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EMPIRICAL PAPER

Patient perspectives on working with preferences in psychotherapy: A consensual qualitative research study

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Abstract
Objective Assessing and accommodating patient preferences is integral to evidence-based practice. This qualitative study sought to explore patient perspectives and experiences of preference work in psychotherapy.
Methods Participants were 13 UK-based patients who had completed up to 24 sessions of a collaborative–integrative psychotherapy. Ten participants identified as female and three as male. Interviews were conducted at endpoint and analyzed using a team-based, consensual qualitative research approach.
Results Three superordinate domains were developed: Preferences Themselves, Process of Working with Preferences in Psychotherapy, and Effect of Preference Work (or its Absence). Patients typically wanted leadership, challenge, and input from their psychotherapist, and an affirming style. Patients attributed the origin of their preferences to personal history, characteristics, or circumstances; the present psychotherapy; or past episodes of psychotherapy. Some preferences changed over time. Preference work was described as having positive effects on the therapeutic relationship and patients' intrapersonal worlds; however, variantly, non-accommodation of preferences was also experienced as beneficial.
Conclusion Our findings provide in-depth answers to a range of novel questions on preference work—potential mechanisms by which preference work impacts outcomes, factors that may facilitate preference work, and origins of preferences—as well as nuancing previously-established quantitative findings. Implications for clinical training and practice are discussed.

Keywords: patient preferences; aptitude-treatment interaction research; alliance; process research; consensual qualitative research

Clinical or methodological significance of this article: This study provides qualitative triangulation to the quantitative finding that preference work is generally beneficial to patients; with some evidence that this is primarily through strengthening the alliance. Effects vary, however, by preference and by patient; and preferences may change over time. Psychotherapists should take an active stance in enquiring into potential sources of patient preferences.

Working with patient preferences is a cornerstone of evidence-based practice (American Psychological Association, 2006), and has been described as an "ethical imperative" (Norcross & Cooper, 2021, p. 38). *Preference work* typically involves eliciting, assessing, discussing, and/or accommodating "the specific conditions and activities that patients want in their treatment experience" (Swift et al., 2019, p. 157). Preference work has received considerable attention in recent years (Swift et al., 2019) and is

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part of a wider movement in the healthcare field towards personalized medicine (Norcross & Cooper, 2021). Also known within psychotherapy as "treatment adaptation" or "responsiveness," the aim of preference work is to develop and deliver interventions that are specifically tailored to the unique characteristics, culture, and desires of the patient (Norcross & Wampold, 2019).

Existing research on preference work suggests that, in general, it has a positive impact in psychotherapy. Three recent meta-analyses have indicated that preference assessment and accommodation is associated with a stronger therapeutic alliance, reduced dropout, and improved outcomes (Lindhiem et al., 2014; Swift et al., 2019; Windle et al., 2020). In addition, qualitative research into patients' experiences of preference work (e.g., Sutherland et al., 2013)—as well as on the closely-related processes of shared decision-making (e.g., Gibson et al., 2020) and work with patient factors such as "wishes," "expectations," and "hope" (e.g., Chui et al., 2020; Gundel et al., 2020)—have also evidenced the positive impact of preference assessment and accommodation. In a qualitative meta-synthesis of patients' experiences of psychotherapy, the tailoring of psychotherapy to patient preferences and expectations was a key process in patient motivation and improved outcomes (McPherson et al., 2020). Similarly, shared decision-making has been found to support patients in their recovery (Hartogs et al., 2013); helping patients to feel recognized, listened to, and accommodated as individuals by their psychotherapist (Gibson et al., 2020). Conversely, a lack of personalized treatment —and patients struggling to discuss their opinions with clinicians—have been identified as key factors impeding treatment recovery in patients with depression (van Grieken et al., 2014).

Norcross and Cooper (2021) have suggested three possible mechanisms by which preference work may contribute to positive change. First, *matching effects*: Patients may have some sense of what works, and does not work, for them, such that treatments guided by these insights may be of improved benefit. Second, *choice effects*, whereby patients may feel more positive as a consequence of being offered options (Handelzalts & Keinan, 2010; Hartogs et al., 2013). Third, *alliance effects*, whereby preference work may increase a sense of collaboration, help patients to feel a stronger bond to their psychotherapists, and enhance alignment on the goals and tasks of psychotherapy. Although evidence is limited here, Heinonen et al. (2022) found that patients had significantly higher alliances where the reported presence, or absence, of unhappy childhood experiences was matched to the form of psychotherapy (long-term psychodynamic versus solution-focused, respectively). From a more discursive perspective, Sutherland et al. (2013) have argued that preference work leads to outcomes through a process of negotiation between psychotherapist and patient. This involved the coordination of actions and dialogues to arrive at shared understandings of outcomes.

Data have also emerged on the types of psychotherapy preferences that people tend to have. In terms of treatment preferences, evidence suggests that the majority of both the general public and those entering treatment prefer CBT over insight-based approaches and consider it more credible (e.g., Bragesjo et al., 2004). However, this research also suggests that psychodynamic therapy tends to be seen as more credible by individuals with previous treatment experiences (Bragesjo et al., 2004). Patients tend to prefer psychotherapists who are similar to themselves in identity and personality (Anestis et al., 2021; Burckell & Goldfried, 2006; Murphy et al., 2004; Russell et al., 2022). Research has indicated wide variations across patients in activity preferences. However, on average, people tend to want direction from their psychotherapist in the form of skills, goals, and structure, as well as encouragement to express their emotions (Cooper et al., 2019; Cooper et al., 2022).

