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Article

Working With Preferences in Psychotherapy: Clinical and Ethical Considerations

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ABSTRACT

Some characteristics of the individual who attends psychotherapy influence its outcomes, and these variables are the main factor associated with change. A treatment that is tailored to each case will be much more effective than one that does not adapt to the uniqueness of each client. This paper focuses on one of the factors to take into account: the patient's preferences, a fundamental pillar of evidence-based practice in psychology. Available empirical evidence is reviewed, along with associated clinical implications and recommendations. This is followed by other ethical considerations, which lead to a discussion about the dilemmas that can arise when working with each individual's preferences.

Trabajando con las Preferencias del Consultante en Psicoterapia: Consideraciones Clínicas y Éticas

Palabras clave
Psicoterapia
Preferencias
Ética
Adaptación del tratamiento
Pericia clínica

RESUMEN

Algunas características de la persona que acude a psicoterapia influyen en los resultados de la misma, siendo estas variables el principal factor asociado al cambio. Un tratamiento diseñado a medida para cada caso resultará mucho más eficaz que otro que no se adapte a la singularidad de cada consultante. Este trabajo se centra en uno de los factores a tener en cuenta, las preferencias de la persona, un pilar fundamental de la práctica basada en la evidencia en psicología. Se revisan las pruebas empíricas disponibles, junto con las implicaciones y recomendaciones clínicas asociadas. A esto le seguirán otras consideraciones de tipo ético, que darán pie a una discusión acerca de los dilemas que se pueden presentar cuando se trabaja con las preferencias de cada persona.

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Introduction

Numerous data underscore the importance of designing specialized psychological interventions tailored to the needs of each particular case, supporting the idea that there is no single therapy that is effective for everyone, but that what is most useful is the creation of a new treatment that is specific to each person (Norcross & Wampold, 2018). Certain variables of the individual and his or her context influence the likelihood that a psychotherapy will have better or worse outcomes, regardless of the type of treatment carried out and the techniques employed (Gimeno-Peón, 2021).

This is not something new. Originally, the major models of psychotherapy were concerned with developing case formulation systems that took into account the particularities of each individual, and not so much a diagnosis based on the categories used in the reference manual in force at the time. In part, it has been the need to reliably demonstrate the efficacy of the different types of psychological treatments that has led to the drift of these, in the sense of taking into account almost exclusively the clinical diagnosis as a criterion when choosing not only the techniques or the form of intervention, but the whole structure of a highly scripted therapy from beginning to end. The frenzy to obtain the category of "empirically supported treatment" has made it possible to confirm the efficacy of psychotherapy (or rather psychotherapies, in the plural) in addressing a whole myriad of psychological problems, as demonstrated by the continuous reviews carried out in this regard (Fonseca Pedrero et al., 2021), validating and promoting its use, both in the public and private spheres. However, it is not because there are more treatments and more evidence in their favor that the overall outcomes have improved in recent decades; there is still a high percentage of cases in which there are no satisfactory outcomes, individuals worsen, or they drop out prematurely (Gimeno-Peón, 2021). It could be argued, not without some reason, that this may be due to variables unrelated to the treatment itself and that there are cases in which *nothing* can be done. But although this is true for an indeterminate number of situations, it is also true that there are studies that show that certain clinical practices significantly increase the results of psychotherapy, reducing, for example, the percentage of premature dropouts or individuals whose condition worsens, such as procedures for repairing ruptures in the therapeutic alliance (Eubanks et al., 2018) or systematic outcome monitoring (de Jong et al., 2021), among others.

