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Acceptability and Preferences for Empirically-Supported Psychological Treatments

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Acceptability and Preferences for Empirically-Supported Psychological Treatments

by

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Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

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CONTENT

FIGURES

Figures Page

TABLES

Tables Page

ABBREVIATIONS

CBT	Cognitive-Behavioral Therapy
ACT	Acceptance and Commitment Therapy
IPT	Interpersonal Therapy
EFT	Emotion-focused Therapy
BHI	Behavioral Health Institute
OQ-45	Outcomes Questionnaire-45
OQ-IR	Interpersonal Relations subscale
OQ-SR	Social Role subscale
OQ-SD	Symptom Distress subscale

ABSTRACT OF THE DISSERTATION

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Over the past decade, mental health has been moving in the direction of empirically-supported treatments. Currently, there are many empirically-supported treatment modalities that have been shown to be efficacious for various psychological disorders, specifically mood and anxiety disorders. However, the face-to-face treatment literature reflects low levels of treatment access and participation. Approximately half of participants with clinically-significant levels of depression received some treatment, evidence-based or not (Kessler et al., 2007). Even for participants who are able to successfully access services, engagement with treatment is often low, and dropout rates are high. There is some evidence that participants' preferences for treatment are positively related to participant engagement and subsequent outcomes. It is possible that low levels of engagement reflect a mismatch between participant preferences and the specific treatment that is delivered by mental health providers. The current study evaluated treatment preferences among a diverse sample of mental health outpatients and will contribute to the growing literature on individual preferences for empirically-supported psychological treatments.

CHAPTER ONE

BACKGROUND AND SIGNIFICANCE

Prevalence, Impact, and Cost of Psychological Disorders

According to the National Institute of Mental Health, mood and anxiety disorders are the most prevalent psychological disorders for adults in the United States (Kessler et al., 2005; Kessler et al., 2007; Reeves et al., 2011). In terms of prevalence rates, over 18% of adults and 25% of children and adolescents meet criteria for anxiety disorders, while approximately 9.5% of adults and 14% of children and adolescents meet criteria for mood disorders (Kessler et al., 2005). There is also a high comorbidity between anxiety and depressive disorders, which can affect these statistics. Anxiety and depressive disorders have been associated with high levels of impairment and disability. The World Health Organization reported that psychological disorders, including anxiety and depression, represented the highest burden of disease in developed countries, surpassing even that of cardiovascular diseases and various cancers (2004). The reported burden of disease for depression was 10.3 years of life lost to illness, disability, or death, which was significantly higher than cardiovascular diseases (3.0-6.8 years of life lost to illness, disability or death). A strong association has been found between psychological disorders and the morbidity and mortality of chronic diseases, such as diabetes, hypertension, stroke, asthma, obesity, cardiovascular diseases, and cancers (Reeves et al., 2011). Psychological disorders have been found to contribute to the development, maintenance, and adverse progression of chronic diseases through multiple pathways, including high-risk behaviors such as alcohol and substance use or failure to seek

appropriate health care. Mental health concerns can lead to impairments that range from minor disruptions in functioning to more severe incapacitation. These disorders have also been associated with lower treatment utilization and adherence as well as increased rates of tobacco, alcohol, and illicit substance use. In terms of overall medical costs in the United States, mental health care costs have been found to exceed approximately $300 billion dollars each year, making psychological disorders the third most costly medical condition tied with cancers and behind cardiovascular diseases and trauma (Mark et al., 2007). It is clear that psychological disorders, especially anxiety and depressive disorders, represent a significant public health concern.

Psychological Treatment Utilization

A large proportion of individuals who endorse symptoms of mood and anxiety disorders do not receive treatment. In a large-scale study assessing treatment utilization for various mental health concerns, Wang et al. (2005) found that approximately 56% of individuals with mood disorders received a form of mental health treatment and approximately 42% of individuals with anxiety disorders received a form of treatment. In this study, treatments were categorized into four sectors, which included: mental health specialty (e.g., community mental health clinic), general medical (e.g., primary care clinic), human services (e.g., religious counseling), and alternative medicine (e.g., acupuncture clinic). The most prevalent treatment setting where patients sought mental health services was the general medical sector (52%) followed by the mental health specialty (34%). As a result, if individuals did not inform their physicians of their

symptoms or seek mental health services on their own, it was unlikely that they would receive psychological treatment for these concerns.

The low percentage of mental healthcare treatment utilization can be attributed to various causes associated both with healthcare professionals and with patients. These disorders are most often identified and treated in medical clinics, and healthcare providers have insufficient training in assessing and treating psychological disorders. Also, healthcare providers have extremely full workloads and are not adequately reimbursed for treating these disorders (Wang et al., 2005). There is also a lack of resources and trained health care providers that can meet the large demand of individuals who present to primary care clinics for mental health treatment. In terms of patient barriers, the following have been reported: stigma and the embarrassment of having a psychological disorder, a lack of motivation for change, negative evaluations of counseling, time constraints, an unwillingness to seek treatment, scheduling issues, and geographically undesirable locations for treatment (Mohr et al., 2010).

Coupled with the low utilization of psychological services is the delivery of psychological treatments that fail to meet adequate quality standards. For individuals who receive mental health treatment, only a small proportion are expected to receive effective treatments that uphold the minimal standards for treatment adequacy. These standards include receiving at least two months of an appropriate medication in conjunction with at least four appointments with a physician or at least eight appointments with a mental health care or human services professional (Wells et al., 2000). Just over 30% of individuals who receive mental health treatments are thought to

receive adequate services and receive any form of follow-up care (Wang et al., 2005). The availability and quality of psychological treatments has clearly been problematic.

Empirically-Supported Psychotherapy Treatments

Over the past decade, there has been a recent surge of interest in the field of psychology in the area of evidence-based practice, in order to address issues regarding treatment dissemination and treatment quality. The movement paralleled the same push for sound research guiding interventions from the Institute of Medicine report in 2001. During the 2005 APA Council of Representatives meeting, evidence-based practice was defined as the implementation of empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention. In conjunction, the American Psychological Association Division 12 created a list of empirically-supported face-to-face treatments that have shown to be efficacious for various Axis 1 disorders. There are many available psychological treatments for individuals with depressive and anxiety disorders. The following treatments have evidenced significant empirical support, including: Cognitive-Behavioral Therapy, Acceptance and Commitment Therapy, Interpersonal Therapy, and Emotion-focused Therapy.

Cognitive-Behavioral Therapy (CBT) has been extensively studied across a wide range of psychological disorders. CBT represents a combination of cognitive therapy and behavioral therapy, which focuses on thoughts and actions, respectively. CBT focuses on the relationship between thoughts, behaviors, and emotions. It aims to identify, challenge, and re-structure maladaptive thoughts as well as alter maladaptive behaviors for the goal of symptom reduction. A large meta-analysis found that CBT has been

efficacious for treating mood disorders, anxiety disorders, somatic disorders, marital distress, chronic pain, eating disorders, and schizophrenia (Butler et al., 2006).

Acceptance and Commitment Therapy (ACT) has a growing empirical base for treating a wide range of disorders, including substance use disorders, depressive disorders, anxiety disorders, psychotic disorders, eating disorders, and chronic pain (Powers et al., 2009). ACT represents the third-wave of CBT and uses acceptance, mindfulness techniques, and committed action to create psychological flexibility. Instead of trying to challenge and re-structure thoughts like in CBT, ACT focuses on noticing and accepting inner experiences. ACT posits that trying to avoid or control thoughts or emotions leads to psychological rigidity, which detracts individuals from behaving in accordance with their values.

The literature on Interpersonal Therapy (IPT) has also demonstrated empirical support for treatment of various psychological disorders, including mood disorders, anxiety disorders, and eating disorders (Cuijpers et al., 2008). IPT focuses on interpersonal issues stemming from childhood that create and maintain psychological problems. Maladaptive communication strategies are identified and the therapist attempts to model and create a new experience. Improving communication and interpersonal relationships lead to reductions in psychological symptoms (O'Shea et al., 2015).

Lastly, there is a growing literature on the efficaciousness of Emotion-focused therapy (EFT) in addressing depressive disorders, trauma, and other anxiety disorders. EFT is an experiential, process-oriented therapy that focuses on accepting, experiencing, regulating, and understanding emotions (Elliott, 2012). It has grown out of the idea that

cognitive and behavioral therapies underemphasize the role of emotional change in psychological symptom reduction. It is clear that each of these empirically supported treatments have been shown to be efficacious in treating many psychological disorders, especially anxiety and depressive disorders.

Differential Efficacy of Psychotherapy Modalities

Researchers have been curious about the differential efficaciousness of psychotherapy modalities. Some studies have found that all psychological treatments are equally effective in achieving positive outcomes (Luborsky et al., 2002; Messer & Wampold, 2002; Wampold et al 1997). This idea has been referred to as the "Dodo-bird hypothesis" from the Alice in Wonderland scene where every character wins the race and receives a prize. This hypothesis states that all therapies lead to positive effects largely due to common therapeutic factors (Horvath & Symonds, 1991). Notably, the therapeutic alliance has consistently been associated with treatment outcomes. In support of this claim, various randomized controlled studies of adults with depressive disorders have failed to show significant differences in efficaciousness among the therapy modalities (Chambless & Ollendick, 2001). On the other hand, some researchers have found evidence of the differential efficaciousness of various therapy modalities. Randomized-controlled trials including adults with specific anxiety disorders have evidenced greater outcomes for behavioral (e.g., exposure) and cognitive-behavioral therapies over more non-directed therapies (Borkovec & Costello, 1993). The study compared non-directive therapy to relaxation and cognitive-behavioral therapy and found the highest gains for

cognitive-behavioral therapy, then relaxation, and then non-directed therapy. The literature on the differential efficacy of psychological treatments remains mixed.

In the studies that have reported differential treatment effects of therapies, the mechanisms underlying these differences are unclear. Potential mechanisms could be specific treatment elements of therapies, patient factors, or therapist factors. The current literature on the differential efficaciousness of treatments has failed to consider the impact of patient expectations and preferences on outcomes. It is possible that patient preferences play a role over and above the intricacies and ingredients of a specific therapy. It has also been shown that individuals are not equally helped by all empirically-supported psychological treatments (Chambless & Ollendick, 2001). Although the role of patient expectations and preferences has not been adequately assessed, evidence-based practice in psychology mandates the incorporation of patient characteristics, needs, values, and preferences with treatments that have research support (Sidani et al., 2006). To date, this mandate has not had sufficient follow through to ensure actual incorporation of these patient factors.

Engagement as a Mechanism of Action for Positive Outcomes

Participant engagement with therapy has been shown to be an important mechanism of action for symptom reduction. In fact, the World Health Organization in 2002 recognized treatment adherence as the primary factor of treatment effectiveness. These dose-response relationships have been consistently found in the medical literature, where the dose of the pharmacological treatment is related to patients' outcome and response (Steenbarger et al., 1994). These dose-response curves have been generalized

from medical outcomes to psychotherapy outcomes. In a meta-analysis of over 30 years of research and 2,400 patients, Howard et al. (1986) found psychological treatment duration to be positively correlated with patient outcomes. Specifically, approximately 8 therapy sessions were found to show improvement for 50% of patients, while 26 therapy sessions were found to show improvement for 75% of patients. Another study by Hansen et al. (2002) found that between 13 and 18 therapy sessions were necessary for improvement, while less than 13 sessions were insufficient to reach significant outcomes. Overall, face-to-face treatment studies have generally found that more psychotherapy sessions attended were associated with stronger positive outcomes (Crisp et al., 2001).

The psychological dose-response literature is not without controversy. Other studies have failed to show dose-response relationships and instead, provide support for brief psychological therapy models. There is a subset of patients that prefer limited exposure to psychological interventions. Brief psychological therapies, ranging from 1 to 12 sessions, have shown to be effective for treating psychological disorders (Rosenbaum, 1994; Austad & Berman, 1991). The study by Rosenbaum found that a proportion of participants (58%) thought a single session of therapy was sufficient treatment. However, the clinician in the study approached the therapy session as it was a stand-alone therapy course, which could have contributed to this finding. Instead of considering these participants as non-engaged or drop outs, they might have achieved what they needed from the single session and thus discontinued therapy. It is also possible that some patients would disengage from psychological interventions due to the perceived complexity and involvement of the treatment (Glasgow, 2007). This finding may indicate the importance of patients' preferences for treatment. Although the literature on

dose-response relationships in psychological interventions has been mixed, the importance of treatment engagement, specifically attending psychotherapy sessions, has been well documented.