The aim of our study was to advance an understanding of preference work in psychotherapy: building on what is currently known and discovering important aspects of preference work that have yet to be considered. We hoped to develop a more complete understanding of issues essential to optimizing the effectiveness of preference work in psychotherapy. To achieve these aims, we chose to examine preference work from the perspective of patients: those who are intimately involved with the processes and effects of these practices. As Fuertes and Nutt Williams write (2017), "there is much more to understand about psychotherapy if the perspective of the client is given greater emphasis" (p. 369). Key research questions guiding our analysis were: What are patients' preferences, what are their origins, and how might these preferences change over the course of psychotherapy? How are preferences worked with in psychotherapy and what patient and psychotherapist activities might promote, or hinder, this work? And, what are the effects of working, or not working, with patients' preferences?

Method

Design

To facilitate a rich and detailed examination of preference work, as it naturally occurred in

psychotherapy, we adopted a qualitative design. Specifically, we chose consensual qualitative research (CQR; Hill, 2012), a well-known and rigorous qualitative method. CQR allowed us to closely examine a small number of cases, use semi-structured interviews so that researchers could nimbly gather data based on participants' responses, and obtain multiple perspectives during data analysis by using both a research team and an auditor. CQR data gathering relies on open-ended questions so that participants' responses are not constrained by a particular theoretical perspective or unduly narrow focus.

Epistemologically, CQR is "predominantly constructivist, with some post-positivist elements" (Hill et al., 2005, p. 197). Regarding constructivism, CQR recognizes that research participants may have multiple, subjectively-experienced versions of the "truth," each of equal validity. It also recognizes the mutual influence of researcher and participant during the data collection process—as well as between researcher and data during analysis. Along more post-positivists lines, however, CQR holds that certain phenomena do exist as "in-the-world" events and processes; and that there may be commonalities in participants' experiencing of such phenomena. A striving for consensus among research team members is also central to the process of data analysis: integrating multiple perspectives to co-construct the best possible (i.e., most accurate) representation of the data.

Participants

Patients. The study was conducted at a no-fee university psychotherapy research clinic where patients were offered up to 24 sessions of *pluralistic* psychotherapy for depression. To be offered psychotherapy at this clinic, individuals needed to (a) be at least 18 years old, (b) have a Patient Health Questionnaire-9 score consistent with a diagnosis of depression (PHQ-9 $\geq$ 10; Kroenke et al., 2001), and (c) not have a severe mental health condition (e.g., drug and alcohol addictions, psychosis, or severe personality disorders).

We aimed for between 12 and 15 participants, as recommended by CQR, to achieve some consistency in results across participants (Hill & Nutt Williams, 2012). Our sample consisted of all clinic patients participating in an exit interview between 27 March 2019 and 16 June 2020 ($N = 13$) (after which there was a lull in recruitment to the clinic due to COVID-19 restrictions). All of these 13 patients had planned endings. In addition, during this time period, three patients terminated psychotherapy in an unplanned way and, as they did not attend exit interviews, were not included in the study. In addition, during this time period, one individual was assessed for psychotherapy but excluded as their PHQ-9 score was less than 10.

Ten of the 13 participating patients were members of the local community (77%), and three were referred from the university's student wellbeing service (23%). Ten of the patients identified as female (77%) and three as male (23%). Ages of the patients ranged from 21 to 64 years old, with a mean of 36.7 years old ($SD = 18.0$). Eight patients identified as White British, and five as of "Any Other White" ethnicity. On average patients had 23.8 ($SD = 0.8$) sessions of psychotherapy.

At baseline assessment (within a month of starting treatment), patients had a mean score of 17.1 ($SD = 5.0$) on the PHQ-9 (Kroenke et al., 2001), which is in the moderately severe depression range. Their mean score on the GAD-7 measure of anxiety (Spitzer et al., 2006) was 13.7 ($SD =$ 4), which is in the moderately severe anxiety range. At endpoint, five of the patients showed clinical improvement on the PHQ-9 (score ≤ 9; Gyani et al., 2013), two of whom also showed clinical improvement on the GAD-7 (score ≤ 7; Gyani et al., 2013). Two further patients showed clinical improvement on the GAD-7 but not the PHQ-9; and six patients showed neither clinical improvement or deterioration on the PHQ-9 or GAD-7.

Psychotherapists. The 13 patients were seen by one of six psychotherapists, each of whom saw between one and four patients. Five of the psychotherapists were female and one was male; two identified as White British, three as any other white, and one as Black British. One of the psychotherapists was fully licensed, four were trainees in a doctoral program in counseling psychology, and one was a trainee on a master's program in counseling. All trainees were either in the penultimate or final year of their studies. The psychotherapists had been trained in person-centered, psychodynamic, and cognitive-behavioral treatment methods. The clinical team included the first author, who saw one patient. At the domaining and coring stages, the first author was excluded from analysis of data from their patient.

Reflexivity. All five researchers were academics in the fields of counseling psychology or clinical psychology. Two researchers were based in the US, two in the UK, and one in Scandinavia. Three researchers were female and two were male; all were of White European ethnicity. Steps were taken to ensure the scientific rigor and trustworthiness of results throughout the analysis; and, in particular,

to bracket the influence of our own biases and expectations (Hill, 2012). To achieve this, we began the study by reflecting upon our own assumptions. Each member of the team wrote down our personal responses to questions about our own experiences of preference work as patients (if we had had psychotherapy), how we felt about preference work, how we anticipated participants might respond to the research questions, and any personal biases. We then discussed our answers with each other.

All of us who had had psychotherapy said that we did not have clear preferences when we entered treatment for the first time. However, we reported positive experiences of preference discussions and accommodation in psychotherapy, and some negative experiences related to a lack of preference accommodation. Some of us described preference accommodation happening implicitly in their therapy. In terms of biases or expectations regarding how patients would respond, three of us said that, given the quantitative research we have conducted on client preferences and pluralistic psychotherapy, we expected to find that, for most of the patients, preference work would be described as beneficial. Two of us also said that we expected significant variation in the preferences that clients held; as well as variations in the impact of accommodating, or not accommodating, them. Regarding the majority of our research questions, however, we did not hold any clear expectations or biases.