Without wishing to detract from the usefulness of manualized treatments−indeed they are useful, and very much so−it should be noted that some careful analyses of the components of effective psychotherapy indicate that the role of specific techniques and models is relatively small (Wampold & Imel, 2015). Other factors, such as those related to the therapeutic alliance, seem to play a more important role. In fact, for decades, data have been consistent regarding the following: the variables that have the greatest weight in the variance of the outcomes of psychological therapies are those related to the individual and the life of the patient, his or her own characteristics, and those of his or her environment, both the closer and the broader environment (Rodríguez-Morejón, 2016). Factors such as the style of coping with difficulties, reactance, readiness to change, or the individual's preferences constitute aspects to which psychological interventions must be adapted (Inchausti et al., 2021), with the aim of making it more likely that the outcome will be satisfactory for the parties involved. Not surprisingly, the definition of evidence-based practice (EBP) in psychology explicitly includes "the characteristics, culture, and preferences of the individual" as one of the foundations on which to base the therapy (APA Presidential Task Force on Evidence-Based Practice, 2006).

One of the aforementioned aspects, the preferences of the patient, will be the subject of discussion in this paper. This factor is particularly important because of its association with ethical issues of great importance, as will be seen below. Next, the concept of preferences in the context of psychotherapy, the categories or types to be taken into account, and the empirical evidence regarding their influence on the intervention process will be presented. This will be followed by some comments regarding the clinical and ethical implications, concluding with a discussion focused on the dilemmas that patient preferences may raise in practitioners.

Preferences in Psychotherapy

Swift et al. (2018) define preferences in psychotherapy as the specific conditions and activities that patients wish to be part of the therapeutic process. These can be general or more specific, although the former are probably more common. It is not so much a question of whether the person wishes specific techniques to be used in certain situations, but of more global aspects, related to the type of treatment, the framework, or the style of the clinician, among others. To appreciate this issue in more detail, see below the types of preferences that have been described in this context.

Three categories have been grouped in the specialized literature: preferences regarding the activity, preferences regarding the therapist, and preferences regarding the treatment (Swift et al., 2018).

- *Preferences regarding the activity*: these relate to what happens within sessions (whether the format is individual, group, or family, for example) and between sessions (whether tasks are assigned and the type of tasks), and the way it is carried out (where aspects related to the practitioner's style, such as greater or lesser directivity, would be found).
- *Preferences regarding the therapist*: this includes characteristics of the practitioner him/herself that cannot be changed at the time, such as age, sex, experience, culture, or interpersonal skills.
- *Preferences regarding the treatment*: here the aspect most studied has been whether a person wants to receive psychological or pharmacological therapy, but the type or model of psychotherapy desired is also relevant.

It is common for there to be, on the part of the general population, a preference for therapy or combined therapy with psychotropic drugs versus exclusively pharmacological treatment, as has also been seen in the context of public mental health services when surveying individuals that have been referred (Valencia-Agudo et al., 2015). It is a dichotomy that may be clearer for patients compared with the decision to have a preference for one theoretical orientation or another, although every day it is becoming more common to find in specialist consultations people who seek to become involved in a particular treatment model (either on the recommendation of someone close to them or because of the information they find on the Internet or other easily accessible resources).

It is also common for patients to look for practitioners with certain characteristics, when they have that possibility (more common in the private sphere): whether it is a woman or a man, older or younger, with certain training or experience, etc. These are characteristics that can be known before a first contact, as opposed to others, also within this category, related to the way the practitioner interacts (for example, his or her capacity for empathy or kindness).

Patients may find it more difficult to make their preferences about the activity explicit, other than issues such as format (individual, group, etc.) and the like, especially when they have had no previous therapeutic experience.

Regarding the available evidence, several meta-analyses conclude that preferences influence the efficacy of psychotherapy. Specifically, when treatment is adjusted to the preferences of each person, better outcomes, better therapeutic alliances, and a lower percentage of premature dropouts are achieved (Swift et al., 2018; Windle et al., 2020). It is noted that it is not simply a matter of keeping those who come to therapy satisfied; in fact, the study by Swift et al. (2018) highlights that no significant differences were found in terms of the degree of satisfaction with the care received when comparing those whose preferences were integrated into their treatment and those who were not. The exact process by which this adjustment leads to a more successful intervention remains to be elucidated.

