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# Understanding Attitude Towards Help Seeking in Predicting Preference for Psychotherapeutic Orientation

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UNDERSTANDING ATTITUDE TOWARDS HELP SEEKING IN PREDICTING  
PREFERENCE FOR PSYCHOTHERAPUETIC ORIENTATION

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Doctor of Philosophy  
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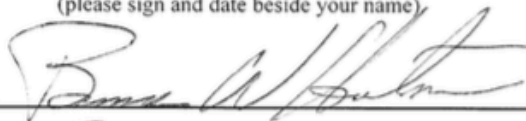
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## Abstract

This research examined the extent to which people's dispositional qualities predict their psychotherapy preferences. Additionally, this study examined the extent to which people's attitude toward seeking professional psychological help would predict their psychotherapy preferences above and beyond their dispositional characteristics.

An online survey was administered to participants ( $N = 312$ ) for remuneration. Personality traits were measured using the HEXACO-60, attachment styles were measured using the Relationships Questionnaire (RQ) and Experiences in Close Relationships Scale- Short Form (ECR-S), attitude toward help seeking was measured with the Attitude Toward Seeking Professional Psychological Help Scale – Short Form (ATSPPHS-SF), and psychotherapy preferences were measured by the Preferences for Psychotherapy Approaches Scale – Revised (PPAS-R) and the Counseling Approach Evaluation Form (CAEF).

Hierarchical regression results revealed that certain personality traits and attachment styles were significant predictors of psychotherapy preferences. In particular, results showed that those who scored higher in agreeableness tended to prefer psychodynamic psychotherapy, where as those who with higher levels of education as well as individuals identifying as gay or lesbian demonstrated a stronger dislike of psychodynamic psychotherapy. No predictive associations were found for person-centered therapy preference. Finally, with regard to people's attitude toward help seeking, it was found that participants who endorsed being more open to seeking psychotherapy demonstrated a stronger preference for CBT. These findings are discussed relative to other studies in this line of inquiry and implications for further research are presented.

**Keywords:** personality, psychotherapy, theoretical orientation, preference

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## CHAPTER I

### INTRODUCTION

Each year, New York magazine releases a new issue titled, “New York’s Best Doctors.” One thousand three hundred doctors were listed in the 2016 issue. In this publication, doctors are listed according to specialization, categorized in alphabetical order from adolescent medicine to vascular surgery (nymag.com, 2016). Interestingly, while psychiatry is listed as a specialization, psychology is not.

How do people go about selecting the right physician considering the myriad of options? First, having specific physical symptoms in need of attention is one of the narrowing factors that enable people to select a category of medicine. After categorical selection (i.e. foot pain equals podiatry), might be personal or professional recommendations: word of mouth about who is the best for a particular problem. Perhaps the soon-to-be patient does his or her own research on the statistical effectiveness of a particular doctor in treating said diagnosis. For many individuals, however, the doctors that they choose to visit can simply be a matter of convenience (i.e. who is in-network or who is closest to their location).

Physician selection can be quite a complex process when considering all of the possible factors that support the decision. Depending on the potential patient, this decision could be quick and easy, or it could be extended and complex. Some people will go to great lengths to find the right doctor for them. Take, for instance, the case of Ian Turner, whose pulsatile tinnitus was cured by a doctor 3000 miles away from his location in Cambridge, England (Innes, 2013).

Ian was suffering from a rare kind of tinnitus that is a sequela of an intracranial problem—often a vascular malformation causing an interruption in the blood flow from the heart to the head (McFerran, 2010). In the case of Ian Turner, his perceptual disturbance was so severe that he was contemplating suicide. Researching different specialists, Ian found Dr. Maksim Shapiro of NYU Langone Medical Center. After sending Dr. Shapiro the MRA scans of his head and neck, Dr. Shapiro emailed the scans back to Ian’s treating physicians (who initially said that nothing could be done to help Ian) with arrows pointing to the exact locations requiring surgery. Ian’s story has a positive ending as the surgical procedure worked to cure his pulsatile tinnitus (Innes, 2013). Had Ian not advocated for himself, done his own research, and refused to give up, he might never have been cured of the loud, omnipresent pulsating sound in his ear.

Of the many notable facets of Ian’s story, one that the article repeats often—likely in an effort to demonstrate the gravity of his problem—was the fact that his pulsatile tinnitus eventually led him to have suicidal ideation. Indeed, highlighting his suicidal thoughts gives readers a perspective on the extent to which his medical issue affected him.