The CQR process involved monitoring, reflection, and collaborative, open discussions of these biases and expectations at all stages of the analysis. This served to reduce tendencies towards unreflected theory- and expectancy-driven decisions. For instance, to counter a potential bias towards viewing preference work positively, we were particularly careful, when "domaining" and "coring" (see below), to identify any negative effects of preference work as well as positive ones.

Interview Schedule

The finalized semi-structured interview schedule began with an introduction in which the researcher described the purpose of the interview (see Supplemental Material 1). Patients were then asked about their overall experiences at the clinic and what they had found helpful and unhelpful in the psychotherapy. Next, to help focus the interview in a way that was relevant to the research aims, we introduced patients to the notion of "preferences" and asked what they understood by this term. The interviewer then explained how the term was being used in the present study. This initial guide to the concept/phenomenon of preferences is in line with the epistemological underpinnings of CQR; and a way of ensuring methodological integrity and utility (Levitt et al., 2017) while not biasing—in response to our questions—the answers that we received. Patients were then asked about their initial preferences when they came into psychotherapy. Once a preference had been identified, patients were asked a series of open-ended questions with regard to this preference, with follow-up probes. Key questions for this study were "Where do you think this preference might have come from?" "How, if at all, did this preference change over the course of therapy?" "To what extent was this preference (a) elicited/discussed and (b) accommodated in the therapy?" "What facilitated this elicitation/discussion/accommodation, if anything?" "What hindered this elicitation/discussion/accommodation, if anything?" and "How did this elicitation/discussion/accommodation affect you?" Once discussion of this preference had been exhausted, the researcher asked patients about other preferences and the process was repeated.

Procedure

Intervention. Pluralistic therapy for depression (PfD) is a collaborative–integrative psychotherapy structured around patient–psychotherapist metatherapeutic communication: moments of shared decision-making in which therapist and patient discuss—and agree on—the goals, tasks, and methods of the psychotherapeutic work (Cooper & McLeod, 2007, 2011; Cooper et al., 2015; McLeod & Cooper, 2012). As such, pluralistic psychotherapy specifically aims to assess, and accommodate, patient preferences—striving to optimize patient engagement in psychotherapy. In pluralistic psychotherapy, patient preferences are assessed on an informal, ongoing basis, and also through the use of the Cooper-Norcross Inventory of Preferences (C-NIP, Cooper & Norcross, 2016) at assessment and review points (Sessions 4 and 10). PfD consisted of a 90-minute face-to-face assessment session followed by up to 24 sessions of one-to-one psychotherapy. All psychotherapy was face-to-face except in two cases where COVID-19 restrictions meant that patients had to complete it online. These patients did not report any alterations in their experiences of preference work as a result of these changes.

Interviews. Three pilot interviews were conducted by the first author with clinic patients at exit interview between 10 January 2019 and 7 February 2019, leading to several significant revisions to our interview schedule. For the main study,

Table I. Preference themselves: domains and categories.

	Frequency/#
Preference Content	
In-session preferences	
What patients wanted	
Psychotherapist style	
Leadership, challenge, or input	Typical/10
Warmth, affirmation, or relatedness	Typical/7
Flexibility or attunement	Variant/6
Psychotherapy process	
Develop strategies or skills	Variant/6
Focus on specific time period	Variant/6
Be listened to, have space to talk or explore	Variant/6
More or longer psychotherapy	Variant/3
Other	Variant/5
What patients did not want	
Psychotherapist style	
Passive, disengaged, or withholding	Typical/7
Rejecting	Variant/2
Psychotherapy process	
Focus on specific time period	Variant/3
Exercises or worksheets	Variant/3
Other	Variant/6
No strong preferences regarding some in-session elements	Variant/6
Preference related to psychotherapist demographics	
No strong preferences regarding some psychotherapist demographics	Variant/6
Age and experience	Variant/3
Gender	Variant/2
Preference Origins	
Personal history, characteristics, or circumstances	General/13
Patient knowledge of, or beliefs about, self	Typical/10
Current struggles	Variant/6
Experiences in past relationships	Variant/5
Personal research or knowledge about psychotherapy	Variant/3
Other	Variant/2
Present psychotherapy	General/12
What patient learnt about themselves in psychotherapy	General/12
What patient found helpful in psychotherapist's interventions	Variant/5
New external situation	Variant/3
Other	Variant/4
Past psychotherapy	Typical/11
Unhelpful experiences	Typical/8
Helpful experiences	Variant/6
Past psychotherapy did not influence some preferences	Variant/2
Changes in Preferences over the Course of Psychotherapy	
Some preferences did not change	Typical/11
Leadership, challenge, or input	Typical/7
Specific temporal foci	Variant/2
Gender of psychotherapist	Variant/2
Other	Variant/6
Some preferences changed	Typical/9
Specific temporal foci	Variant/4
Towards more emotional expression	Variant/2
Other	Variant/3

Note. Total $N = 13$. Italic text = categories and subcategories.

approximately two-thirds of the interviews were conducted by the second author and one-third by the first author. All participants were informed about the purpose, content, and anonymity of the interviews, as well as how their data would be used and their right to withdraw. Interviews were conducted with participants within one month of ending psychotherapy and lasted for approximately 90 min. Ten interviews were conducted face-to-face and three via video communication. All interviews were audio recorded and transcribed by the second author. Any potentially identifying information was removed from the transcript, and each participant was assigned a code number to further their anonymity.