Low Engagement in Psychological Treatments

It is evident that only a small percentage of patients receive the psychological services they need. In a large national database study of over 6,000 mental health patients, the average number of therapy sessions attended was five, which is considered significantly lower than the adequate dose of psychological treatment (Hansen et al., 2002). Low levels of participant engagement and high levels of dropout have been characteristic of face-to-face therapy. Drop out rates from psychotherapy have ranged from 8%-66% in many settings from research trials to outpatient clinics (Hunt & Andrews, 1992; Barkham et al., 2006; Souto & Crosland, 2005). Another meta-analysis found average drop out rates from psychotherapy research trials of 48% of participants (Wierzbicki & Pekarik, 1993). Low engagement and dropout have been characteristic of all psychotherapy modalities, although rates have been found to vary according to the intensity of the treatment, the definition and measurement of dropout, the treatment setting, and the patient population (Bados et al., 2007). Dropout rates differ among patients at mental health clinics, hospitals, and medical clinics. Lincoln and colleagues (2005) found lower rates of dropout in intensive treatment programs. It is possible that more motivated patients are referred to intensive programs and that it is easier to focus attention on the intensive treatment program for a duration than attending weekly outpatient therapy over the course of a few months. Some studies considered therapy

dropout as a failure to attend one session, discontinuing after a few sessions, and terminating before the therapist believes the treatment should be discontinued. Bados and colleagues (2007) found higher rates of dropout in patients with eating disorders, impulse control difficulty, and affective difficulties. However, this result has not been replicated and may be better attributed to confounding variables such as the therapeutic relationship, therapist factors, and other patient factors.

There are many potential reasons for these high rates of drop out and low levels of engagement. Common reasons for dropout include low motivation from the patient, problems with transportation, scheduling, and time commitment, having external factors arise that take precedence over therapy (e.g., illness), having already reached therapy goals, dissatisfaction with the therapist, and dissatisfaction with the therapy (Pekarik, 1992; Sheldon et al., 2010). In fact, one study found that dissatisfaction with the therapy as well as the therapist accounted for the largest percentage of drop out (Bados et al., 2007). This dissatisfaction can arise when the patients' expectations and preferences are not aligned with the implemented therapy.

Participant Preferences and Expectations

Participant preferences and expectations have been consistently found in the medical literature. This idea has been clearly demonstrated through the placebo effect, which stresses the importance of expectations in driving outcomes. Placebos have been widely studied in pharmacological investigations. Many studies have shown that participants given an inert pill, but told that they would be receiving an active substance to create some effect, report experiencing the effect they were initially told they would

receive (Moerman & Jonas, 2002). Placebo studies have been extended to non-pharmacological outcomes, including sham-surgeries and psychotherapy. What appears to be of value is the meaning that the patients make about the specific treatment or intervention. Expectations have been shown to be important in psychotherapy since they appear to be self-fulfilling. Expectations have been categorized in two ways, including prognosis and role expectancies, where the former relates to the likelihood of having success in therapy and the later relates to how the patient expects to act in therapy (Tracy & Dundon, 1988).

A related idea to expectations that has received increased attention in the psychotherapy literature is that of patient preferences. Preferences are defined as what the patient would desire the therapy encounter to be like, and preferences refer to the type of treatment (e.g., medication verse therapy, CBT verse IPT), the type of therapist (e.g., older, male therapist), and what experiences will take place during the therapy (e.g., advice giving, homework; Swift et al., 2013). Psychotherapy patients have been shown to identify treatment preferences (Aita et al., 2005), but it remains unclear whether preferences matter for all patients (Swift et a., 2013). One study found an association between having stronger treatment preferences and the following variables: female gender, high education level, high SES, city dwellers, previous treatment experiences, and knowledge about disorders and treatments (Frovenholt et al., 2007).

Participant preferences have been shown to be an important aspect of psychotherapy. Tompkins and colleagues (2013) have posited that patient preferences are important for a variety of reasons. They reported that matching preferences instills the patients' power of choice, hope, and role as an expert in their own lives, increases the

patients' investment in the therapy, and validates that patients know what treatments they have already tried and what treatment they would be willing to try in the future. These researchers conceptualize patient preferences using the Cognitive Dissonance Theory (Cooper, 2012). From this perspective, having the patient contribute to the choice of therapy would lead to increased intrinsic motivation and commitment to engage in the therapy. Studies have found that incorporating patient preferences have led to positive therapeutic outcomes, including increased engagement with therapy, lower rates of drop out, a stronger therapeutic alliance, and improved psychological outcomes (Tompkins et al., 2013; Iacoviello et al., 2007).

Potential Mismatch Between Preferences and Treatment

There is a likelihood that high rates of drop out and low levels of engagement are due to a mismatch between patient preferences and the therapy provided. In an online intervention study for cancer survivors, Gorlick et al. (2012) found that participants' goals that were aligned with the goals of the intervention were predictive of general engagement with the intervention. Specifically, the alignment of participants' preferences with intervention goals lead to more time spent engaging with the intervention. Therefore, it is possible that a mismatch with patient preferences would lead to negative treatment outcomes. Engagement with psychotherapy could be negatively affected due to a perceived lack of credibility of the specific therapy, a lack of rapport building with the therapist, a poor therapeutic alliance, low patient motivation, and failure to attend sessions regularly or complete the therapeutic tasks. This mismatch

would reduce therapeutic outcomes despite evidence for the efficaciousness of the actual therapy modality.

Personalized Medicine

The National Institutes of Health have recently stressed the importance of personalized medicine. From this perspective, medical treatments should be tailored to the specific individual since there are meaningful differences among individuals. Tailored healthcare includes implementing the right treatment for the individual, at the appropriate dose, and at the right time. This idea of personalizing physical healthcare has been extended to mental healthcare. The American Psychological Association has recognized the importance of patient factors and providing the appropriate care to each individual. A significant component of evidence-based care includes the incorporation of patient attitudes, characteristics, culture, and preferences into psychotherapy (Report of the Presidential Task Force of Evidence-Based Practice, 2006). There have been multiple efforts to tailor psychotherapy to individuals. One method has been creating manual-based treatments that have been provided to individuals based on their diagnoses. However, due to the large heterogeneity within the diagnostic classifications, others have tailored psychotherapies to individual characteristics, including demographic variables, coping style, level of resistance, cognitive style, levels of distress, and severity of symptoms. There is evidence that this second form of tailoring has been more successful (Beutler et al., 1997). Although methods of tailoring have had some success with improving engagement with psychological interventions, levels of engagement remain low. It is possible that patients' expectations and preferences could be more predictive of

engagement with psychotherapy than diagnostic information and demographic information. In that case, tailoring to patients' preferences might be more useful.

Incorporating Patient Preferences

Part of personalized medicine requires the assessment of patients' expectations and preferences for psychotherapy. The assessment would inform the therapists' choice of the most appropriate empirically supported treatment for the patient. There is a growing literature on the assessment of treatment preferences before beginning therapy. One way to assess for preferences is to directly ask the patient what they would like their therapy experience to be like. There are also questionnaires that assess for preferences on a likert scale. Some of these questionnaires include the Psychotherapy Expectancy Inventory-Revised (Berzins, Herron, & Seidman, 1971; Rickers-Ovsiankina, Geller, Berzins, & Rogers, 1971), the Treatment Preferences and Experience questionnaire (Berg, Sandahl, & Clinton, 2008), and the Treatment Preference Interview (Vollmer, Grote, Lange & Walker, 2009). Patient preferences have been described as having four different dimensions, including the appropriateness of the treatment in addressing the diagnosis, the suitability of the treatment to the patient, the convenience of participating in the treatment, and the effectiveness of the treatment (Sidani et al., 2009). Preferred treatments are perceived to be appropriate, reasonable, non-intrusive, consistent with the patients' lifestyle, effective, and easy with which to engage (Tarrier et al., 2006).

Once patient preferences have been elicited, tailored, patient-centered therapy can begin. Studies have found that preference matching has led to positive outcomes. In a recent meta-analysis, Swift et al. (2011) found that preference-matched patients had

better outcomes and lower rates of drop out over non-preference matched patients. Non-preference matched patients were twice as likely to drop out of therapy than their matched counterparts. In a follow-up study, the researchers found that preference effects were consistent across many demographic variables, including age, gender, education, and marital status (Swift et al., 2013). Another study by King et al. (2005) found that once patients learned they might not receive the treatment they prefer, between 22-74% of patients refused randomization into a therapy modality.

Current Patient Preferences Literature

To date, the majority of studies have assessed preferences for psychotherapy or pharmacology. In a recent meta-analysis, researchers found a significantly larger preference for psychotherapy (i.e., 75% of participants) over medication for treating psychological disorders (McHugh et al., 2013). This preference of psychotherapy has been consistently found in the literature (Riedel-Heller et al., 2005; van Schaik et al., 2004). Studies comparing preferences of the various forms of psychotherapy have been sparse. One older study by Sobel (1979) found that overall, participants favored gestalt therapy over behavioral and analytic therapies. The study asked participants who have never received therapy to report their treatment preferences given an imagined depressive disorder and anxiety disorder. Another study that had psychiatric hospital patients view videos depicting psychodynamic, cognitive-behavioral, and humanistic therapies found that participants preferred the cognitive-behavioral orientation (Wanigaratne & Barker, 1995). This preference for cognitive-behavioral therapy has been observed in more recent studies of a non-psychiatric sample, a depressed sample, and a student sample with

trauma (Bragesjo et al., 2004; Hardy et al., 1995; Tarrier, et al., 2006). One study of college students presented with an imagined case of depression reported a preference for Interpersonal Therapy techniques, followed by behavioral techniques, cognitive techniques, and then medication (Banken & Wilson, 1992). The descriptions of therapy modalities were not the same across studies, which make results difficult to generalize. Additional research is needed to assess for preferences among the various empirically supported treatments that have recently emerged, including Acceptance and Commitment therapy and Emotion-focused therapy. Previous studies have not compared patient preferences among CBT, ACT, IPT, and EFT treatments for anxiety and depression. Furthermore, additional studies in a community outpatient setting would contribute to the literature. Since these participants are seeking therapy, they would likely benefit the most from this line of research, over participants without exposure to or a desire for therapy.

It is common for studies to assess the differential efficacy of psychotherapy without taking into consideration treatment preferences. Most studies are randomized controlled designs that do not account for treatment preferences. Partially randomized preference trials have also been implemented, which provide the participant with the opportunity to either be randomized or choose their treatment. Studies using this design to detect differential outcomes based on preferences have been mixed and the design has been shown to underestimate preference effects (Swift & Callahan, 2009). The current treatment preferences literature remains largely unexplored. It is likely that additional survey studies and qualitative studies could provide important insights into treatment preferences. The current study attempts to expand the treatment preferences literature on

a wider breadth of psychotherapies using a combination of a quantitative and qualitative design, and potential moderators of treatment preferences will be addressed.

Summary and Statement of the Problem

Currently, there are many empirically-supported treatments for psychological disorders. Studies have found these treatments to have a similar level of effectiveness in improving depressive and anxiety disorders. Part of the trend for evidence-based treatment includes the integration of patient characteristics. Therefore, it is important to determine individuals' preferences for treatment, as there have been associations between patient preferences, engagement with treatment, and subsequent outcomes. Unfortunately, engagement in face-to-face psychotherapy has been characteristically low, which might reflect a mismatch between patient preferences and therapists' chosen treatments. The current study will assess for patients' treatment preferences for psychotherapy, which will add to the current treatment preferences literature. Understanding patient preferences could lead to better alignment between preferences and provided treatments. Ultimately, this alignment could improve rates of engagement and treatment efficacy.

Specific Aims

The current study was largely exploratory and attempted to better understand patient preferences for empirically-supported treatments. Many predictor variables were assessed since the previous literature has not determined which variables were predictive of preference. In this study, initial analyses of predictor variables were conducted (i.e.,

bivariate correlations, t-tests, and chi-square analyses) to determine which predictors were entered into multivariate analyses. The current literature on treatment preferences has been largely unexplored and the current study assessed 9 tentative hypotheses.

First, it was hypothesized that there was a difference in the proportion of participants who have heard of each of the four therapies. Since CBT has been well-established and studied, it was hypothesized that more participants would have heard of that therapy over ACT, IPT, and EFT.