Ian’s story is a poignant demonstration of the degree to which a person will search for the right physician for him or herself, and stories like his are not uncommon. If a person would go to such great lengths to cure his or her physical ailment, then why would not one put the same effort into finding the right psychologist? Interestingly, it was not until Ian experienced a psychological consequence of his physical ailment—suicidal ideation—that he was motivated to seek additional help. Surely a psychological disorder can be every bit as severe as a physical malady. This is not to suggest, however, that psychological and physiological disorders are distinct. Conversely, each often has interacting effects with the other. Why then, would not New

York Magazine include psychologists in their list of best doctors? Perhaps, this is because it is difficult to explain what makes one psychologist objectively better than another. Could one begin to even answer the question of what makes one psychologist better for a particular client than another? Before endeavoring to answer this question, it is necessary to look at the research regarding what makes for good therapy in the first place.

Psychotherapy efficacy studies have often shown that various theories have proven to be about equally effective in therapy (Benish, Imel, & Wampold, 2008; Wampold, Mondin, Moody, Benson, & Ahn, 1997). The concept of theoretical equivalence captured by the term *dodo-bird effect*, made popular by Luborsky, Singer, and Luborsky (1975), has been debated by some who have stated, essentially, that it is impossible to truly compare the efficacy of various psychotherapies because of conceptual and statistical limitations (Crits-Christoph, 1997; Howard, Moras, Brill, Martinovich, & Lutz, 1996). More recently, there seems to have been agreement that the common factors inherent in many therapeutic approaches account for therapeutic efficacy over and above specific treatment methods (Wampold, 2010). The process by which these common factors are made more salient in some therapeutic dyads as opposed to others is one that has partially been addressed in research concerning client preferences in therapy, and it is often attributed to the therapeutic relationship (Wampold, 2010).

Clarkin (2012) has pointed out that successful treatment outcomes in psychotherapy are largely dependent on both clients and therapists. Specifically, the interactive process and the therapeutic alliance between the psychologist and client is critically important in determining psychotherapeutic efficacy. Moreover, he iterated that there is not one single approach to the process of establishing an alliance, since both client and therapist differ individually with regard to how they relate to others. Clarkin (2012) has explained that the way the therapeutic

relationship is co-constructed greatly determines whether or not treatment continues and the degree of success of treatment outcomes. His point about individual differences between clients and therapists is an important consideration that is revisited later in this chapter.

The effectiveness of a particular psychologist in establishing a strong therapeutic relationship may not be as clearly measurable as the effectiveness of a medical doctor in treating a physical ailment. For instance, the process of treating a broken clavicle should not change from one patient to another across cultures, varied personality characteristics, or socioeconomic variation, because these intrinsic qualities alone have limited (if any) influence on a person's physiology. Simply put, a physician can be effective treating a broken clavicle regardless of the cultural distinctions with which a patient presents. However, in psychology the multitudes of multicultural elements that describe a person mediate the process of therapy and the concordant effectiveness of psychotherapeutic approaches (Beutler et al., 2004; Clarkin, 2012). For example, as Beutler and colleagues (2004) have pointed out, therapists may use more directive techniques successfully with clients who are open to learning, whereas clients who are more defensive may respond better to exploratory therapeutic approaches.

While research has identified the difficulties in assessing the effectiveness of one psychotherapeutic modality over another (see Bergin & Garfield, 1994; Howard et al., 1996; Kisch & Kroll, 1980; Lafferty, Beutler & Crago, 1989), certain elements have been empirically shown to positively influence the therapeutic process and outcome. One such ingredient is therapeutic alliance (Barber, Connolly, Crist-Christoph, Gladis, & Siqueland, 2000; Horvath, 2005; Horvath & Luborsky, 1993; Martin, Garske, & Davis, 2000).

### **Therapeutic Alliance**

The concept of *therapeutic alliance* arguably dates back to the early work of Freud (as cited in Horvath & Luborsky, 1993), who described the process of transference between the client and therapist as a sympathetic understanding leading to a positive attachment on the part of the client toward the therapist. Building on this, the object-relations theorists described therapeutic alliance as a process wherein the client—as part of therapy—forms a positive, need-gratifying relationship with his or her therapist (Horvath, 2005; Horvath & Luborsky, 1993). However, it was in 1965 that Greenson (as cited in Horvath & Luborsky, 1993) coined the term *working alliance*. Greenson (1965, as cited in Horvath & Luborsky, 1993) distinguished working alliance from Freud's *transference* when he pointed out that alliance “is more of a conscious process, whereas transference is unconscious” (p. 563). Furthermore, a strong alliance was described as a paradigm wherein both client and therapist share mutually endorsed goals and positive personal attachment based on mutual trust, acceptance, and confidence (Horvath & Luborsky, 1993). Horvath and Luborsky (1993) pointed out that many variations of the terms (working alliance, therapeutic alliance, helping alliance) have been used, and that they all essentially describe the same concept.