Data Analysis

Data were analyzed according to CQR methods (Hill, 2012; Hill & Knox, 2021; Hill et al., 2005). Team members worked collaboratively to co-construct an understanding of the data, integrating their multiple perspectives. Based on their initial reading of the data, and guided by the research questions, the primary team (the first four authors) developed overarching *domains*. These were topic areas that covered all of the data across cases. Once all data were placed into these topic areas, the primary team developed *core ideas* to capture the essence of the data in each domain for each patient. Here, the essential meaning of each chunk of data, as we understood it, was captured into its core idea(s), staying as close to patients' words as possible. As before, the primary team came to consensus as to the wording of the core ideas. Following the coring of three transcripts, we split the primary team in two sub-teams to work separately on the coring of the remaining transcripts. Each sub-team then *audited* the other teams' consensus versions (i.e., the domained and cored data) internally before sending it to the external auditor (the fifth author) for review. Auditing, both internally and externally, consisted of providing detailed feedback on the coherence, structure, and organization of the analysis; which auditees then had the option of incorporating into a revised analysis. For example, the external auditor proposed that several of the core ideas coded under "Other" in the domain "Preference origins" could, in fact, fit within particular categories; and this was revised accordingly. The research team discussed all of the external auditor's feedback and revised the consensus versions accordingly. Finally, the research team completed a *cross-analysis* of the data, in which we identified categories that emerged from the core ideas across

cases within each domain. The cross-analysis was then sent again for external auditing, the audit was discussed, and the cross-analysis was revised accordingly.

Results

In presenting the findings, we followed CQR guidelines in labeling category frequencies (Hill, 2012). Thus, *general* categories refer to 12 or 13 cases, *typical* categories refer to 7–11 cases, and *variant* categories refer to 2–6 cases. Findings that emerged in only a single case were not included. Tables I–III present the complete findings for all categories and subcategories where $n \geq 2$. Data for a final superordinate category, Other, are not presented in narrative or table format and consisted of just four text units. In addition, the analysis had a section on "contextual" findings (e.g., Patient Definition of Preferences), which is available as Supplemental Material 2.

Table II. Process of working with preferences in psychotherapy: domains and categories.

	Frequency/#
Communication of Preferences	
How or By whom?	
Explicitly	General/12
Patient initiated	Typical/8
Psychotherapist initiated	Typical/7
Via measures	Variant/6
Other	Variant/5
Did not occur or did not remember it occurring for some preferences	Typical/7
Implicitly	Variant/5
Patient held themselves back from expressing preference	Variant/2
When communication occurred	
Initial sessions	Variant/6
Regularly	Variant/4
After initial sessions	Variant/3
Other	Variant/2
Accommodation of Preferences	
Were accommodated	General/12
Leadership, challenge, or input from psychotherapist	Variant/5
Developing strategies or skills	Variant/5
Specific temporal foci	Variant/3
Flexibility or attunement	Variant/2
Listened to, space to talk or explore	Variant/2
Patient did not want exercises or worksheets	Variant/2
Other	Variant/4
Were not accommodated	Variant/6
Wanted leadership, challenge, or input from psychotherapist	Variant/2
Wanted more or longer therapy	Variant/2
Other	Variant/3
Factors that Facilitated Preference Elicitation, Discussion, or Accommodation	
Psychotherapist actively asking and encouraging	Variant/6
Other	Variant/2
Factors that Inhibited Preference Elicitation, Discussion, or Accommodation	
Patient inhibition	Variant/5
Nothing	Variant/4
Other	Variant/3

Note. Total $N = 13$. Italic text = categories and subcategories.

Preferences Themselves

Our first superordinate domain concerned the nature of patients' preferences: what they were, where they came from, and whether they changed over the course of psychotherapy (Table I).

Table III. Effect of preference work and its absence: domains and categories.

	Frequency/#
Effect of Eliciting, Discussing, or Accommodating Preferences	
Positive effect	General/13
Benefitted psychotherapy process or relationship	General/12
Patient felt safe, comfortable, trusting, or accepted	Typical/8
Patient felt listened to or responded to	Typical/7
Methods and activities experienced as helpful	Typical/7
Increased patient engagement or motivation with psychotherapy	Variant/6
Enabled patient to try something new or different	Variant/6
Provided psychotherapy a sense of direction or focus	Variant/5
Psychotherapy felt more collaborative or equalizing	Variant/4
Other	Typical/8
Positive intrapersonal effect on patient	General/12
Insight or learning	Typical/8
Positive emotions (e.g., joy, happiness)	Variant/6
Self-confidence, self-empowering, or regaining control	Variant/4
Greater self-compassion	Variant/3
Other	Variant/3
Negative effect	Variant/3
Led to patient concerns about effective use of psychotherapy time	Variant/3
Patient realized it was an unhelpful preference	Variant/2
Effect of Not Eliciting, Discussing, or Accommodating Preferences	
Positive effect	Variant/5
Patient insight or learning	Variant/4
Negative effect	Variant/5
Patient frustration	Variant/3
Led to patient concerns about effective use of psychotherapy time	Variant/3
Other	Variant/2
Patient adjusted preferences or accepted non-accommodation	Variant/4

Note. Total $N = 13$. Italic text = categories and subcategories.

Preference content

In-session preferences. *What patients wanted.* In terms of preference content, patients typically indicated that they preferred a psychotherapist style that offered leadership, challenge, and input. For instance, one patient said that they wanted a psychotherapist who would push them to "go straight into the difficult stuff … someone who is going to call you out on that bullshit." Patients also typically described wanting a psychotherapist style that was warm, affirming, relational, and caring. For instance, one patient said that they wanted a psychotherapist who would be "validating" and "affirmatory," "someone to tell me that I'm not stupid." Variantly, patients described wanting a psychotherapist style that was flexible and attuned to them, someone who would be responsive to their needs or issues at particular points in time.