Second, it was hypothesized that acceptability ratings of each of the four therapies would significantly differ. Although results of previous studies have not necessarily found this relationship, the investigators of the current study expected to see significant differences in either total acceptability or the specific facets of acceptability (e.g., appropriate, suitable, effective, willing, and ease of use). The therapies each emphasize different elements and it was possible that some participants prefer certain elements to others. Investigators did not hypothesize which therapy would have the highest acceptability.

Third, investigators were interested in the predictors of therapy acceptability for CBT, ACT, IPT, and EFT separately. Multiple predictor variables, such as age, gender, and previous experience with therapy, were collected in the questionnaire and it was unclear which variables were predictive of acceptability.

Fourth, it was hypothesized that the majority of participants would have a preference for a therapy. The limited research on therapy preferences has indicated treatment preferences in some studies, but not with the specific combination of therapies included in the current study.

Fifth, it was hypothesized that certain variables would predict whether participants had a preference or not. Previous research on this topic has been limited so this analysis was more exploratory.

Sixth, it was hypothesized that there would be a difference in the proportion of participants who ranked each of the four therapies as their top preference. The limited research on therapy preference has found cognitive and behavioral therapies to be highly preferred. Investigators hypothesized that participants would prefer ACT as it has continued to show promising outcomes in randomized controlled trials against CBT.

Seventh, it was hypothesized that acceptability was related to preference. In the current literature, some studies have assessed for acceptability of therapies while others have assessed for preference. These constructs were assessed separately in the questionnaire and the current study aimed to understand the relationship between these two constructs. It was hypothesized that participants' acceptability ratings of therapies would discriminate among their therapy preferences.

Eighth, it was hypothesized that demographic variables would discriminate among participants' therapy preference. This analysis was exploratory and it was unclear which variables, if any, would be predictive of participants' preference.

Ninth, it was hypothesized that participants' comments regarding what they would like their therapy experience to be like would fall under the following categories: general non-specific factors and specific treatment factors. This question was designed to further assess for participants' expectations and preferences for therapy. It was also meant to measure the contribution of common factors in therapy.

CHAPTER TWO

METHODS

Participants

Participants were recruited into the study through the Loma Linda University Behavioral Health Institute (BHI), an outpatient community mental health clinic. Participants were at least 18 years old, fluent in English, and enrolled in therapy. It was initially projected that 150 participants would be recruited into the study to allow for sufficient power to detect therapy preferences and be able to evaluate moderators of these preferences. Efforts were made to recruit a diverse sample based on individual characteristics (i.e., age, gender, education, marital status, income, ethnicity, presenting problem, and distress).

Approximately 300 questionnaires were disseminated at the BHI between April 2014 and February 2015. Three duplicate questionnaires were identified and excluded leaving a total of 119 questionnaires collected. However, it was later determined that the initial iteration of the questionnaire had discrepancies in response options for the acceptability questions. Because it was unclear whether this led to a certain pattern of responding, the initial 26 returned questionnaires were excluded from analyses. The questionnaire was fixed and the second iteration of the questionnaire was used in analyses. The current study included 95 participants, all from the BHI. The 95 questionnaires used in analyses were checked and guaranteed to represent 95 different participants. It was not feasible in the current study to determine how many patients at the BHI declined participation or the specific reasons for not completing the questionnaire since they could just throw away the questionnaire if they did not want to

participate. The recruitment yield of the current study was approximately 32%, if using the total of 95. The yield was 40%, if using the initial total of 119.

Procedures

The current study was reviewed and approved by the Loma Linda University IRB. It was initially conceptualized that participants had to be new patients to the Behavioral Health Institute (BHI) with no previous treatment experience at that clinic. Specifically, participants would be recruited who were attending their first or second clinic visit. However, since only 12% of disseminated questionnaires were completed and returned within the first couple months of recruitment, it was decided to broaden recruitment efforts to include all adult patients enrolled in psychological services at the clinic. Previous experience with therapy and familiarity with therapies were controlled for in analyses. A script was created for front desk staff at the clinic to deliver to patients when they checked in for appointments. A flier was also posted in the window of the front desk of the BHI (Appendix 1). Front desk staff was responsible for disseminating the questionnaire to interested potential participants. The consent form included the purpose and rationale of the study, the risks of participating, incentives for participating, the rights of a research participant, and an explanation of study procedures (Appendix 2). The consent form served as the cover sheet of the study materials so participants who completed the questionnaire would have provided their consent. The questionnaire (Appendix 3) was estimated to take approximately 30 minutes to complete. After choosing to complete the questionnaire and returning it to the front desk of the BHI,

participants could receive payment in one of two ways, being mailed a $10 Target gift card or receiving the gift card from front desk staff at the BHI.

Measures

Individual Characteristics

Demographic variables were collected, including age, gender, marital status, education, income, and ethnicity. Participants were asked about their reason for seeking therapy at the clinic. Participants were also asked about previous therapy experience, as that could affect therapy acceptability and preference. It is possible that participants who have never engaged in therapy would have fewer preferences than someone who has previously engaged in psychological treatment. The questionnaire also assessed for participants' familiarity with each of the four therapies. It was expected that some participants would be reading about a type of therapy for the first time, while others might have had preconceived opinions before reading the description in the questionnaire. The Outcomes Questionnaire-45 (OQ-45) was given to assess for participants' current psychological symptoms and level of distress (Lambert et al., 2010).

Therapy Descriptions

An adaptation from the Sidani et al. (2009) article for assessing treatment acceptability and preferences was used in the current study. Clear descriptions were created for the following four therapies, including Cognitive-Behavioral Therapy, Acceptance and Commitment Therapy, Interpersonal Therapy, and Emotion-focused Therapy. These therapies were chosen because they exhibited significant empirical

support for successfully treating adults with anxiety and depressive disorders. The written descriptions included the name of the modality and a general overview of the treatment. The written descriptions were written at an 8th grade reading level and psychological jargon was avoided. To assure for valid and unbiased descriptions as best as possible, the written content was taken from well-known published studies and manuals. For the Cognitive-Behavioral Therapy description, information was adapted from the Beck Institute website. For the Acceptance and Commitment Therapy description, information was taken from the Act Made Simple Workbook by Russ Harris and the Association for Contextual Behavioral Science website. Information from the International Society For Interpersonal Psychotherapy website and Interpersonal Psychotherapy: A Guide to the Basics (Stuart, 2006) article was used to compose the Interpersonal Therapy description. Lastly, information was found on the Emotionfocusedtherapy.com website for the Emotion Focused Therapy description. The descriptions could be found in Appendix 3.

Treatment Acceptability

Acceptability was assessed using five specific domains, including appropriateness, suitability, effectiveness, convenience, and ease of use (Sidani et al., 2009; Houle et al., 2013). The acceptability of each therapy modality was evaluated with five identical questions assessing these specific domains. Responses were on a 5-point likert scale ranging from 1= not at all, 2, 3=neutral, 4, 5=extremely. The questions were the following:

1. How appropriate do you think this type of therapy would be for you?

2. How suitable do you think this type of therapy would be for you?

3. How effective do you think this type of therapy would be for you?

4. How willing would you be to participate in this type of therapy?

5. How easy do you think participating in this type of therapy would be?

Treatment Preferences

Participants answered a YES/NO question whether they have a preference for a specific therapy after reading the four therapy descriptions and answering the acceptability questions. The questionnaire also asked participants to rank the four treatments from one to four in descending order of their preference. In order to further assess for treatment preferences and expectations, participants answered the following open-ended question, "What would you like your therapy experience to be like?" The qualitative portion was expected to provide additional detail regarding participants' preferences and shed light on the role of general therapeutic factors along with specific therapy factors.

CHAPTER THREE

DATA ANALYSIS

The sample was first categorized using descriptive statistics. Means, standard deviations, frequencies, and percentages were calculated for the following demographic variables, including age, gender, income, ethnicity, marital status, education level, and distress levels (i.e., symptom distress, interpersonal relationships, and social roles). Age and distress scores were continuously coded variables, while income, ethnicity, marital status, education, and gender were categorically coded. To have adequate sample sizes in analyses, multiple demographic variables were recoded, including income, ethnicity, marital status, and education. Income was recoded into three levels instead of five, collapsing $41,000-60,000, $61,000-80,000, and over $80,000. The ethnicity variable was recoded into three levels instead of five by collapsing African American, Asian, and the other category. Marital status was recoded into three levels instead of four by collapsing separated, widowed, and divorced. Education was recoded into four levels instead of five, by collapsing less than a high school diploma and high school diploma. Previous experience with therapy and having heard of CBT, ACT, IPT, and EFT were all coded dichotomously, while familiarity with CBT, ACT, IPT, and EFT was coded ordinally (i.e., none, somewhat, very). To ensure an adequate sample size in analyses, the familiarity variable was recoded into two levels instead of three by collapsing the somewhat and very options. Reason for seeking therapy at the BHI was assessed by an open-ended question and frequencies and percentages were computed for different categories of reported referral reasons. Therapy acceptability was calculated for each of the five specific domains as well as a total acceptability variable for each therapy that

was the sum of the five domains. Having a preference for a therapy was reported as well as the mean ranks of each therapy. The individual ranks of each therapy were recoded into a categorical top ranked therapy variable.

To determine if there was a significant difference in how many participants have heard of each of the four therapies, a chi-square analysis was conducted. The numbers of participants who have heard of CBT, ACT, IPT, and EFT were included in the analysis.

To test the hypothesis that acceptability ratings of each of the four therapies would differ, six separate repeated measures ANOVAs were run. The dependent variables were total acceptability of each therapy, appropriateness of each therapy, suitability of each therapy, willingness of each therapy, effectiveness of each therapy, and ease of use for each therapy. Only predictor variables that were related to the dependent variables at the bivariate level were included in analyses as covariates. This was done to avoid entering too many independent variables into the models. To assess for bivariate relationships between the predictor and dependent variables, a mean acceptability score was calculated from the total acceptability scores for CBT, ACT, EFT, and IPT. Only the ethnicity variable comparing white v other participants (i.e., African American, Asian, and other) was significantly correlated with the average acceptability variable and entered into the model as a covariate. Age, gender, income, marital status, distress, previous experience with therapy, having heard of each therapy, and having a familiarity with each therapy were not related to acceptability at the bivariate level and so were excluded from analyses.

To determine which variables were associated with the total acceptability of CBT, ACT, IPT, and EFT, four linear regressions were run. Each of the predictor variables

was initially assessed for bivariate relationships with the dependent variables. This was done to avoid entering too many predictors into the regression models. For the CBT regression, having heard of CBT, having heard of IPT, having heard of EFT, OQ-IR, familiar with CBT, and familiar with EFT were included as they were significantly related to the dependent variable. For the ACT regression, familiarity with ACT and white v other ethnicity were included as they were significantly related to the dependent variable. For the EFT regression, the white v other ethnicity variable was included as it was significantly associated with the dependent variable. There were no significant associations between demographic variables and the IPT acceptability variable at the bivariate level so no covariates were added into the model.

To assess what percentage of participants had a preference for therapy, the frequencies and percentages of participants who answered whether they had a therapy preference or not was calculated. Also, frequencies, means, and standard deviations of demographic and acceptability measures were also reported separately for participants who had a preference and for participants who did not.

To determine which variables predicted having a treatment preference, a binary logistic regression was run. The dependent variable was whether the participant had a preference or not, which was dichotomously coded. In order to determine which variables would be included as predictors in the analysis, t-tests and chi-square analyses were used to test relationships between potential variables and the dependent variable. The variables that were significantly associated with the dependent variable were then added to the logistic regression model. Having heard of CBT, HS v some college, and

HS v BA degree were included as predictors. The χ^2 was interpreted for the model as well as the odds ratio for the individual predictors.

To test the hypothesis that there was a significant difference in the proportion of participants rating each treatment as their top preference, a chi-square analysis was run. A categorical variable was created that captured participants' top rank therapy and had 4 levels, one for each type of therapy (i.e., CBT, ACT, IPT, and EFT). Two chi-square analyses were run, one for the entire sample and one for participants who endorsed having a therapy preference only.

To test the hypothesis that acceptability of the therapies differentially discriminated between the top rank therapy variable, a discriminant function analysis was run. The dependent variable was the top rank variable, which was comprised of the four therapy levels, and the independent variables were CBT total acceptability, ACT total acceptability, IPT total acceptability, and EFT total acceptability. Wilks' lambda scores, a structure matrix, and function scores were reported.