Clinical Implications

Based on results obtained in the more than 50 studies analyzed on the importance of preferences in psychotherapy, Swift et al. (2018) have produced a series of clinical recommendations: to assess the preferences of each individual, at the beginning of the treatment and periodically, paying special attention to those that are most important to him/her; to facilitate the expression of preferences, providing clear and reliable information, and reducing the fear of upsetting the practitioner; to explain clearly and neutrally the different options available for the treatment of the problems raised, given the characteristics and circumstances of the individual; to show acceptance and not judge the person for his or her preferences, expressing, when necessary, the relevant ethical or clinical contraindications−decision making regarding the intervention should be done collaboratively between the two; to explore previous therapeutic experiences, inquiring into the aspects that were useful and those that were not; to refrain from forcing the expression of preferences and respect the person's wish not to make them explicit or to trust the practitioner's judgment. A more detailed elaboration of these recommendations can be found in Inchausti et al. (2021).

It is the clinician's responsibility to explain to each individual the importance of including this factor in the assessment and design of the intervention, providing as much information as necessary to ensure that the best possible decision is made. A neutral presentation of the available treatment options is advised, i.e., the clinician should avoid prioritizing his or her own preferences as to what may be best for the patient. To give a somewhat reductionist example, if it is agreed that the person is suffering from a depressive disorder, theoretically he/she should be informed of all the treatments that have been shown to be efficacious in this type of case (of which there are many). Whether the practitioner is competent in each of them is another matter that will be discussed later. In the hypothetical case that it would be possible to begin each of these modalities of therapy, the evidence indicates that doing so with the one selected by the patient would increase the probability of a positive outcome.

The general principle to follow, in short, is to try to adapt the therapy to the preferences expressed by the individual, whenever possible. Tailoring the intervention to preferences is easier when working in a team with several practitioners and there is the possibility of assigning to each one the cases to which they show the greatest affinity. In some respects, this already happens naturally when it is the patient who asks for an appointment with a female specialist, rather than with a man, guided by his/her preference to be attended by a woman, for example. When there are options, it would be advisable to make this prior evaluation before scheduling a first session. The author of this article has had the experience of knowing public mental health centers, during his period as a clinical psychology resident, where team meetings were held to discuss the referrals that arrived and where they were assigned to one or another clinician, taking into account several criteria, one of them being preferences (in the case of any of them being spontaneously recorded, and not because they had been formally evaluated). Unfortunately, it is also known that other centers do not follow this dynamic. Systematic evaluation, even a screening exercise by the referring service or at the time of registering the request, could be integrated into the organization with relative ease.

Based on the available evidence, the evaluation of preferences can be considered an aspect that should be integrated into any psychotherapy process from the initial stages. This can be done in a less structured way, through the clinical interview itself, or with the help of a standardized instrument. In the case of opting for the second alternative, the Cooper-Norcross Inventory of Preferences, C-NIP (Cooper & Norcross, 2016) is available. This is a questionnaire divided into two blocks. The first is made up of scale questions that explore four factors referring to preferences regarding the greater or lesser directivity of the therapist, greater or lesser emotional intensity of the sessions, temporal orientation (focusing on the person's past, present, or future), and the practitioner's style, whether warm or confrontational. The second block presents a series of open-ended questions that inquire about issues such as the preferred frequency or duration of sessions, the type of format (individual, group, family, etc.), type of treatment, some clinician characteristics, and situations that could be both pleasant and unpleasant if they occurred during therapy, among other issues. The C-NIP is an instrument of free access and use (visiting the web https://www.c-nip.net/) of which there are versions in different languages, including an Argentinean adaptation (Santangelo & Conde, 2022). Validation with a Spanish population is currently underway, as part of a research plan on the influence of preferences and expectations on therapy outcomes (A. Rovira Samper, personal communication, February 5, 2023). Returning to the example of the diagnosis of depression, the assessment of preferences such as those reflected in the C-NIP can help to find more precisely the best type of intervention for a given person. For example, a strong preference for a directive approach on the part of the therapist would point to the choice of a treatment such as behavioral activation; a strong preference for emotional intensity would point to the possibility that emotion-centered therapy would be appropriate. These are simplifications to serve as examples. Obviously, behavioral activation therapy can be done in a less directive way and have a

lot of emotional intensity. In fact, this would be advisable; no matter what approach is agreed upon, it is desirable that the way of proceeding be adjusted to those preferences that are most important to the individual.