With regard to preferences related to the process of psychotherapy, four variant preferences emerged. First, patients wanted to develop strategies and skills, such as "prevention techniques" for not relapsing back into depression. Second, they wanted to focus on specific time periods, specifically the present or the past. Third, patients wanted to be listened to, have space to talk, or to explore. Fourth, they wanted more or longer psychotherapy.

What patients did not want. Typically, in terms of the psychotherapist style, patients said that they did not want someone who was passive, disengaged, or withholding. One patient, for instance, said that sometimes just being listened to could be "a bit of a rabbit hole," which could mean they would be "opening a box and looking in and getting some topics out," but then just leaving those topics, "on the table." Variantly, patients did not want a psychotherapist style that was rejecting, for instance by being homophobic. In terms of the process of psychotherapy, two variant categories emerged: Patients did not want a specific temporal focus (in each case, talking about the past); and patients did not want exercises, worksheets, or other techniques associated with CBT.

Preferences related to psychotherapist demographics. As a variant category, patients indicated that they did not have strong preferences for psychotherapist demographics, such as gender, age, or marital status. However, two variant preferences did arise: Some patients wanted a psychotherapist who was older and experienced, and some patients wanted a psychotherapist who was female.

Preference origins. *Personal history, characteristics, circumstances*. Patients generally described the origins of preferences in terms of their own personal qualities and experiences. Such preferences were typically based on patients' knowledge of, or beliefs about, the self. As an example, one patient preferred not to have goals in psychotherapy because they saw themselves as "not very good at goal setting." Another patient knew that they had a tendency to avoid things, and therefore wanted a psychotherapist who would push them a little bit, to help them take the step of: "Okay, I'm going to work on myself, I'm going to address these things." As a variant subcategory, patients also noted that their preferences arose from current struggles and issues, for example, if an immediate crisis arose that they wanted to focus on. Experiences in past relationships emerged as a third, variant source of preferences, whether positive (e.g., one patient wanted to go straight into emotions because they were used to doing so with their mother) or negative (e.g., one patient wanted a female therapist because this patient had a history of hurtful relationships with men). Finally, patients' preferences variantly were based on personal research, or knowledge, about psychotherapy. For instance, one patient's preference for focusing on the present and future came from listening to online lectures of Jordan Peterson, whom they understood as a proponent of such an approach.

Present psychotherapy. Generally, patients also attributed the origins of their preferences to events or learnings during the current period of psychotherapy. A general subcategory here was things they had learnt about themselves during the psychotherapy. One patient, for instance, said that they came to appreciate a more exploratory approach as the psychotherapy progressed: "I am quite a solutions-based person, but I've realized it's not a solution-based thing in the sense that [the psychotherapist] can't tell me what to do." As a variant subcategory, patients also attributed their preferences to things they had found helpful in the psychotherapist's interventions. For instance, one patient found it helpful when their psychotherapist brought up "values" and then wanted to work on this preference more; another patient found that, as their psychotherapist became more challenging, they preferred a more challenging style of intervention. Finally, new external situations, concurrent with the present psychotherapy, were also a variant source of preferences. For instance, one patient's preference for working with tasks became more intense as they approached the ending of university, as they needed to work out what to do next in their lives.

Past psychotherapy. Typically, patients also attributed the origins of their preferences to past experiences of psychotherapy. For instance, one patient did not want a psychotherapist who was too "over the top"

with positive affirmations (such as "'Be kind to yourself'") because they had hated it when a previous psychotherapist had done that. Another patient wanted input and engagement from their therapist because they had felt frustrated in a past therapy that was "too open-ended." As a variant category, patients also said that their preferences arose from helpful experiences in past psychotherapy, most commonly being challenged, using CBT methods such as psychoeducation, and keeping a food diary.

Changes in preferences over the course of psychotherapy. Typically, patients reported that preferences did not change over the course of psychotherapy. For instance, one patient said that, although the issues that they talked about changed, "the preference [for psychotherapist guidance] would stay the same throughout." As with this patient, as a typical subcategory, patient desires for psychotherapist leadership, challenge, or input did not change. For instance, another patient noted that their preference for psychoeducation had not changed over the course of psychotherapy. As variant categories, patient preferences for specific temporal foci, and for a psychotherapist of a particular gender, also did not change over the course of psychotherapy.

Equally typically, however, patients also reported that preferences had changed over the course of psychotherapy. For instance, one patient's preferences, "changed quite dramatically because it went from looking towards the past to just having to deal with the present." As with this patient, as a variant subcategory, patients' temporal foci changed (e.g., from initially wanting to focus on the present to now wanting to focus on the past, or vice versa). In a second variant subcategory, patients wanted more emotional expression as psychotherapy progressed.

Process of Working with Preferences in Psychotherapy

Our second principal superordinate domain concerned patients' experiences of preference work in the psychotherapy process: how preferences were communicated and elicited, whether or not they were accommodated by the psychotherapist, and the factors that facilitated and inhibited preference work (Table II).

Communication of preferences. In terms of how preferences were communicated, and by whom, patients generally said that such communication was done explicitly in the psychotherapy. As a typical subcategory, patients reported that they had initiated this communication. For example, one patient reported that, in their first meeting with their psychotherapist, the patient had said, "there's a lot that I need to talk about … it would be beneficial for me to tell you everything that has happened." In another typical subcategory, however, patients also reported that this communication about preferences was initiated by their psychotherapists. For instance, one patient reported that their psychotherapist would ask them at the start of most sessions, "What do you want to talk about?" Variantly, communication of preferences was initiated through the use of the C-NIP.

In terms of when this explicit communication of preferences occurred, three variant categories emerged. Such communication took place in the initial, intake session; occurred regularly (e.g., every few sessions, at the start of regular sessions); or occurred after initial sessions (e.g., halfway through the sessions).