To test the hypothesis that demographic variables would discriminate between the top rank therapy variable, another discriminant function analysis was run. The dependent variable was the top rank variable, which was comprised of the four therapy levels, and the independent variables included age, gender, previous experience with therapy, heard of CBT, heard of ACT, heard of IPT, heard of EFT, OQ-IR, OQ-SD, OQ-SR, income, education, marital status, and ethnicity. This analysis was exploratory as it was unclear which variables would be associated with the dependent variable. Wilks' lambda scores, a structure matrix, and function scores were reported.

To gather more detailed information about participants' expectations and preferences, a qualitative analysis was run using content analysis. The investigators created a codebook of the various themes of expectations and preferences that emerged from the open-ended question. Frequencies and percentages were calculated for each obtained code.

CHAPTER FOUR

RESULTS

Table 1 provides demographic information for the 95 participants included in the study.

Table 1. Demographic variables of the participant sample.

	Participants (n=95)
Age M (SD)	39.4 (14.0)
Gender n (%)	
Male	21 (22.1)
Female	74 (77.9)
Income M (SD)	
0-20,000	54 (58.7)
21,000-40,000	17 (18.5)
41,000-60,000	12 (13.9)
61,00-80,000	2 (2.2)
> 80,000	7 (7.6)
Ethnicity n (%)	
White	47 (53.4)
Hispanic	31 (35.2)
African American	3 (3.4)
Asian	3 (3.4)
Other	4 (4.5)
Marital Status n (%)	
Married	29 (30.5)
Single	47 (49.5)
Separated/Divorced	17 (17.9)
Widowed	2 (2.1)
Education n (%)	
Some high school	3 (3.2)
High school graduate	12 (12.9)
Some college	39 (41.9)
Bachelor's degree	23 (24.7)
Post Bachelor's degree	16 (17.2)
Previous experience with therapy n (%)	
Yes	66 (69.5)
No	29 (30.5)

The average age of participants was 39 years old. The majority of subjects were white, single females. 42% of participants had a Bachelor's degree or higher and over half of the sample made less than $20,000 per year. Approximately 70% of participants endorsed previous experience with some form of psychological treatment, including psychotherapy and medication management. Reasons for seeking treatment at the BHI fell under multiple categories that were outlined in Table 2. Over 80% of participants were seeking treatment at the BHI for relationship conflicts, depressive symptoms, and anxiety symptoms.

Table 2. Charactering reasons for seeking therapy.

Reasons for seeking therapy	n (%)
Relational conflicts	31 (32.6)
Depression	27 (28.4)
Anxiety	20 (21.1)
Situational/phase of life/other concerns	13 (13.7)
Previous abuse/PTSD	12 (12.6)
Anger issues	5 (0.5)
Bipolar Disorders	4 (0.4)
OCD	3 (0.3)
Borderline Personality disorder/self-harm	2 (0.2)
Grief	2 (0.2)
Eating concerns	2 (0.2)
Schizophrenia	1 (0.1)

Participants' knowledge of each therapy was also assessed (Table 3). For Cognitive-Behavioral Therapy, less than half of participants had previously heard of the therapy or were familiar with the therapy. For Acceptance and Commitment Therapy and Interpersonal Therapy, over 90% of participants had never heard of the therapies or had any familiarity with them. For Emotion Focused Therapy, over three fourths of

participants had not heard of the therapy nor had any familiarity with it. For those who reported having some familiarity with CBT, ACT, IPT, or EFT, this was typically through an educational course or previous therapy experience.

Table 3. Characterizing knowledge with CBT, ACT, IPT, and EFT.

	CBT n (%)	ACT n (%)	IPT n (%)	EFT n (%)
Have you heard of the therapy?				
Yes	38 (41.2)	7 (7.5)	9 (9.7)	11 (11.8)
No	54 (58.7)	86 (92.5)	84 (90.3)	82 (88.2)
Familiarity with the therapy?				
Not at all	61 (66.3)	85 (91.4)	85 (92.4)	83 (89.2)
Somewhat	19 (20.7)	5 (5.4)	6 (6.5)	9 (9.7)
Very	12 (13.0)	3 (3.2)	1 (1.1)	1 (1.1)

The Outcome Questionnaire-45 was completed by participants to assess for participants' distress levels (Table 4). Over half of participants endorsed symptom distress (OQ-SD), impairments in interpersonal relationships (OQ-IR), and impairments in social roles (OQ-SR) that were clinically significant.

Table 4. OQ-45 score distribution for the sample.

OQ score	M (SD)	> cutoff score n (%)
Symptom Distress (OQ-SD)	43.2 (18.0)	59 (65.6)
Interpersonal Relationships (OQ-IR)	17.5 (7.9)	56 (62.2)
Social Roles (OQ-SR)	12.3 (5.7)	50 (55.6)
Total	73.1 (27.9)	59 (65.6)

In order to determine whether there was a significant difference between the proportions of participants who have heard of CBT, ACT, IPT, and EFT, a chi-square

analysis was completed. There was a significant difference in the proportion of participants who have heard of each of the four therapies, χ^2 (3) = 35.903, p < .05. Approximately 41% of the sample had heard of CBT, while only 7.5%, 9.7%, and 11.8% of the sample had heard of ACT, IPT, and EFT, respectively.

Six separate repeated measures ANOVAs were run to test for differences in acceptability ratings among the four therapies. The average acceptability ratings for each therapy were shown in Table 5.

Table 5. Acceptability ratings for each therapy.

	CBT	ACT	IPT	EFT
	M (SD)	M (SD)	M (SD)	M (SD)
Appropriate	4.0 (.95)	3.7 (1.1)	3.9 (1.3)	3.7 (1.1)
Suitable	3.9 (.99)	3.7 (1.1)	3.9 (1.2)	3.7 (1.1)
Effective	3.7 (.99)	3.5 (1.1)	3.8 (1.2)	3.6 (1.1)
Willing	4.0 (1.1)	3.8 (1.1)	3.8 (1.2)	3.7 (1.1)
Easy	3.0 (1.1)	2.8 (1.2)	3.2 (1.2)	3.1 (1.2)
Total	18.8 (3.7)	17.4 (4.6)	18.6 (5.0)	17.8 (4.7)

The ethnicity variable comparing white v other (i.e., African American, Asian, and other) was included as a covariate since it was associated with the mean therapy acceptability variable at the bivariate level. No other demographic variables were predictive of therapy acceptability at the bivariate level and so were excluded. CBT, ACT, IPT, and EFT did not differ in total acceptability (Greenhouse-Geisser F(2.652) = 2.362, p = .080), appropriateness (F(3) = 2.468, p = .062), suitability (F(3) = 1.807, p = .146), effectiveness (Greenhouse-Geisser F(2.775) = 1.847, p = .144), or willingness (Greenhouse-Geisser F(2.642) = 1.933, p = .133). However, CBT, ACT, IPT, and EFT significantly differed in ease of use (Greenhouse-Geisser F(2.716) = 2.461, p = .049).

Specifically, IPT was rated as significantly easier to use than ACT, F(1) = 5.684, p = 019 (Table 7). No other significant contrasts were found for ease of use of the therapies.

Table 6. Results of repeated measures ANOVA analyses for each type of therapy acceptability measure.

Variable	Sphericity	df	*F*	*p*
Total acceptability	No	2.652	2.362	0.080
Appropriateness	Yes	3.000	2.468	0.062
Suitability	Yes	3.000	1.807	0.146
Effectiveness	No	2.775	1.847	0.144
Willingness	No	2.642	1.933	0.133
Ease of use	No	2.716	2.461	0.049*

Note: * = significant at the 0.05 level.

Table 7. Within-subjects contrasts for ease of use among CBT, ACT, IPT, and EFT.

Contrast	df	*F*	*P*
CBT v ACT	1	3.373	0.146
ACT v IPT	1	12.121	0.019*
IPT v EFT	1	0.642	0.553

Note: * = significant at the 0.05 level.

Four linear regressions were conducted to assess for predictors of the total acceptability of CBT, ACT, IPT, and EFT separately (Table 8). Each of the predictor variables was initially assessed for bivariate relationships with the dependent variables. Only those variables that were significant at the bivariate level were included to avoid entering too many predictors into the regression models. The first multiple regression for CBT acceptability included having heard of CBT, having heard of IPT, having heard of EFT, OQ-IR, familiar with CBT, and familiar with EFT as those variables were significant at the bivariate level. The model was significant, F(6,78) = 3.107, p = .009,

and accounted for approximately 19.3% of the total variance. Having difficulties with interpersonal relationships was associated with increased acceptability of CBT, $\beta = .263$, $p = .017$. However, having heard of CBT, having heard of IPT, having heard of EFT, having familiarity with CBT, and having familiarity with EFT were not significantly associated with acceptability of CBT. The second multiple regression for ACT acceptability included the white v other variable and familiarity with ACT, as those were the only variables that were significant at the bivariate level. The model was significant, $F(2,88) = 4.832$, $p = .010$, and accounted for approximately 9.9% of the total variance. Having a familiarity with ACT was associated with an increased acceptability of ACT, $\beta = .253$ $p = .015$. There were no significant predictors of IPT acceptability at the bivariate level so no variables were entered into a regression analysis. For EFT acceptability, the white v other variable was included as that was the only associated variable at the bivariate level. The model was significant, $F(1,91) = 4.884$, $p = .030$ and accounted for approximately 5.1% of the total variance. The other ethnicity variable (i.e., African American, Asian, and other) was associated with increased acceptability of EFT compared to Whites, $\beta = .226$ $p = .003$.

Table 8. Results of regression analyses for demographic variables on therapy acceptability.

	Therapy Acceptability			
Variable	CBT (β)	ACT (β)	IPT (β)	EFT (β)
Age	NI	NI	NI	NI
Gender				
Male	NI	NI	NI	NI
Female	NI	NI	NI	NI
Previous experience	NI	NI	NI	NI
Heard of CBT	-0.004	NI	NI	NI
Heard of ACT	NI	NI	NI	NI
Heard of IPT	0.250	NI	NI	NI
Heard of EFT	0.094	NI	NI	NI
OQ-IR	0.263*	NI	NI	NI
OQ-SD	NI	NI	NI	NI
OQ-SR	NI	NI	NI	NI
OQ-total	NI	NI	NI	NI
Income				
$0-20,000	NI	NI	NI	NI
$21-40,000	NI	NI	NI	NI
> $41,000	NI	NI	NI	NI
Ethnicity				
White	NI	NI	NI	NI
Hispanic	NI	NI	NI	NI
Other	NI	0.158	NI	0.226*
Marital status				
Married	NI	NI	NI	NI
Single	NI	NI	NI	NI
Separated/widowed/divorced	NI	NI	NI	NI
Education				
HS graduate	NI	NI	NI	NI
Some college	NI	NI	NI	NI
BA degree	NI	NI	NI	NI
Post BA degree	NI	NI	NI	NI
Familiarity with CBT	0.060	NI	NI	NI
Familiarity with ACT	NI	0.253*	NI	NI
Familiarity with IPT	NI	NI	NI	NI
Familiarity with EFT	0.035	NI	NI	NI

Note: NI = Not included, non-significance at bivariate level.

* = Significant at the 0.05 level.

Frequencies and percentages were calculated to determine the proportion of participants who had a preference for one of the four therapies. Over half of participants (57%) endorsed a preference (Figure 1).

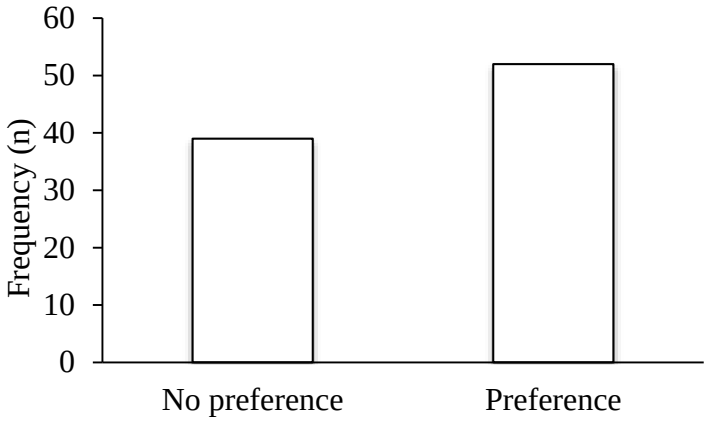

Figure 1. Frequency of participants with a preference for therapy (n=95).

