recognising what you can offer clients is essential in responding effectively to clients' stated preferences—you will need to know whether what they ask for is something you can adopt or not.

Assessment of client preferences most commonly takes place at initial, or intake, appointments. It is probably best if this assessment takes place towards the end of that session—clients often come to therapy anxious, or with their own accounts that they want to offload—and it may be a few sessions before clients are ready to say something of what they

prefer. We recommend that the clients' treatment goals (the 'where') be established before ascertaining their preferences (the 'how').

There are many ways that clients can be invited to express their preferences, for instance:

- What do you think that we can do here that might be helpful to you? Do you have any sense of what wouldn't be helpful?
- What would you like in our work together? What kind of preferences do you have?
- Try this brief exercise. Close your eyes, breathe deeply a few times, and imagine in your mind's eye what you would strongly like to happen in here. What would I ideally do? What would I not do?
- Let's think together about how you might get what you want from therapy. Which treatment method? What type of therapy relationship? What type of out-of-office activities: self-help, exercise, apps, and so on?'

Assessment of client preferences can also take place before that intake meeting. For instance, on an initial phone conversation, a prospective therapist may ask about particular treatment preferences or preferences about the therapist to ensure there is a basic compatibility before moving forward. Scheduled review sessions are another point at which clients may be asked about their preferences, and whether the therapist's methods and style seems to be of help. And, of course, throughout the therapy sessions there may be occasions where it is appropriate and helpful to discuss client preference: for instance, at the start of sessions, when the therapy is not progressing well, when there is an alliance rupture, or when the ending approaches. In fact, recursive assessment of preferences often becomes part of routine outcome monitoring.

Based on the research and our clinical experience [2], we offer several principles of good practice in preference assessment:

- Focus on *strong* preferences—what clients might *really* want and *really* dislike—rather than milder or more moderate preferences; it's the former where accommodation or non-accommodation is most likely to count.
- Ask clients what worked and did not work in previous therapies, if they have had them. It's often the most simple and natural way in to helping identify what might be helpful now.
- 'It's the relationship, stupid': preference assessment needs to be framed within the context of a respectful, warm, collaborative therapeutic relationship; if not, it may be little more than a sterile data gathering process.
- Make it clear that asking about preferences is a normal part of counselling and psychotherapy. Clients may be surprised to be asked, and assume that therapy is like other, practitioner-led 'treatments'.
- Actively invite clients to share their preferences: given client deference (see above), it's not enough just to assume that, if they have preferences, they'll verbalize them.
- Be part of the dialogue yourself: shared decision making means *shared*—you need to work with the client to help decide, together, what might be best for them.
- Be confident: at its worst, preference assessment can communicate to clients that we don't know how to help them, and that it's their responsibility to decide. So the message we want to communicate to clients is, 'We've got lots of ideas about how to help you, but we're really interested in your ideas too. I am the expert on therapy and you are the expert on you.'

- Suggest alternatives through 'scaffolding': clients can easily feel overwhelmed if they're presented with a 'blank sheet of paper' and asked, 'What do you want?' Rather, it is often helpful to suggest 2 or 3 specific possibilities, for instance, 'We could talk about your grandmother this session, or perhaps you would like to focus on your boyfriend?'
- Don't 'overcook' it: if clients do not have ideas about will help them, or seem reluctant to talk about it, then move on. You can come back to their preferences later on in the therapeutic process, if it seems appropriate.
- Tailor the tailoring: some clients, some of the time, want to have their preferences assessed and accommodated; others, do not. Hence adjust the amount of preference work to the individual client—there is no one size fits all, even when it comes to the client's preferences.

Through our research, we have developed a tool to assess strong client preferences, the Cooper-Norcross Inventory of Preferences (C-NIP) [8]. This measure, now translated into over ten languages and freely available for use digitally or on paper (see c-nip.net), invites clients to express their preferences for therapy along four dimensions: (a) Therapist directiveness vs Client directiveness, (b) Emotional intensity vs Emotional reserve, (c) Past orientation vs Present orientation, and (d) Warm Support vs Focused challenge. The measure takes clients about five minutes to complete and can be immediately scored in session to indicate whether the client has strong preferences on any of these dimensions. This then serves as the basis for discussion about how the therapist and client can work together. Our research suggests that clients generally find the C-NIP helpful, supporting their ability to articulate how they want to proceed in treatment. And, they say, it feels good to be asked.