Typically, patients reported that the communication of some preferences did not occur, or they did not remember it occurring. For instance, one patient, on being asked whether their psychotherapist had known that they did not want to talk about their childhood, responded, "No, I don't think so." Variantly, and as a subcategory, patients described holding themselves back from expressing preferences: For example, they feared that they would offend their psychotherapist, or that their preferences would be rejected.

Finally, patients variantly noted that the communication of preferences occurred implicitly. Patients reported, for instance, that their psychotherapist "picked up" on their preference without it specifically being spoken about, or used their "instincts" to gauge the patient's reaction to what was going on in psychotherapy.

Accommodation of preferences. Generally, patients said that their preferences had been accommodated in psychotherapy. For instance, one patient, at the start of psychotherapy, had told their psychotherapist that CBT did not work for them. They reported that the psychotherapist had been, "spot on with that, she never pushed it [CBT] and to her credit believed me upfront." Preferences that had been accommodated, all as variant subcategories, were leadership, challenge, or input from psychotherapist; developing strategies and skills; specific temporal foci; flexibility or attunement; feeling listened to, space to talk, or explore; and not wanting exercises or worksheets. Variantly, patients also reported that some preferences were not accommodated, including wanting leadership, challenge, or

input from psychotherapist; and wanting more, or longer, psychotherapy.

Factors that facilitated or inhibited preference elicitation, discussion, or accommodation. Patients variantly reported that the psychotherapist actively asking and encouraging them to express their preferences facilitated the elicitation and discussion of preferences. Variantly, patients reported that their own discomfort, reluctance, or inexperience in expressing their preferences, for example, fearing that they would "insult" or "burden" their psychotherapist, inhibited the elicitation or discussion of preferences.

Effect of Preference Work or Its Absence

Our third principal superordinate domain concerns the effect of preference work, as well as the effect of its absence (Table III).

Effect of eliciting, discussing, or accommodating preferences. *Positive effect*. Generally, patients said that doing preference work had a positive impact. Such impacts yielded two general subcategories: benefits to the psychotherapy process or relationship, and positive intrapersonal effects on the patient.

Benefitted psychotherapy process or relationship. Typically, patients said that preference work led them to feel safer, more comfortable, more trusting, and more accepted in psychotherapy. For instance, one patient, whose preference was to not go into a past traumatic experience, said that she would have felt very "disrespected" by the psychotherapist if the psychotherapist had tried to push her to talk about her trauma.

Typically, patients also reported that preference work made them feel listened, or responded, to. For instance, one patient said that having a preference accommodated:

> [M]ade me feel … listened to and that we were working on things together and, like a partnership, and she [the psychotherapist] would give her feedback and her ideas, and I'd give mine and I think it made it in some ways more collaborative.

Typically, patients also said that having their preferences accommodated facilitated progress because it increased the perceived helpfulness of the specific therapeutic methods or activities. With respect to their preference for being "pushed" to confront difficult things, for instance, one patient said: "I think it very much helped with the outcomes … because in therapy you can just not bring up stuff that you don't want to, or shouldn't, talk about. I wasn't let off the hook, which is what I wanted."

In addition, four variant categories also emerged here. First, patients noted that the preference work increased their engagement with, or motivation for, psychotherapy, including their willingness to stay in psychotherapy. Second, patients reported that preference work enabled them to try something different, or new, in psychotherapy, for example, talking about the present, which one patient felt they could not do with other people. Third, patients stated that preference work provided them with a sense of direction or focus, for example, that they were "trying to achieve certain things" and "going somewhere." Finally, patients reported that preference work led them to feel that the therapeutic relationship was more collaborative or equalizing, for example, the relationship was "collegiate" in which they and their psychotherapist were "figuring it out together."

Positive intrapersonal effect on patient. Typically, patients said that preferences work led to insight or learning. By having their preference for an engaged psychotherapist style met, for instance, one patient said that, "there's lots of things that [the psychotherapist] has said that will stay with me." Three variant subcategories emerged here as well. First, patients experienced preference work as enhancing their feelings of self-confidence, self-empowerment, or regaining a sense of control. One patient, for instance, said that having their preferences for a female psychotherapist and focusing on the present, being listened to, and accommodated helped them feel empowered. Second, patients reported that having their preferences accommodated led to positive emotions, such as joy, whether immediately or by the end of psychotherapy. Third, patients said that preference accommodation had led to greater self-compassion, for example, they were kinder and more positive to themselves.

Negative effect. Variantly, patients said that preference work had a negative impact, further specified via two variant subcategories. First, preference work led to concerns about effective use of psychotherapy time, for example, that patients were "wasting time" by having their preferences accommodated, because it was not what led to helpful activities. Second, patients said that the preferences that they had initially indicated, and that were accommodated, turned out to be unhelpful. For instance, one patient who indicated a preference for exploration then felt overwhelmed and "a bit depressed" to realize how many problems they had uncovered via the exploration.

Effect of not eliciting, discussing, or accommodating preferences. Variantly, patients described positive impacts of not having their preferences elicited, discussed, or accommodated. As a variant subcategory, patients noted insight or learning that arose from such non-accommodation. One patient, for instance, described it as "very powerful" to be gently pushed into a psychotherapeutic activity (writing a letter) against their initial preference. Another patient, whose preference had been to have more sessions of psychotherapy, felt that psychotherapy was "kick started" when they realized that the psychotherapist was not going to accommodate this preference.

Patients also variantly described negative impacts of not having their preferences elicited, discussed, or accommodated, as further reflected in two variant subcategories. First, patients felt frustrated. One patient, for instance, described feeling frustrated because their desire for clarity and direction in the psychotherapeutic work was not met. Second, patients expressed concerns about effective use of the psychotherapy time. One patient, for instance, said that they were "convinced" that the psychotherapy would have been more helpful if their preference for homework and suggestions for reading had been accommodated.