It should not be forgotten that there are limits to be taken into account with respect to the accommodation of preferences. It is not a matter of accepting whatever the patient proposes or desires. These limits are formed by empirical evidence, clinician competence, and professional ethics, and will be discussed in the following section.

Norcross and Cooper (2021) have published an excellent monographic handbook in which they explain in detail how to work with this factor, from the assessment process to accommodating preferences in therapy. To sum up very briefly, they propose the following; when preferences are in line with current evidence, are ethically acceptable, and the therapist is competent in what is being asked of him/her, the best course of action is to adapt completely to what the patient desires. At other times, depending on the above criteria, treatment modifications will have to be made, alternatives offered, or referral made to another practitioner or resource. When the individual's preferences cannot be met, it is important to respect them, validate their feelings at not being able to see them satisfied, explain the reasons why this has to be so, and seek another solution, on a consensual basis. Again, informed decision making is encouraged.

Other clinically relevant factors are directly or indirectly associated with these therapeutic practices. For example, some of the factors and items of the C-NIP refer to key factors in the personalization of evidence-based treatment, such as the level of reactance (Beutler et al., 2018a) or the coping style (Beutler et al., 2018b), along with the importance of the therapeutic alliance (Flückiger et al., 2018). Likewise, working with preferences has aspects in common with practices based on systematic client feedback (Gimeno-Peón et al., 2018), especially when using methodologies such as the one proposed by PCOMS, in which clinicians try to elicit the ideas that people have about what is wrong with them, what they need to change, and the expected role of the therapist, with the intention of adapting as much as possible to such feedback (Duncan & Reese, 2015).

Ethical Implications

Helping the people who come to therapy specify and prioritize their preferences and ideas contributes, among other things, to abandon a paternalistic model of therapy and replace it with another in which the capabilities and autonomy of the person seeking help are considered (Norcross & Cooper, 2021). The issue goes beyond the limits of the psychotherapy framework and strikes at the heart of core aspects such as respect for the Law of Patient Autonomy (2002), in force in Spain. In this sense, the evaluation and consideration of preferences no longer has to do only with EBP in psychology, but also with an ethical necessity. Unfortunately, on many occasions there is a lack of knowledge or compliance with the ethical imperatives of mental health workers (Pastor & Del Río, 2022). The aforementioned law encompasses essential aspects of the human being, such as dignity, informed consent, and freedom. For example, Article 2.3 states that "*the patient or user has the right to decide freely, after receiving adequate information, among the clinical options available*"; likewise, Article 2.6 states that "*all practitioners involved in the care activity are obliged not only to deliver their techniques correctly, but also to comply with the duties of information and clinical documentation, and to respect the decisions taken freely and voluntarily by the patient*" (Law 41/2002).

Just as it is ethical to take these preferences into account, so is the requirement to know the existing limits. It is ethical to consider preferences, and it is also ethical not to conform to unacceptable wishes of the patient. For example, in the context of family therapy or therapy involving a minor as an identified patient, one of the adults involved might verbalize a desire to withhold or misrepresent clinically relevant information. Another situation that is more common than one might expect is that in which a person demands that a clinician collaborate in a deception in order to attract a third party to the consultation. These and other situations cannot be accepted, but neither should they be criticized outright, rather the role of the therapist is, in these cases, to explain the reason for the rejection of the patient's preferences.