The sample was divided into those with a therapy preference and those without a preference and demographic and acceptability variables were categorized separately for the two groups (Tables 9-11).

Table 9. Demographic variables as a function of having a therapy preference or not.

Variable	No Preference	Preference	p-value significant?
Age M (SD)	41.10 (14.74)	37.33 (12.62)	No[a]
Gender n (%)			No[b]
Male	9 (23.1)	15 (21.2)	
Female	30 (76.9)	30 (78.8)	
Income M (SD)			No[b]
0-20,000	22 (59.5)	29 (56.9)	
21,000-40,000	8 (21.6)	8 (15.7)	
41,000-60,000	5 (13.5)	7 (13.7)	
61,00-80,000	0 (0.0)	2 (3.9)	
> 80,000	2 (5.4)	5 (9.8)	
Ethnicity n (%)			No[b]
White	18 (46.2)	26 (50.0)	
Hispanic	2 (5.1)	4 (7.7)	
African American	12 (30.8)	18 (34.6)	
Asian	1 (2.6)	2 (3.8)	
Other	6 (15.4)	2 (3.8)	
Marital Status n (%)			No[b]
Married	13 (33.3)	15 (28.8)	
Single	17 (43.6)	30 (57.7)	
Separated/Divorced	7 (17.9)	7 (13.5)	
Widowed	2 (5.1)	0 (0)	
Education n (%)			Yes[b]
Some high school	1 (2.6)	1 (1.9)	
High school graduate	7 (18.4)	5 (9.6)	
Some college	21 (55.3)	16 (30.8)	
Bachelor's degree	5 (13.2)	18 (34.6)	
Post Bachelor's degree	4 (10.5)	12 (23.1)	
Previous experience with therapy n (%)			No[b]
Yes	13 (33.3)	37 (71.2)	
No	26 (66.7)	15 (28.8)	
Distress M (SD)			
OQ-SD	46.19 (20.42)	41.49 (16.43)	No[a]
OQ-IR	18.89 (9.26)	16.73 (6.71)	No[a]
OQ-SR	12.86 (6.29)	12.12 (5.18)	No[a]
OQ-total	77.94 (32.91)	70.33 (23.94)	No[a]

a = independent samples t-test
b = chi-square analyses

There was a significant difference between the two groups in terms of education. Participants who had a preference for therapy tended to be more educated than participants without a preference. Comparisons of the data revealed no significant differences between the two groups on age, gender, income, ethnicity, marital status, previous experience with therapy, and distress scores.

Table 10. Knowledge of the four therapies as a function of having a therapy preference or not.

Variable	No Preference	Preference	p-value significant?
Heard of CBT n (%)			Yes[b]
No	28 (73.7)	23 (45.1)	
Yes	10 (26.3)	28 (54.9)	
Heard of ACT n (%)			No[b]
No	36 (94.7)	47 (90.4)	
Yes	2 (5.3)	5 (9.6)	
Heard of IPT n (%)			No[b]
No	36 (94.7)	45 (86.5)	
Yes	2 (5.3)	7 (13.5)	
Heard of EFT n (%)			No[b]
No	33 86.8)	46 (88.5)	
Yes	5 (13.2)	6 (11.5)	
Familiar with CBT n (%)			No[b]
None	28 (73.7)	30 (58.8)	
Somewhat	7 (18.4)	12 (23.5)	
Very	3 (7.9)	9 (17.6)	
Familiar with ACT n (%)			No[b]
None	36 (94.7)	46 (88.5)	
Somewhat	1 (2.6)	4 (7.7)	
Very	1 (2.6)	2 (3.8)	
Familiar with IPT n (%)			
None	36 (97.3)	46 (88.5)	No[b]
Somewhat	0 (0)	6 (11.5)	
Very	1 (2.7)	0 (0)	
Familiar with EFT n (%)			No[b]
None	32 (84.2)	48 (92.3)	
Somewhat	5 (13.2)	4 (7.7)	
Very	1 (2.6)	0 (0)	

b = chi-square analyses

Comparisons of the data revealed that the groups significantly differed with respect to having heard of CBT. Specifically, participants with a preference had heard of CBT at a higher rate than participants without a therapy preference. The two groups did not significantly differ with respect to having heard of ACT, IPT, EFT or having a familiarity with CBT, ACT, IPT, and EFT.

Table 11. Acceptability of the four therapies as a function of having a therapy preference.

Variable	No Preference	Preference	p-value significant?
CBT acceptability			
Total	18.38 (4.77)	19.27 (2.87)	No[a]
Appropriate	3.92 (1.16)	4.15 (.75)	No[a]
Suitable	3.85 (1.25)	4.06 (.75)	No[a]
Effective	3.59 (1.25)	3.88 (.76)	No[a]
Willing	3.90 (1.23)	4.12 (.98)	No[a]
Ease of use	2.97 (1.17)	3.06 (.98)	No[a]
ACT acceptability			
Total	18.24 (4.35)	16.77 (4.83)	No[a]
Appropriate	3.85 (1.04)	3.58 (1.21)	No[a]
Suitable	3.74 (1.12)	3.60 (1.18)	No[a]
Effective	3.72 (1.05)	3.31 (1.04)	No[a]
Willing	3.90 (1.02)	3.67 (1.15)	No[a]
Ease of use	3.16 (1.20)	2.62 (1.21)	Yes[a]
IPT acceptability			
Total	19.53 (5.33)	18.06 (4.89)	No[a]
Appropriate	4.10 (1.30)	3.79 (1.26)	No[a]
Suitable	4.0 (1.30)	3.81 (1.15)	No[a]
Effective	3.74 (1.33)	3.83 (1.15)	No[a]
Willing	4.00 (1.62)	3.67 (1.20)	No[a]
Ease of use	3.44 (1.14)	3.04 (1.20)	No[a]
EFT acceptability			
Total	18.68 (4.87)	17.06 (4.51)	No[a]
Appropriate	3.77 (1.14)	3.60 (.09)	No[a]
Suitable	3.79 (1.29)	3.62 (1.11)	No[a]
Effective	3.82 (1.14)	3.44 (1.15)	No[a]
Willing	3.97 (1.00)	3.46 (1.08)	Yes[a]
Ease of use	3.31 (1.26)	2.94 (1.04)	No[a]

Note: a = independent samples t-test

Comparisons of the data revealed significant differences between the two groups with respect to ease of use of ACT and willingness to use EFT. The preference group tended to find ACT less easy to use than the group without a preference. Also, the preference group was less willing to use EFT compared to the group without a preference.

A binary logistic regression was run to determine the predictors of having a preference for therapy. Results of independent t-tests and chi-square analyses found that only three variables were significantly associated with having a therapy preference, which were having heard of CBT, HS v some college, and HS v BA degree. The logistic regression model was significant, $\chi^2(3) = 12.144$, $p = 0.007$. However, none of the predictor variables included in the model significantly predicted therapy preference.

Table 12. Multivariate logistic regression results for the predictors of treatment preference.

Variable	*B*	*SE*	Wald X^2	df	*P*	*OR*	95% *CI*
Heard of CBT	.880	.497	3.132	1	.077	2.411	.911-6.388
HS v some college	-.576	.525	1.203	1	.273	.562	.201-1.573
HS v BA	.878	.700	1.570	1	.210	2.405	.610-9.490

Note: OR = Odds ratio

A chi-square analysis was run to test the hypothesis that there was a significant difference in the proportion of participants who rated each therapy as their top preference. Two separate analyses were run, one for all participants who ranked the treatments (n = 82) and one for only those participants who had a treatment preference (n = 46). Results of both chi-square analyses for the preference group and whole sample found no significant difference in the proportion of participants' top-rated therapy preference, $X^2(3) = 7.044$, $p > .05$ and $X^2(3) = 4.537$, $p > .05$, respectively.

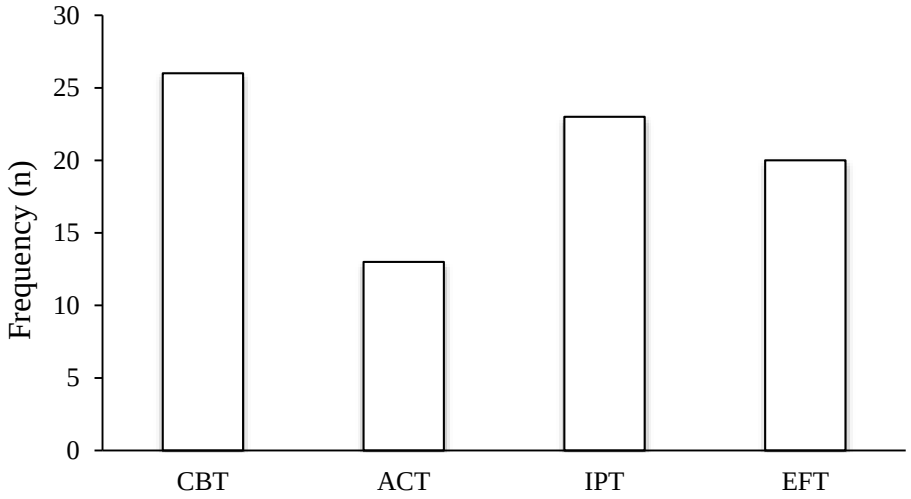

Figure 2. Top rank therapy distribution.

Table 13. Mean rank of each therapy.

Therapy	M (SD)
CBT	2.28
ACT	2.53
IPT	2.32
EFT	2.36

To determine if levels of acceptability discriminated between the top rank therapy preference variable, a discriminant function analysis was run. Three functions significantly discriminated among the levels of the top rank therapy variable (Tables 14-16).

Table 14. Wilks' lambda values for discriminant function analysis.

Function	Wilks' lambda	Chi-square	df	p-value
1 through 3	.451	57.270	12	.000*
2 through 3	.719	23.802	6	.001*
3	.910	6.804	2	.033*

Table 15. Structure matrix values for discriminant function analysis.

Variable	1	2	3
CBT acceptability	-.604*	.046	.187
ACT acceptability	.198	.596*	-.279
IPT acceptability	.295	-.442*	.213
EFT acceptability	.246	.528	.625*

* Largest absolute correlation between each variable and any discriminant function

Table 16. Standardized function coefficients.

Variable	1	2	3
CBT acceptability	-1.139	0.004	0.144
ACT acceptability	0.314	0.570	-0.977
IPT acceptability	0.626	-.845	0.025
EFT acceptability	0.268	0.544	1.112

All three of the functions were statistically significant. Therapy acceptability successfully discriminated among participants' top rank therapies. Function 1 significantly discriminated between acceptability of CBT and ACT, IPT, and EFT. Function 2 discriminated between ACT and IPT, specifically high acceptability of ACT and low acceptability of IPT. Lastly, function 3 discriminated between EFT and CBT, ACT, and IPT.

To determine if there were patterns of responses in the independent variables that discriminated among levels of the top rank therapy variable, another discriminant function analysis was run. None of the variables (e.g., age, gender, previous experience with therapy, heard of CBT, heard of ACT, heard of IPT, heard of EFT, OQ-IR, OQ-SD,

OQ-SR, income, education, marital status, and ethnicity) significantly discriminated among the levels of the top rank therapy variable (Table 17).

Table 17. Wilks' lambda values for discriminant function analysis.

Function	Wilks' lambda	Chi-square	df	p-value
1 through 3	.317	59.179	57	.396
2 through 3	.565	29.374	36	.775
3	.826	9.832	17	.911

Qualitative analysis was conducted to identify themes of participant expectations and preferences for therapy. A codebook was created and codes were applied to participants' comments. Seven general themes, with 23 specific themes, emerged from the data: general positive statements, specific empirically-supported therapies, therapy components, style of therapy, therapy composition, therapeutic relationship, and other preferences.

Table 18. General themes obtained from qualitative data.