Discussion

While the existing research on preference accommodation in psychotherapy illustrates generally positive effects (e.g., Swift et al., 2019), our in-depth qualitative investigation suggests a more nuanced, complex, and individualized picture. All of our patients reported that, in at least some ways, preference work was beneficial; and were generally satisfied with their therapists' willingness to take their preferences seriously. However, some patients reported negative effects, and benefits also accrued when preferences were not accommodated. Thus, we must be cautious in adopting a "black-and-white" understanding of the effects of preference work: It is neither wholly helpful nor wholly hindering, but useful in relation to particular preferences for particular patients at particular times (cf., Paul, 1967).

A common criticism of preference work is that patients may not know what their preferences are or have preferences that are unproductive (Norcross & Cooper, 2021). Our findings suggest that these concerns reflect genuine challenges. However, patients and psychotherapists were able to find ways of working together to address them. For example, patients described episodes in which their psychotherapist was able to support them to engage in activities that, to that point, did not correspond to their stated preferences.

Understanding the specific mechanisms through which preference work may have effects may be the most productive means of identifying when and where it may be most beneficial. Our findings provide particular support for alliance effects (Norcross & Cooper, 2021). Patients indicated that preference elicitation, discussion, and accommodation benefitted their relationship with their psychotherapists, helping them feel safer, more listened to, and leading to a relationship that felt more collaborative. This increase in the alliance would then be predicted to have positive effects on clinical outcomes (Fluckiger et al., 2018; Zilcha-Mano, 2017). However, we also found some support for matching effects, with patients typically indicating that the specific methods or activities that the psychotherapists adopted, as a consequence of preference work, were of enhanced helpfulness. Evidence in support of choice effects was more minimal, with just one variant category of enhanced self-empowerment as a result of preference work.

Our study examined, for the first time, factors that may facilitate or inhibit preference work—a critical question when striving to optimize practice. We found, however, only one meaningful category for both facilitative and inhibiting factors: Patients saw their psychotherapists as having an active role to play in eliciting preferences, and identified their own lack of confidence and willingness to communicate as a principal inhibitor. These findings are consistent with research in the shared decision-making (SDM) field, where factors increasing the amount of SDM include "buy-in" and explicit support and encouragement from clinicians, while barriers include a lack of patient knowledge and confidence (The Health Foundation, 2012). This finding suggests that psychotherapists should be proactive in exploring patients' preferences, as will be discussed further below.

Understanding the sources of patient preferences was another original area of discovery for this study. Patients spoke of preferences emerging from their own lives and self-understandings. However, such preferences could either be a reflection of what they believed worked for them, or what they believed they needed to do differently. This suggests that patients may value both "capitalizing" and "compensatory" aspects of treatment (Rude & Rehm, 1991): recognizing the potential of both for good outcomes.

As with quantitative studies of preferences using the C-NIP, we found wide variations in preferences across patients (Cooper & Norcross, 2016; Cooper et al., 2019; Cooper et al., 2021). However, as with previous literature, a majority of patients indicated preferences for an active, therapist-led psychotherapist style, as

opposed to a more patient-led, unstructured approach. This qualitative finding provides important triangulation for quantitative evidence. Furthermore, this preference for a therapist-led style appeared relatively consistent over psychotherapy, even when working with psychotherapists who were predominantly trained in more client-led (i.e., person-centered and psychodynamic) approaches. Patients also tended to want a warm, relational, and attuned psychotherapy style. This combination of psychotherapist qualities—dominant and affiliative (in terms of the interpersonal circumplex, Wiggins, 1979)—bears some similarity to the characteristics of "supershrinks," as identified in the therapist effects research field (e.g., Anderson et al., 2009).

Limitations

General limitations to our study are the lack of ethnic diversity amongst researchers, psychotherapists, and patients. This lack of diversity across patients meant that we could not triangulate findings on the preferences of participants to marginalized ethnic groups. In addition, our design meant that we excluded the perceptions of patients who dropped out of treatment, and whose preferences may be different from completers. We studied preference work within the context of just one form of psychotherapy, and one that specifically encouraged psychotherapists to assess and accommodate preferences. Thus, we must be cautious about generalizing from our findings to other psychotherapeutic approaches. The semi-structured nature of our interview schedule also meant that not all patients were asked all questions to the same extent, which may have affected our frequency counts (e.g., those participants with more preferences may have contributed disproportionally to the data).

Another potential limitation of this study is the risk of confirmatory bias: "proving" what we already believed to be true about preference work. Potentially, this bias could have affected the questions that we asked (and how they were asked), our process of analysis; and patients may also have felt subject to demand characteristics (i.e., feeling obliged to "talk up" the value of preference work, knowing that this was the focus of the pluralistic intervention and research program). As the participants were all completers of a pluralistic intervention, it is also possible that they were positively disposed towards preference work. However, we believe that this risk was mitigated in several ways. First, we conducted a highly rigorous process of data analysis with extensive triangulation and auditing across experienced researchers. An initial process of reflexivity also helped ensure that our own assumptions and biases were bracketed, as far as possible, from the analysis process. Second, this bias, even if it were present, would only have affected findings in one of our principal domains: the *Effect of eliciting, discussing, or accommodating preferences*. For our other domains, such as the nature of patient preferences, their origins, and factors that facilitated and inhibited preference work, we reflexively identified no *a priori* assumptions or biases. Third, as can be seen in our analysis, several of our findings are contrary to any "pro-preference work" bias.