As mentioned in the previous section, along with professional ethics, empirical evidence and competence form the limits of working with preferences in psychotherapy. As is to be expected, one should not accept wishes to frame treatment in ways that current research has shown to be inadvisable, either because they have been shown not to contribute to better outcomes or because they may be directly harmful to an individual. On the other hand, it may be the case that the patient wants to engage in a type of treatment that does have empirical support, but in which the specialist is not competent. In this case, Norcross and Cooper (2021) advise offering alternatives that are appropriate to the situation and in which the clinician is competent, or referring the patient to another colleague who does have sufficient expertise in their preferred treatment.

However, to what extent are therapists willing to adapt to the criteria of those who request their services? The former have their own preferences, one of the most counterproductive being to prioritize their supposed expert knowledge and clinical criteria rigidly and unquestionably, as opposed to the ideas and suggestions of the patients. This is what some authors have called "therapist-centrism", an attitude that studies clearly discourage (Norcross & Wampold, 2018). Keep in mind that, most likely, the majority of clinicians who adopt a similar stance do so confident that their decision is the most appropriate and potentially beneficial for the patient. It is assumed that their confidence in this approach is based on their theoretical and scientific knowledge and not on random criteria. An example of this could be a practitioner working within a cognitive-behavioral approach who is convinced that the empirical evidence supports the superiority of his or her model over other alternatives. Even though the above premise could be accepted, is it ethical to ignore studies that demonstrate the importance of considering the person's preferences? Is it ethical not to inform about other options, to advise against them, or to criticize them despite the existence of evidence in their favor? It could be the case of the therapist of a particular orientation who rejects the current diagnostic classifications and the validity of the research designs used in clinical trials to decide when a treatment is or is not considered efficacious, based in turn on other studies that do confirm his or her own theory and vision of psychological therapy. The point is not to conclude whether he or she is right or wrong;

the point is that any intervention that is wished to be considered rigorous (scientifically and ethically) must also take into account the preferences of the individual, which implies respect for his or her autonomy. And this is contrary to a professional stance that remains rigid, however much the practitioner may want to disguise it as something else.

To conclude this section, it goes without saying that everything that refers to autonomy and the capacity to decide on one's own health is valid for adults with the necessary cognitive capacities preserved. In fact, the results of the studies on the evaluation of preferences and their integration in therapy come from samples composed of an adult population, and the importance and applications that they may have with children and adolescents are as yet unknown.

Discussion

The previous section raised the question of the extent to which it is ethical for a therapist to prioritize his or her theoretical model or methodology over other evidence-based intervention options. The evidence supporting preference adjustment in therapy opens up another related question: should one then be able to deliver all available treatment alternatives? It seems clear that such a goal is unrealistic, especially if one thinks about the study of empirically supported treatments. Is it possible to be proficient in the dozen or so therapies that have demonstrated efficacy in addressing depression? One can try, but the most obvious risk is well known: ending up knowing a little bit about everything, without being an expert in anything. Not to mention the associated theoretical problems.

Finding a solid explanation as to why adjusting to the preferences of the patient produces better outcomes is still a pending issue. At first glance, the evidence on this issue seems to support postulates akin to approaches such as pluralistic practices (McLeod, 2013), approaches from which it seems easier to embrace the principles and recommendations reviewed. However, it leaves up in the air basic questions regarding the theories that aim to explain the functioning of this type of model. Moreover, this is something that happens often in many areas of psychotherapy: knowledge of things that work, unaware of how they work.

Be that as it may, knowing how to adequately manage these factors is something that requires general therapeutic skills, the ability to adapt to the needs and characteristics of each person, a key aspect of clinical expertise (Prado-Abril et al., 2019b). Exploring and adjusting preferences is a process that requires precision and clear and explicit communication. For example, correcting and collecting C-NIP scores is not enough, as Norcross and Cooper (2021) point out. After all, as with so many other questionnaires, what a particular item means to one person may be very different from what is understood by another, including the specialist. It is therefore necessary to discuss the answers with the patient, clarifying their meaning, clearing up any doubts, and adjusting expectations. The conversation itself that involves the evaluation of preferences can be therapeutic if it is done in the right way, either by helping to strengthen the therapeutic relationship or by the message, implicit or explicit, that conveys that the patient's ideas are important and are taken into account very seriously when seeking a solution to the problems experienced.