Theme	n (%)
Therapy Components	54 (60.0)
General positive statements	30 (33.3)
Therapeutic relationship	30 (33.3)
Style of therapy	10 (11.1)
Specific empirically-supported therapies	6 (6.7)
Other	4 (4.4)
Therapy composition	2 (2.2)

Over half (60.0%) of participants made statements reflecting preferences for Therapy Components. Specific themes in this category included: a desire to receive advice on specific issues as well as feedback from the therapist (11.1%), to change behaviors to be less problematic and more adaptive and congruent with participants' desires (8.9%), to learn coping strategies to problem solve and deal with past and current issues (8.9%), to gain insight and understanding of participants' thoughts, emotions, and behaviors (7.8%), to learn how to deal with negative emotional states (6.7%), to learn how to deal with and reduce negative thoughts (6.7%), to practically apply concepts learned in therapy to everyday life (6.7%), to be able to get help in times of crisis (1.1%), to be able to vent frustrations out to the therapist (1.1%), and to gain accountability for participants' thoughts, feelings, and actions (1.1%). To further illustrate the theme of Therapy Components, one participant stated "help me work with the unpleasant experiences and emotions I have and try to look at them in a different way". Another participant reported "I would like to be asked questions that make me think critically about the situation".

Table 19. Specific themes associated with Therapy Components.

Theme	n (%)	Description
Therapy components		
Advice and information	10 (11.1)	Desire for advice and feedback on issues
Changing behaviors	8 (8.9)	Develop more adaptive behaviors
Learning coping strategies	8 (8.9)	Problem solving and dealing with past/current issues
Gaining insight	7 (7.8)	Develop an understanding and ability to think critically
Negative emotions	6 (6.7)	Deal with negative emotions
Negative thoughts	6 (6.7)	Deal with negative thoughts
Putting therapy into practice	6 (6.7)	Desire for assignments to practice outside of therapy
Crisis intervention	1 (1.1)	Able to deal with crisis situations
Desire to vent	1 (1.1)	Desire to vent and share thoughts and emotions
Accountability	1 (1.1)	Foster accountability

33.3% of participants mentioned brief General Positive Statements to describe their preferred therapy experience. Specific themes in this category reflected participants' desire for a therapy experience that was helpful, positive, and fulfilling (32.2% of participants). Some participants (4.4%) endorsed a satisfaction with their current therapy at the BHI so far. To further illustrate this theme, one participant stated "a fulfilling one". Another participant reported "I am very happy with my therapy experience".

Table 20. Specific themes associated with General Positive Statements.

Theme	n (%)	Description
General positive statements		
Helpful	26 (32.2)	Feel like therapy is fulfilling and positive
Having positive experience	4 (4.4)	Satisfied with their therapy experience

Approximately one-third (33.3%) of participants made comments that represented the general theme of the Therapeutic Relationship. Specific themes in this category included: the importance of feeling safe with a therapist and able to share openly and honestly knowing the therapist would listen empathetically and nonjudgmentally (27.8%), having participants' experiences validated by the therapist (3.3%), and feeling like the therapist is intelligent and experienced in the field (2.2%). To further illustrate this theme, one participant stated "I have to be able to connect with the therapist and open up and know that the both of us are gonna work together to try to make progress". Another participant reported "someone to hear me and understand my pain".

Table 21. Specific themes associated with Therapeutic Relationship.

Theme	n (%)	Description
Therapeutic relationship		
Safe environment	25 (27.8)	Feel comfortable sharing with therapist, not judged
Feeling validated	3 (3.3)	Have experience validated
Experienced therapist	2 (2.2)	Have an experienced and intelligent therapist

11.1% of participants endorsed preferences that reflected the Style of Therapy. Specific themes included a desire for therapy to be goal-directed, structured, and guided (5.6%), to be personally relevant and tailored to participants (4.4%), and for therapy to be easy and approachable (1.1). To illustrate this theme, one participant stated "organized, goal oriented and structured". Another participant mentioned "applicable to my personal situation".

Table 22. Specific themes associated with Style of Therapy.

Theme	n (%)	Description
Style of therapy		
Goal directed	5 (5.6)	Structured around goals and progress is measured
Personally relevant	4 (4.4)	Tailored and applicable to individual
Easy	1 (1.1)	Easy and approachable to engage in

6.7% of participants fell into the category of desiring Specific Empirically-Supported Therapies. This code represented participants' preference for engaging with specific types of therapies, including CBT, ACT, IPT, and EFT. To further illustrate this theme, one participant stated "a mixture of CBT and IPT". Another participant reported "I would like to focus on mindfulness".

Table 23. Theme of Specific Empirically-Supported Therapies.

Theme	n (%)	Description
Use of specific therapy	6 (6.7)	Desire for a specific therapy or think one will be helpful

4.4% of participants' preferences reflected the general theme of Other Preferences. Specific themes included being unsure of what participants wanted their therapy experience to be like (2.2%) and generally wanting their experience with therapy to be different or better than it currently is (2.2%). To further illustrate this theme, one participant stated "not sure first time ever" and another participant reported "more intense".

Table 24. Theme associated with Other Preferences.

Theme	n (%)	Description
Other		
Unsure	2 (2.2)	Unsure of preference
A different experience	2 (2.2)	Desire for better therapy, more intense therapy

Lastly, 2.2% of participants endorsed preferences that were reflective of Therapy Composition (2.2%). The specific themes were a preference for group therapy where participants could interact with similar others (1.1%), and a preference for individual therapy where participants would engage one on one with the therapist (1.1%). To illustrate this theme, one participant stated "1 on 1" and another participant stated "interactive with others".

Table 25. Specific themes associated with Therapy Composition.

Theme	n (%)	Description
Therapy composition		
Group	1 (1.1)	Interact with others and engage in group therapy
Individual	1 (1.1)	One on one therapy

CHAPTER FIVE

DISCUSSION

Main Findings

The current study tested nine hypotheses related to acceptability and preferences for the following empirically-supported therapies for anxiety and depressive disorders, including CBT, ACT, IPT, and EFT. A larger proportion of participants had heard of or was familiar with CBT over the other therapies. This was consistent with investigator's hypothesis and could be attributed to the fact that CBT has been widely studied and implemented over the past decades and has been considered a gold standard treatment (Beck, 2005). It should also be noted that generally, participants were not very familiar with the treatments. When mental health providers briefly discuss empirically-supported treatments with patients, it is likely that they lack an understanding of what these therapies entail and why they are important. It might be helpful for providers to give additional education to patients before beginning an empirically-supported therapy protocol.

Only the ease of use domain of acceptability was significantly different among the therapies. Contrasts indicated that IPT was rated as significantly easier to use over ACT. This result remains unclear, as there is a lack of research on ease of use of therapies. It is possible that this result is related to the description of ACT. Since ACT is an experiential therapy that conceptualizes treatment of psychopathology in a significantly different way than other treatments (e.g., not as focused on symptom reduction), it could be confusing or difficult for patients to understand. No other differences in acceptability were observed, which might reflect a general tolerability of empirically-supported therapies, as

they all have sound evidence for efficacy. Previous research has shown similar levels of acceptability for therapies, including CBT and IPT (deMello et al., 2005). Since perceptions around ease of use of therapies might effect engagement with the therapies, additional research on ease of use would be useful.

Predictors of total acceptability for each of the four therapies were difficult to assess and conceptualize. Generally, there was a lack of previous research to support and explain the few significant findings in the current study. Difficulties with interpersonal relationships were predictive of increased total acceptability of CBT. This was an unexpected finding because it could more likely be conceptualized that a patient with interpersonal difficulties might rate IPT as more acceptable due to the interpersonal focus of the therapy. It is possible that the descriptions might not have provided sufficient information for patients to be able to adequately distinguish between them. Also, the descriptions were brief and patients might have lacked a sound understanding of the different therapies after reading the descriptions. Having a familiarity with ACT was associated with increased total acceptability of ACT. It is possible that having a familiarity with a therapy implies that the patient likes what they already knew about it, but it is also possible that a patient can dislike what they know about a therapy. Interestingly, there were no significant predictors of IPT, which might be due to a lack of power in detecting moderators. Lastly, African American, Asian, and "other" ethnicity participants had higher total acceptability of EFT compared to Whites. One study by Dwight-Johnson et al. (2000) has indicated ethnicity as a predictor of credibility of and preference for therapy over medication, but there has not been specific findings on the

relationship between ethnic minorities and EFT. It is possible that with increased power, additional predictors would have been identified.

Fifty-seven percent of participants endorsed a preference for a certain therapy. This was consistent with the hypothesis that participants would endorse a preference after reading short written descriptions of the therapies. The preference group significantly differed from the no- preference group on education, having heard of CBT, ease of use of ACT, and willingness to engage with EFT. More educated participants tended to endorse a preference, which was consistent with Frovenholt and colleagues (2007). It is possible that participants with a higher education level might consider all of the relevant information and make an informed decision about which therapy they would prefer. Additionally, having heard of CBT, rating ACT less easy to use, and rating EFT less willing to try, significantly discriminated between those with a preference and those without a preference. The research on moderators of preference is limited so interpretations of results are tentative. It is possible that having heard of CBT was significant because it is the most well established therapy out of the four therapies. Reasons for the other two significant predictors were unclear, but may have to do with how the descriptions were written.

Results of the logistic regression indicated that predictors of preference were difficult to assess and understand. Having heard of CBT, receiving some college, and receiving a BA degree were included in the regression and the model was significant overall, but none of the predictors were significant. It was possible that multicollinearity among the variables decreased the unique predictive contribution of each variable. It was

also possible that there was not enough power to detect significant moderators. Additional analyses would be useful to be able to detect predictors of preference.

There was no significant difference between the proportions of participants who ranked each therapy as their top choice. It was expected that there would be a difference in which therapies were preferred overall. However, this result was consistent with one study by Sandell et al. (2011) that identified multiple preference clusters, including individuals without a preference and individuals with preferences for specific treatments like CBT and IPT. Although not statistically significant, CBT was most frequently ranked number one and then IPT, EFT, and ACT. This was in contrast to the hypothesis that ACT would be most preferred. Again, it was possible that the written description of ACT was seen as less preferable since it stated a focus on acceptance rather than symptom reduction, which could be what patients where looking for while reading the descriptions. Although results of analyses did not reach clinical significance, the test statistic was approaching the critical value. It was possible that CBT was more frequently ranked first because more participants were knowledgeable about the therapy. Also noteworthy was that the majority of participants who did not endorse a preference still ranked the therapies from most to least preferred. Those two questions might be representing separate constructs and Froventolt et al. (2007) suggested more attention be paid to which treatment a patient actually chooses and not just their perceived preferences.

Total acceptability of each therapy was found to discriminate between the top rank variable. It appeared that acceptability was related to preference, which was expected. Specifically, CBT acceptability, ACT verse IPT acceptability, and EFT

acceptability varied across preference groups. It is possible that the more acceptable a therapy is, the more likely it is to be ranked as a top choice. However, preferences are more complex and it remains unclear what other factors constitute preferences. When predictors were included into the analysis, none of them reached significance. This difficulty predicting acceptability and preference was consistent with other analyses of predictors in the current study. It remains unclear what variables predict participants' preference for therapy, if any.

The qualitative analysis provided rich, detailed information about patient preferences and expectations. It was originally hypothesized that participants' comments would fall under the categories of general, non-specific therapeutic factors and specific therapy factors. Both of these categories were found in the analysis, but a total of seven general themes comprised of 23 specific themes reflected significantly more specificity than was originally hypothesized. The most commonly endorsed themes were therapy components, general positive statements, and the therapeutic relationship. These results were aligned with previous research on common factors. Nacross and Lambert (2011) found medium effect sizes for the therapeutic alliance, empathy, goal collaboration, and positive regard/affirmation in therapy. The therapy components theme in the current study reflected general skills and topics that most therapies address in their own way, including a conceptualization of thoughts, emotions, and behaviors, gaining insight, learning how to effectively deal with stressful life events, applying what is learned in therapy to everyday life, fostering accountability, and engaging in discussion and providing feedback. Qualitative analysis found that themes reflecting common factors, including therapy components, general statements, and the therapeutic relationship, were

more frequently endorsed by participants than specific therapy factors. Previous research has found that the specific therapy method accounted for around only 1% of the total outcome variance (Wampold, 2001).

Limitations

There were some noteworthy limitations to the current study. First, the sample size was relatively small for moderator analyses. Significant efforts were made to obtain an adequate sample size of at least 150 participants, but there were some barriers. With only two front desk staff at the BHI, the study was not always mentioned to patients. Having an investigator present and making frequent contact with front desk staff did improve the likelihood that staff would deliver study information to patients to some degree. Extending the inclusion criteria early on to include all participants seeking psychological services instead of just new patients at the BHI also helped increase sample size.