Additional limitations of this study are that we did not distinguish between the impact of the process of preference work (i.e., patients' in-session experience of having their preferences elicited, discussed, and accommodated) and the impact of the outcomes of preference work (i.e., what happened as a result of getting particular preferences met). We also did not gather information on patients' previous episodes of psychotherapy; and did not obtain participant consent for "member checking," which could have helped to validate our findings and further guard against confirmatory biases. Our sample size limited our ability to identify differences across patients, as well as the impact of differing levels of preference strengths. Interviewing patients about their preferences after psychotherapy had ended (rather than, for instance, before or during psychotherapy) increases the risk that recollections will be erroneous or biased. However, it has the advantage that patients' experiences of preferences, within the context of their psychotherapy as a whole, can be reported on. By focusing on patients' perceptions alone, we may have failed to fully capture the co-created, inter-relational nature of preference elicitation, assessment, and accommodation.

A final important limitation of this work is that we did not compare patient perceptions across good and poor outcomes. Our understanding of what is helpful and unhelpful in preference work, therefore, is limited to patients' subjective perceptions, and does not necessarily relate to the "objective" outcomes of psychotherapy. For instance, while seven of our 13 patients indicated that they preferred a warm relational style, it is possible that the expression, and accommodation, of this preference is actually associated with poorer results. Even if this were the case, however, as we state in our Introduction, patients' subjective perceptions and experiences are an important area of understanding in their own right.

Implications for Practice and Training

Despite these limitations, given the frequency with which patients indicated positive effects to

preference work, our findings lend support to the practice of preference elicitation, discussion, and accommodation in psychotherapy, as well as to training clinicians in these skills. Such work may be particularly important at the start of psychotherapy as a means of establishing the therapeutic alliance and fostering patient engagement. In addition, given the identified alliance effects, preference work may be of particular value at times of therapeutic ruptures. Psychotherapists should be alert, however, to the possibility that preference work may not always be beneficial. Nuanced application, tailored to each patient and each preference, remains important to maximize benefits.

We note, as well, that a majority of patients preferred a more therapist-led psychotherapy style, as well as one that was interpersonally affirming. Given the triangulation with previous literature, practitioners may find it useful to reflect on the extent to which their psychotherapeutic style matches such preferences. Explicit elicitation and discussion of the patient's preferences, early in psychotherapy, may help address any mismatches, maximizing the likelihood of a strong therapeutic alliance developing.

Our identification of three key origins to preferences may serve a useful clinical function in helping psychotherapists, educators, and researchers develop more comprehensive systems for preference elicitation. For instance, at assessment, patients might be asked the following questions: (a) "Based on your personal history, characteristics, or circumstances, are there things that you know work, or do not work, for you in trying to deal with problems?" (b) "Are there things you have learned from previous episodes of psychotherapy (if any) about what you find helpful or unhelpful in psychotherapy?" In addition, during psychotherapy (for instance, at regular review points), patients might be asked, (c) "Is there anything that you have learned about what works for you here in psychotherapy that you would like to do more, or less, of?" These questions would add to pre-existing preference elicitation tools, such as the C-NIP (Cooper & Norcross, 2016) and the Therapy Preference Interview (Vollmer et al., 2011). Our categorization of patients' in-session preferences into a 2 × 2 taxonomy (i.e., What they do want/What they do not want × Psychotherapist style/Psychotherapy process) could also serve as the basis for preference elicitation strategies.

Conclusions and Future Directions

Our study makes an original contribution to identifying factors that may facilitate, or inhibit, preference work, as well as the origins of patients' preferences. We have also generated rich data that can illuminate the possible mechanisms through which preference work may have effects. We recommend that the findings from this study should now be followed up through large-scale surveys—quantitative as well as qualitative—to assess their generalizability. Further qualitative investigations into each of our domains and subdomains (for instance, Changes in Preferences over the Course of Psychotherapy) could also serve to deepen understandings and clinical recommendations. Another fertile area for research is the association between patient perspectives on preference work and clinical outcomes. This question could be examined through either quantitative research—as with, for instance, Cooper et al.'s (2021) multilevel analysis of the relationship between C-NIP scores and clinical outcomes—or through comparisons of sub-group responses in qualitative research (e.g., recovered versus unchanged cases, completers versus non-completers). For a study of this latter type, Hill and Nutt Williams (2012) advise larger sample (e.g., 15–19 participants). Longitudinal qualitative studies, with interviews at multiple time points over the course of psychotherapy, would also be helpful in deepening an understanding of the processes and effects of preference work—particularly if combined with an analysis of clinical outcomes.

Future studies should be constructed in such a way that heterogeneity across patients can be honored and strengths of patient preferences can be taken into account. Studies that examine preference work as a co-created phenomenon—using, for instance, conversational analytic methods (e.g., Cantwell et al., 2021) or interviews with patient–psychotherapist dyads—could also serve to deepen and extend an understanding of these processes.

Swift et al. (2019) wrote, "Qualitative research into patients' experiences of expressing preferences in psychotherapy and having those preferences honored or not has the potential to become a fertile area of psychotherapy research, with significant implications for practice" (p. 167). We believe that our study shows this to be the case. Not only does this qualitative study significantly extend the large body of quantitative research on the outcomes of preference work and the nature of patients' preferences that already exists, it also provides rich, nuanced, and multifaceted answers to several other important questions. Most significantly, perhaps, our findings have the potential to stimulate a wide range of further qualitative, as well as quantitative, enquiries into patient

preferences. Ultimately, such research may help clinicians, educators, and researchers develop more effective, sophisticated, and personalized ways of tailoring psychotherapy to the unique needs and wants of each individual patient.

Ethical Approval

This study was approved under the procedures of the University of Roehampton's Ethics Committee (now entitled the Research Integrity and Ethics Committee).

Informed Consent from Participants

Participants provided informed written consent to take part in the research prior to the commencement of the study.

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Disclosure Statement

MC co-developed the C-NIP and receives a licensing fee for its commercial use. The C-NIP is in the public domain for individual users under the license CC BY-NC-ND 4.0.

Supplemental data

Supplemental data for this article can be accessed doi:10.1080/10503307.2022.2161967.

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