Working with Client Preferences in Therapy

Once clients' preferences are assessed, there is the question of how they are accommodated—or not—into the therapeutic work. In our book, *Personalizing Psychotherapy*, we suggest four possibilities: *adopt*, *adapt*, *alternative*, or *another*.

Adopt means that we integrate the client's strong preferences, pretty much as they are, into treatment—bearing in mind, of course, that these preferences (and our scope of practice) may change over time.

Adapt is offering something along the lines of what the client wanted, but adjusted to take into account our own views of what might prove most effective, the research evidence, ethical considerations, or the limits of our own scope of practice. In the case of Hamza, for example, there was a small but significant mismatch between what he wanted from treatment and the therapist's (Mick's) understanding of what might be most helpful for him:

> Hamza presented with high levels of depression and anxiety and was becoming increasingly withdrawn from his college and social environment. The therapist view, based on an understanding of core behavioural principles, was that Hamza needed to be encouraged to get out and re-engage with his world. The more he withdrew, the more anxious and isolated he became. Hamza sensed this pattern as well. However, he also indicated that, based on a previous episode of CBT, it was unhelpful for him to be told by a therapist, 'If you don't do what I'm suggesting, you're not going to get better.' He related that it left him feeling guilty, ashamed, and even less confident to go out into the world. The adaptation challenge was to find methods of communicating to Hamza that he *could* change his behaviours, without implying that he was 'bad' or 'wrong' if he did not. A delicate balance needed to be struck

between helping Hamza own some responsibility and, at the same time, avoiding his strong dislike of feeling blamed. [2]

The third option is to respectfully propose *alternatives* to patients' strong likes and dislikes. This would be when we believe their preferences will not be most suited to the particular context, or when we do not think it will produce the desired results. Just because clients want something does not mean that we should automatically provide it. Ethical, legal, and clinical constraints still bind us to responsible and effective practice. In some cases, for instance, clients may be unconsciously trying to recreate problematic relationship or to test the therapy's frame. Three 'E's may be helpful when proposing alternatives to clients [2]:

- *Explain* your reasoning for not accommodating or adapting.
- *Empathize* with probable patient disappointment.
- *Educate* the client about the proposed alternative, so that they understand why it is being proposed.

When a client's strong preferences prove congruent with the research evidence and best practices, but not our own scope of practice, then referral to *another* becomes a strong possibility [2]. This is a practice that students often receive little training in, but it is an essential competence, given our inevitable limits and our desire for clients to have the best therapy possible. Some helpful pointers for therapists may be:

- Accept your limits as a clinician: see onward referral as a sign of your commitment to your clients' mental health rather than as an indication of your failings.
- Be aware that some clients may experience onward referral as a sign of rejection or an indication that their mental health problems are incurable. Make clear that it is due to your competency boundaries as a therapist, rather than their failure as a patient.
- Refer onwards in a collaborative way with clients so that it is experienced as a shared and empowering experience, rather than as something imposed on them.
- Provide concrete suggestions and specific sources in mind, as opposed to vague referrals to other services. This may mean being aware of other resources in your community—for instance, low-cost CBT practitioners or substance misuse programmes—before having these discussions with clients.
- Obtain proper permission or releases so that you can communicate with other clinicians or clinics; that will ensure continuity of care and help the treatment personalization forward. [2]

Conclusion

Assessing and accommodating clients' preferences constitutes a complex, nuanced set of practices and interactions that evolve over the course of therapy. It is, at heart, about creating a more egalitarian, empowering, and responsive relationship that enables clients to use counselling and psychotherapy most effectively. Both research and practice attest to the success of preference work.

But there is still much more to learn. Which clients in which situations, for instance, are most (and least) benefitted by preference work? How can we most effectively help clients articulate their preferences? Answering these kinds of questions is part of a wider movement towards personalised care, in which our clients are treated as more than just instances of a general class (for instance, 'depressives' or 'borderline types'), but as unique human beings with specific and individual desires. When we ask clients about their preferences, as with Buber's 'I–Thou attitude' [9], we affirm them as agentic participants or partners, who have

the power—and right—to direct their own process of change. This is certainly not the only means of conveying such valuing and respect to our clients, but it becomes an integral part of a deeply affirming, empowering relationship.

Further Reading

Our book, *Personalizing Psychotherapy: Assessing and Accommodating Client Preferences*, is now available from APA. For UK readers, a 40% discount is available for the book with free standard delivery. Please go to www.eurospanbookstore.com/personalizing-psychotherapy.html and use the 'code Psychotherapy40'. This offer valid until at least 31/3/21 and open to customers based in the UK, Europe, Middle East, and Africa.

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