Another limitation was the descriptions of the therapies in the questionnaire. Attempts were made to have the descriptions be as reliable as possible, but there was no specific reliability check built into the current study. It would have been helpful to have the descriptions read by a psychologist with expertise in the particular therapy. Some previous studies on preferences have been able to incorporate feedback from psychologists who have written extensively on the specific therapies involved in the particular studies. This was not feasible for the current study and the descriptions were adapted from validated written materials. Also, the questionnaire only included four empirically-supported therapies (i.e., CBT, ACT, IPT, and EFT). These therapies were

chosen as they are considered empirically-supported therapies for anxiety and depression, but there are additional therapies such as behavior activation and exposure therapy that were not included due to the limited scope of this project. It is possible that preferences might arise from therapies that were not included in the current study.

The sample was not representative of all patients seeking outpatient therapy. Around half of the sample was White and one-third was Hispanic. This was more representative than the well-documented disparity in mental health services based on ethnicity (Alegr et al., 2002). Over half of participants had an education level of some college or less and an income of less than $20,000. This may be more representative of the BHI, a university-based clinic staffed mostly with graduate student practitioners. The majority of participants were female and half were single. Anxiety and depressive symptoms were among the most common referral reasons, which was consistent with the literature on the high prevalence rates of anxiety and depressive disorders (Kessler et al., 2007). Similarly, over half of participants were experiencing significant levels of distress, which is consistent with their seeking therapy at the BHI. Additional research would be needed on more representative samples of outpatients to assess for additional therapy preferences.

The qualitative codes were not double coded for inter-rater reliability due to time constraints. However, both investigators helped develop the codebook from the item responses. The purpose of including a qualitative question in the current study was to gain a more detailed understanding of participants' expectations and preferences for therapy.

Lastly, due to the extent of statistical analyses conducted in the current study, there was a higher probability of Type 1 error. However, the study was meant to be largely exploratory since the previous literature has been limited. The significant findings can be seen as a foundation for future research. The sample was comprised of patients receiving outpatient therapy services, who are likely to receive one of the treatments included in the study. Data collected was extremely relevant over college student samples and samples of individuals who were not seeking therapy. This study was also one of the few in the literature to compare multiple empirically-supported therapies and incorporate extensive moderator analysis.

Clinical Implications

Findings of the current study have important implications for delivering empirically-supported therapies. The idea of nonspecific therapeutic factors has been evident for decades. Recently, there has been a push in the field for empirically-supported psychotherapy (APA Presidential Task Force on Evidence-Based Practice, 2006). In the current study, total acceptability did not differ among the therapies, which was consistent with previous research that there are multiple efficacious therapies for anxiety and depressive disorders to date (Chambliss & Ollendick, 2001). The majority of participants in the sample also reported that they had a preference for therapy, which might bolster the argument for tailoring to therapy preferences. Equally interesting was that the therapies did not significantly differ in the frequency of participants rating each as their preference. Participants' comments were mostly reflective of an interest in general therapeutic factors. It is important for therapists to stress these non-specific

factors, including the therapeutic relationship, and not become hyper-focused on the specific empirically-supported treatment manual. Evidence-based practice is meant to incorporate the best available research findings with patient factors, but there seems to be a swing in the direction of specific empirically-supported treatments. It is important to find the balance and view both general therapeutic factors and specific treatments as complementary and not as dichotomies.

Conclusion

The current study was more exploratory in nature. Although the importance of individual expectations and preferences for psychological treatment has been indicated, there have been few studies that have systematically evaluated these constructs. Results of the current study suggested that the majority of participants had preferences for therapy. These preferences were somewhat difficult to quantify and predict. It would be worth additional research to expand on this study and further evaluate acceptability and preferences for a larger number of therapies with a larger and more representative sample of therapy outpatients. Also, empirically-supported therapy is a concept understood by clinicians, but not patients. It will be necessary for clinicians to ensure that their patients have a clear understanding of the treatments available to them so they make well-informed decisions about their preferences for treatment. Attempts to further understand, quantify, and predict therapy expectations, acceptability, and preferences could improve the alignment between therapy and patient, which could potentially increase engagement in therapy, and most importantly subsequent outcomes.

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APPENDIX A

FLIER ATTACHMENT

- ✓ **Are you being treated here at the BHI?**
- ✓ **Are you interested in helping us understand how to better meet your treatment needs?**
- ✓ **Just complete a brief, one-time survey (no more than 30 minutes)**
- ✓ **All participants will receive a $10 gift card**

APPENDIX B

FLIER ATTACHMENT

Invitation to Participate in a Research Study

You are invited to participate in a research study to evaluate attitudes about different kinds of psychological therapies. If you are interested in participating, please read the consent form on the next page and keep a copy of this for your records. If you choose to participate, just fill out the attached questionnaires and return it to the front desk when you check-in for your next appointment at the Behavioral Health Institute. When you return the questionnaire with your contact information, you will be compensated with a $10 gift card to Target. The questionnaire must be completed to receive a gift card.

This questionnaire packet contains a range of questions related to your experiences and preferences for various psychological treatments. The information you share with us will play an important role in improving our knowledge about preferences for psychological therapy.

Remember, there are no right or wrong answers, and you may choose to stop the questionnaire at any time. Your decision to participate or not will in no way impact the care you receive at the Behavioral Health Institute, and your responses will be kept strictly confidential.

INFORMED CONSENT SHEET TO PARTICIPATE IN RESEARCH

Title: Evaluating Acceptability and Preferences for Evidence-based Psychological Treatments

Principal Investigator: Jason Owen, Ph.D.
Adjunct Professor
Department of Psychology
Loma Linda University
11130 Anderson St.
Loma Linda, CA 92350
(909) 558-8706

Study Staff: Amanda Gorlick, M.A.
Graduate student researcher
Department of Psychology
Loma Linda University
11130 Anderson St., Ste. 3
Loma Linda, CA 92350

1. Why is this study being done?

The purpose of the study is to learn more about people's preferences for psychological treatment.

You are asked to participate in a research study conducted by Jason Owen, Ph.D. and Amanda Gorlick, M.A., from the Department of Psychology at Loma Linda University. You were selected as a possible participant in this study because you are seeking counseling at the Behavioral Health Institute. By completing and returning the questionnaires, you are providing your informed consent.

2. How many people will take part in this study?

Approximately 150 people will participate in this study.

3. How will I be involved?

You must meet the following requirements to be in the study: at least 18 years or older, fluent in English, and seeking psychological counseling

If you meet the screening requirements and you choose to take part in the study, then the following procedures will take place:

- Complete the set of questionnaires that will take approximately 30 minutes. You can either complete it while you are at the Behavioral Health Institute and return it to the front desk or complete it at home and either return it person to the

Behavioral Health Institute or by mail to the Psychology Department in the attached envelop.

5. What are the reasonably foreseeable risks or discomforts I might have?

There are minimal risks associated with completing the questionnaires. Participants may become frustrated with the time commitment or uncomfortable with answering a question. You are free to decline to answer any questions you do not wish to answer or discontinue at any time, as participation is completely voluntary.

6. Will there be any benefit to me or others?

Participation in the study is unlikely to provide direct benefit to you. Information obtained from the questionnaires will not influence your treatment and will not be shared with your current provider. However, this research will help develop an understanding of psychological treatment preferences.

7. What are my rights as a subject?

Participation in the study is voluntary. Your decision, whether or not to participate, decline, or withdrawal at any time during the study, will not impact your care at the Behavioral Health Institute.

8. What happens if I want to stop taking part in this study?

You are free to withdraw from the study at any time. You may just throw away the questionnaire and you do not have to inform the investigators.

9. Will I be informed of significant new findings?

You will not be contacted after the study ends about results of the study.

10. What other choices do I have?

The only alternative to participating in the study is to decline participation.

11. How will information about me be kept confidential?

Efforts will be made to keep your personal information confidential, and your responses to the questionnaire will be linked only with a confidential study identification number and not with your name or other identifying information. If you choose to provide your name and address on the last page in order to receive the $10 gift card, this information will be stored separately from your responses to the questionnaire and will not be linked in any way to your responses. Only the investigators will have access to your responses on the questionnaire. You will not be identified by name in any publications describing the results of the study.

12. Will I be paid to participate in this study?

You will receive a $10 gift card to Target for completing the questionnaire. To have the gift card mailed to you, you will have to leave your name and address on the form at the end of the questionnaire. In order to receive a gift card, you must leave your mailing information. However, if you are uncomfortable providing this information, you do not have to, but you will not receive a gift card.

13. Will study staff receive payment?

The principal investigator and study staff are not receiving payment for conducting the study.

14. Who do I call if I have questions?

If you have any questions about your participation in the study, please feel free to contact Amanda Gorlick, M.A. at agorlick@llu.edu or Jason Owen, Ph.D. at (909) 558-8706.

If you wish to contact an impartial third party not associated with this study regarding any questions about your rights or to report a complaint you may have about the study, you may contact the Office of Patient Relations, Loma Linda University Medical Center, Loma Linda, CA 92354, phone (909) 558-4647, e-mail patientrelations@llu.edu for information and assistance.

15. Subject's statement of consent

Completing and returning the attached questionnaire to the Behavioral Health Institute implies that you consent to participate in the study.

APPENDIX C

QUESTIONNAIRE

Questionnaire

For any questions, please contact Amanda Gorlick, M.A. at agorlick@llu.edu or Jason Owen, Ph.D. at (909) 558-8706.

DEMOGRAPHIC INFORMATION

1. Age: _____

2. Gender (please circle):

Male Female

3. Marital status (please circle):

Married Single Separated/Divorced Widowed

4. Education (please circle):

Some high school High school graduate Some college BA degree Post-BA degree

5. Income (please circle):

$0-20,000 $21,000-40,000 $41,000-60,000 $61,000-80,000 $>80,000

6. Ethnicity (please circle):

White African American Hispanic/Latino Asian Other _____

7. What is your reason for seeking therapy or your current concern you would like to address in therapy?

_____

_____

_____

EXPERIENCE WITH THERAPY

8. Do you have any previous experience with therapy? (please circle)

Yes No

If Yes, please specify below.

_____

_____

_____

9. Cognitive Behavioral Therapy (CBT)

9a. Have you heard of CBT? (please circle)

Yes No

If Yes, please specify below.

_____

_____

_____

9b. How familiar are you with the CBT? (please circle)

Not at all Somewhat Very

10. Acceptance and Commitment Therapy (ACT)

10a. Have you heard of ACT? (please circle)

Yes No

If Yes, please specify below.

_____

_____

_____

10b. How familiar are you with ACT? (please circle)

Not at all Somewhat Very

11. Interpersonal Therapy (IPT)

11a. Have you heard of IPT? (please circle)

Yes No

If Yes, please specify below.

_____

_____

_____

11b. How familiar are you with IPT? (please circle)

Not at all Somewhat Very

12. Emotion-focused Therapy (EFT)

12a. Have you heard of EFT? (please circle)

Yes No

If Yes, please specify below.