In this work of flexibility and adaptation, of developing clinical expertise, it is important to include reflective practices that help the practitioner become aware of his or her own preferences and how he or she behaves with respect to them, especially when they conflict with those of the people he or she treats. The C-NIP includes a therapist version that facilitates this reflective process. Another useful tool is the Spanish version of the Personal Style of the Therapist Questionnaire [*Cuestionario de Evaluación del Estilo del Terapeuta* in Spanish] (Prado-Abril et al., 2019a), which facilitates reflection on the clinician's habitual way of acting in his or her daily work. Likewise, Norcross and Cooper (2021) recommend the clinicians undertake personal work in which they conscientiously consider the aspects in which they are competent and those in which they are not, an introspective scrutiny, in which humility and sincerity towards oneself prevail.

For those who have full confidence in their model and way of working, it is not necessary to change their methodology or follow other theoretical orientations. However, they are asked to be honest enough not to try to force the patient and make him/her adapt to their professional preferences, instead of the other way around. They are required to be able to explain their approach, to defend it if they wish to do so, referring to the data they consider appropriate, but informing the patient that there are other alternatives (if this is the case) and other styles, referring them to another colleague when this is the most advisable course of action. In the same way that it is not advisable to force people to undergo treatment that they do not wish to receive, neither would it be advisable to force the clinician to work in an integrative or pluralistic manner if it does not fit with his or her vision of psychology and psychotherapy. It is probably more feasible to find a way, within one's own theoretical framework, to accommodate the treatment characteristics desired by the individual. Rather than the choice of treatment model, other types of preferences will be found more frequently in psychology consultations: the type of format, the type of structure of the sessions, the focus, etc. Again drawing on expertise, the most effective clinician will be the one who is able to accommodate these factors in each individual case. For example, a therapist of an approach considered directive, such as cognitive-behavioral therapy, will find a way to interact in a way that the person perceives as non-directive while remaining faithful to the theoretical assumptions of his or her model. Conversely, a clinical psychologist reluctant to assign homework between sessions may be able to step out of his or her comfort zone and meet the demand of an individual eager to try things out; an expert in systemic therapy, with a preference for the family format of sessions, may be able to work individually with someone who shows a strong predilection for doing so; etc.

It has already been mentioned that it does not seem possible to be an expert in all models, formats, and styles. However it does seem more feasible to acquire competencies in some skills related to the adaptation to relevant characteristics of the person, such as those mentioned above: learning to be directive and non-directive; to focus on the symptoms and on the individual; to work in individual and group formats; etc. It is therefore important that the training plans of future practitioners who have among their competencies the practice of psychotherapy include training in skills of this type, with supervision and feedback, based on a model of constant and intentional practice (Prado-Abril et al., 2019b).

Conclusions

Assessing, considering, and adjusting the psychotherapy to the preferences of each person is an EBP that increases the likelihood that treatment will be effective, therefore every mental health professional should take it into account in their daily work. In addition to its clinical importance, this is an ethical issue that deals with fundamental aspects such as respect for autonomy and informed decision making. Therapists' flexibility, within limits, and their ability to adapt to the wishes of each patient are as important as knowing under what circumstances and what kind of preferences cannot be accepted, using scientific evidence, professional competence, and ethics as key criteria. It is not a matter of accepting whatever is proposed, but of building a context of collaboration in which decisions are made with sufficient information (reliable, updated, relevant, and presented in an understandable and unbiased way) and in a consensual manner, enhancing the personal resources of the patients.

Conflict of Interest

There is no conflict of interest.

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