_____

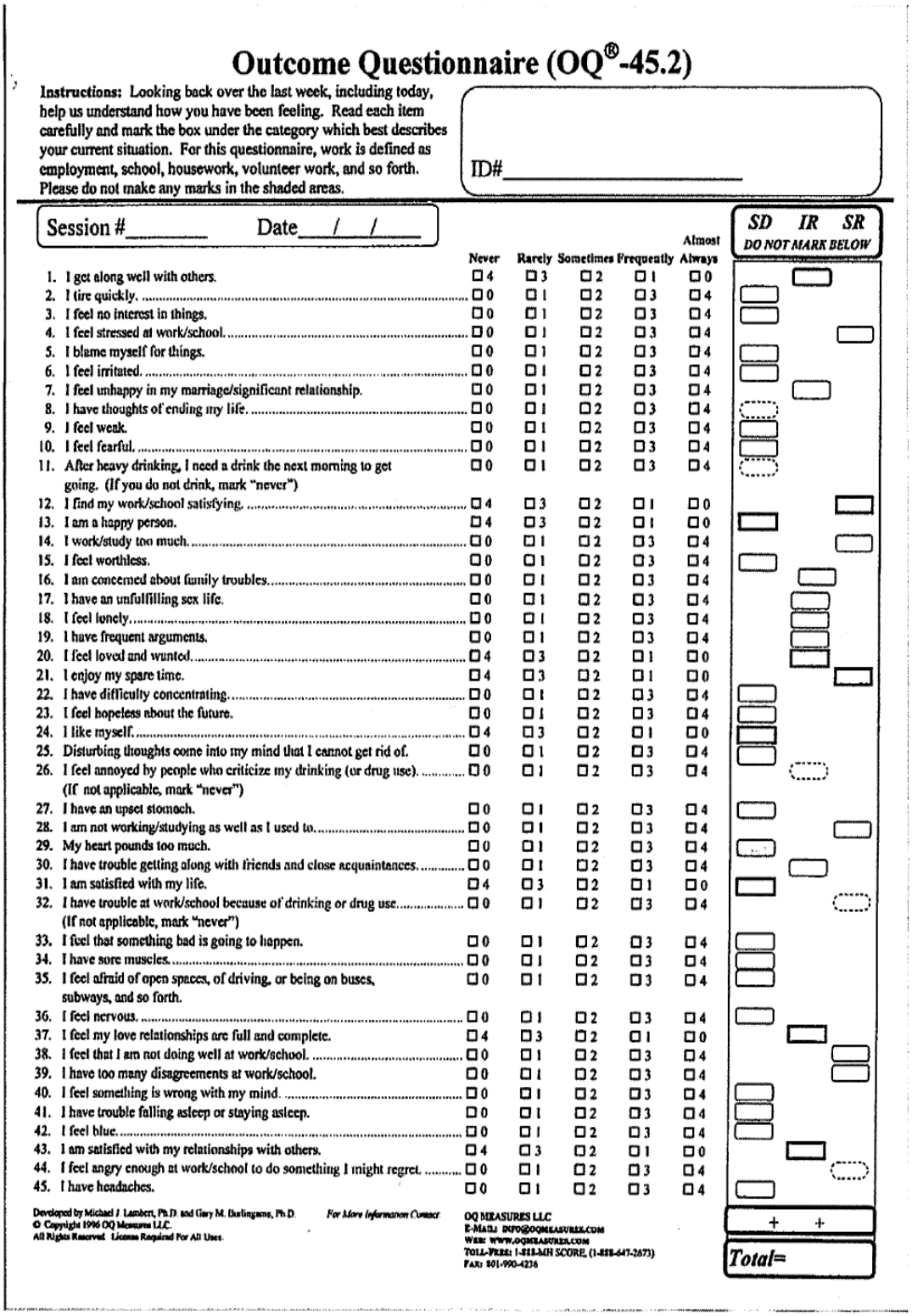
_____

_____

12b. How familiar are you with EFT?

Not at all Somewhat Very

13. Outcome Questionnaire (OQ-45)



Outcome Questionnaire (OQ®-45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

ID#_____

Session #_____ Date__/__/____

	Never	Rarely	Sometimes	Frequently	Almost Always
1. I get along well with others.	☐4	☐3	☐2	☐1	☐0
2. I tire quickly.	☐0	☐1	☐2	☐3	☐4
3. I feel no interest in things.	☐0	☐1	☐2	☐3	☐4
4. I feel stressed at work/school.	☐0	☐1	☐2	☐3	☐4
5. I blame myself for things.	☐0	☐1	☐2	☐3	☐4
6. I feel irritated.	☐0	☐1	☐2	☐3	☐4
7. I feel unhappy in my marriage/significant relationship.	☐0	☐1	☐2	☐3	☐4
8. I have thoughts of ending my life.	☐0	☐1	☐2	☐3	☐4
9. I feel weak.	☐0	☐1	☐2	☐3	☐4
10. I feel fearful.	☐0	☐1	☐2	☐3	☐4
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	☐0	☐1	☐2	☐3	☐4
12. I find my work/school satisfying.	☐4	☐3	☐2	☐1	☐0
13. I am a happy person.	☐4	☐3	☐2	☐1	☐0
14. I work/study too much.	☐0	☐1	☐2	☐3	☐4
15. I feel worthless.	☐0	☐1	☐2	☐3	☐4
16. I am concerned about family troubles.	☐0	☐1	☐2	☐3	☐4
17. I have an unfulfilling sex life.	☐0	☐1	☐2	☐3	☐4
18. I feel lonely.	☐0	☐1	☐2	☐3	☐4
19. I have frequent arguments.	☐0	☐1	☐2	☐3	☐4
20. I feel loved and wanted.	☐4	☐3	☐2	☐1	☐0
21. I enjoy my spare time.	☐4	☐3	☐2	☐1	☐0
22. I have difficulty concentrating.	☐0	☐1	☐2	☐3	☐4
23. I feel hopeless about the future.	☐0	☐1	☐2	☐3	☐4
24. I like myself.	☐4	☐3	☐2	☐1	☐0
25. Disturbing thoughts come into my mind that I cannot get rid of.	☐0	☐1	☐2	☐3	☐4
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "never")	☐0	☐1	☐2	☐3	☐4
27. I have an upset stomach.	☐0	☐1	☐2	☐3	☐4
28. I am not working/studying as well as I used to.	☐0	☐1	☐2	☐3	☐4
29. My heart pounds too much.	☐0	☐1	☐2	☐3	☐4
30. I have trouble getting along with friends and close acquaintances.	☐0	☐1	☐2	☐3	☐4
31. I am satisfied with my life.	☐4	☐3	☐2	☐1	☐0
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")	☐0	☐1	☐2	☐3	☐4
33. I feel that something bad is going to happen.	☐0	☐1	☐2	☐3	☐4
34. I have sore muscles.	☐0	☐1	☐2	☐3	☐4
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.	☐0	☐1	☐2	☐3	☐4
36. I feel nervous.	☐0	☐1	☐2	☐3	☐4
37. I feel my love relationships are full and complete.	☐4	☐3	☐2	☐1	☐0
38. I feel that I am not doing well at work/school.	☐0	☐1	☐2	☐3	☐4
39. I have too many disagreements at work/school.	☐0	☐1	☐2	☐3	☐4
40. I feel something is wrong with my mind.	☐0	☐1	☐2	☐3	☐4
41. I have trouble falling asleep or staying asleep.	☐0	☐1	☐2	☐3	☐4
42. I feel blue.	☐0	☐1	☐2	☐3	☐4
43. I am satisfied with my relationships with others.	☐4	☐3	☐2	☐1	☐0
44. I feel angry enough at work/school to do something I might regret.	☐0	☐1	☐2	☐3	☐4
45. I have headaches.	☐0	☐1	☐2	☐3	☐4

SD IR SR
DO NOT MARK BELOW

\+ +

Total=

For More Information Contact:
OQ MEASURES LLC
E-MAIL: INFO@OQMEASURES.COM
WEB: WWW.OQMEASURES.COM
TOLL-FREE: 1-888-MH SCORE, (1-888-647-2673)
FAX: 801-990-4236

DESCRIPTIONS OF THERAPIES

14. Cognitive-Behavioral Therapy (CBT)

CBT is focused on solving problems in the here and now. It states that the way we perceive and think about situations influences how we feel about them and ourselves. So it is not the situation that makes us feel sad or angry, but our thoughts about the situation. Our thoughts can be inaccurate and unrealistic at times which can make us feel distressed. With CBT, you can learn how to identify your unrealistic thoughts and change them to be more accurate and realistic. When your thoughts are more realistic, you feel better emotionally as well. You will also learn to change your behaviors so they can better reflect your more realistic thoughts.

14a. How appropriate do you think this type of therapy would be for you? (please circle)

1 Not at all appropriate
2
3 Neutral
4
5 Extremely appropriate

14b. How suitable do you think this type of therapy would be for you? (please circle)

1 Not at all suitable
2
3 Neutral
4
5 Extremely suitable

14c. How effective do you think this type of therapy would be for you? (please circle)

1 Not at all effective
2
3 Neutral
4
5 Extremely effective

14d. How willing would you be to participate in this type of therapy? (please circle)

1 Not at all willing
2
3 Neutral
4
5 Extremely willing

14e. How easy do you think participating in this type of therapy would be? (please circle)

1 Not at all easy
2
3 Neutral
4
5 Extremely easy

15. Acceptance and Commitment Therapy (ACT)

ACT is focused on being able to live a full and meaningful life, even though there is pain and sadness that goes along with it. Our minds are constantly making critical thoughts about ourselves, our pasts, and our futures. These thoughts make us feel bad emotionally. How we try to deal with these painful thoughts and emotions is not always helpful for us. We try to avoid them or change them. With ACT, you can learn to notice your critical thoughts and instead of trying to change them, just accept them. You will also learn what it is that you value in life and begin to live it out. You can stop struggling with your thoughts and emotions and accept them.

15a. How appropriate do you think this type of therapy would be for you? (please circle)

1 Not at all appropriate
2
3 Neutral
4
5 Extremely appropriate

15b. How suitable do you think this type of therapy would be for you? (please circle)

1 Not at all suitable
2
3 Neutral
4
5 Extremely suitable

15c. How effective do you think this type of therapy would be for you? (please circle)

1 Not at all effective
2
3 Neutral
4
5 Extremely effective

15d. How willing would you be to participate in this type of therapy? (please circle)

1 Not at all willing
2

3 Neutral
4
5 Extremely willing

15e. How easy do you think participating in this type of therapy would be? (please circle)

1 Not at all easy
2
3 Neutral
4
5 Extremely easy

16. Interpersonal Therapy (IPT)

IPT is focused on our interpersonal relationships in the here and now. We do not always communicate with others in the best way, especially with people who we care a lot about, such as a family member or significant other. Our communications with others can make us feel distressed. With IPT, you can learn to improve your relationships by changing the way you communicate with others or by changing your expectations about your relationships. You will also learn to deal with relationship issues better and improve your social support network. In addition to feeling better, you will also feel better about your relationships.

16a. How appropriate do you think this type of therapy would be for you? (please circle)

1 Not at all appropriate
2
3 Neutral
4
5 Extremely appropriate

16b. How suitable do you think this type of therapy would be for you? (please circle)

1 Not at all suitable
2
3 Neutral
4
5 Extremely suitable

16c. How effective do you think this type of therapy would be for you? (please circle)

1 Not at all effective
2
3 Neutral
4

5 Extremely effective

16d. How willing would you be to participate in this type of therapy? (please circle)

1 Not at all willing
2
3 Neutral
4
5 Extremely willing

16e. How easy do you think participating in this type of therapy would be? (please circle)

1 Not at all easy
2
3 Neutral
4
5 Extremely easy

17. Emotion-Focused Therapy (EFT)

EFT is focused on our emotions in the here and now and how to best use them to live our lives. We tend to see unpleasant emotions like anger, fear, and sadness as bad, but they can be helpful sources of information and wisdom. Unpleasant emotions can even serve a purpose for us to pay attention to what we need and give us the energy to get that need met. We do not like feeling unpleasant emotions and often try to suppress them. With EFT, you can learn to work with your emotions and understand them and how they can help you take care of yourself. You will also learn how to take an unpleasant emotion that is not serving you well and turn it into an emotion that will serve you better.

17a. How appropriate do you think this type of therapy would be for you? (please circle)

1 Not at all appropriate
2
3 Neutral
4
5 Extremely appropriate

17b. How suitable do you think this type of therapy would be for you? (please circle)

1 Not at all suitable
2
3 Neutral
4
5 Extremely suitable

17c. How effective do you think this type of therapy would be for you? (please circle)

1 Not at all effective
2
3 Neutral
4
5 Extremely effective

17d. How willing would you be to participate in this type of therapy? (please circle)

1 Not at all willing
2
3 Neutral
4
5 Extremely willing

17e. How easy do you think participating in this type of therapy would be? (please circle)

1 Not at all easy
2
3 Neutral
4
5 Extremely easy

TREATMENT PREFERENCES

18. After reading about the four therapies, do you have a preference for a certain treatment?

Yes No

19. Rank the therapies in the order of your preference (1=most preferred treatment, 4=least preferred treatment).

_____ Cognitive-Behavioral Therapy (CBT)
_____ Acceptance and Commitment Therapy (ACT)
_____ Interpersonal Therapy (IPT)
_____ Emotion-focused Therapy (EFT)

20. What would you like your therapy experience to be like?

_____

_____

_____

21. Optional Gift Card Reimbursement

This part is completely optional. If you are uncomfortable leaving your contact information, you can leave it blank. If you would be interested in receiving a $10 Target gift card in the mail for your participation, please leave your name and mailing address in the space provided below. Once we receive the questionnaire, we will immediately detach this form from the rest of your responses and store it in a locked cabinet where it will be kept confidential. Your name and address will not be linked to your responses.

Name: _____

Address line 1: _____

Address line 2: _____

City/State/Zip code: _____