Since Greenson (1965), several studies have demonstrated the powerful influence of the therapeutic alliance on outcomes of therapy (see Barber, Connolly, Crist-Christoph, Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Horvath, 2005; Horvath & Luborsky, 1993; Martin, Garske, & Davis, 2000). To illustrate, Martin et al.'s (2000) meta-analysis of 79 studies that had been completed over an 18-year span found a significant, moderate, positive ( $r = .22-.23$ ) relationship between therapeutic alliance and therapy outcomes, regardless of variation in moderating variables, such as type of outcome measure used, client's presenting problem(s), time of alliance assessment, and type of treatment provided. These results are meaningful

because, as Martin and colleagues (2000) have stated, irrespective of psychological intervention, if a strong alliance is created between client and therapist, clients are likely to experience a positive therapeutic outcome. More specifically, the strength of the therapeutic alliance is directly predictive of therapy outcome.

The findings of Martin et al. (2000) were further reinforced by research done by Barber and colleagues (2009), who examined therapeutic alliance as a predictor of the treatment outcomes of 86 clients who presented with generalized anxiety, chronic depression, and avoidant and or obsessive-compulsive personality disorder. The results of their hierarchical regression analysis indicated that therapeutic alliance significantly predicted a decrease in depression scores as measured by BDI scores at three different intervals (sessions 2, 5, and 10), with significant beta weights of  $b = -.30$ ,  $b = -.25$ , and  $b = -.33$  respectively).

While it is evident from prior research that therapeutic alliance has a significant effect on outcomes in psychotherapy, the question remains: What accounts for therapeutic alliance? What factors, exactly, are responsible for the creation of this measurable therapeutic effect? Del Re et al. (2012) explored this very question when they asked how the therapist and client each contribute to the therapeutic alliance. In their meta-analysis of 69 studies (a subset of data from that of Horvath and colleagues' (2011) meta-analysis), the researchers examined several moderators of the alliance-outcome correlation in an effort to better understand factors that accounted for alliance. They concluded that while both client and therapist variation exerted an influence on therapeutic alliance, therapist variability had a greater influence with regard to the alliance-outcome correlation, after several potential covariates were controlled (Del Re et al., 2012, p. 642). Del Re et al. (2012) noted the difficulty in establishing causality given that

alliance cannot ethically be manipulated experimentally (p. 643). Del Re and colleagues' (2012) extended DeRubeis, Brotman, and Gibbon's (2005) claim that therapeutic alliance may be accounted for not only by the client and therapists' contributions, but also by the match of client and therapist. The construct of therapist-client *match* is one that is integral to this line of inquiry, and it is revisited throughout this dissertation. As previously mentioned, Wampold (2010) highlighted the importance of common factors that transcend theoretical nuances to account for therapeutic efficacy vis-à-vis alliance. While considering common factors in therapy is of obvious importance in understanding therapeutic alliance, no known research to date has examined the extent to which clients' dispositional characteristics may influence the successful emergence and implementation of common factors in treatment. While it has been shown that therapists differ in their ability to form alliances with various clients, the question remains: What exactly accounts for therapeutic alliance?

### **Accounting for the Alliance**

Clarkin (2012) argued that it is problematic to say that one approach in psychotherapy is the "right" approach even for the same diagnosis across people. Rather, since therapists and clients vary, "the process of therapy takes on a life of its own" (Clarkin, 2012, p. 57). With such variability, how could a client ever make a decision regarding the therapist with whom he or she will be able to form the strongest alliance? Conversely, how can a therapist set the stage for the strongest possible alliance?

Research has been conducted on the role of client preferences with regard to the development of therapeutic alliance and help-seeking behaviors among people seeking psychotherapy. Specifically, prior research has shown client preferences to be an important



moderator of help-seeking behavior, therapeutic alliance formation, and resultant therapeutic efficacy (Berg, Sandahl, & Clinton, 2008; Cabral & Smith, 2011; Elkin et al., 1999; Glass, Arnkoff, & Shapiro, 2001; Holler, 2007; Swift & Callahan, 2010; Swift, Callahan, Ivanovic, & Kominiak, 2013).

Elkin et al. (1999) found that when client preferences for treatment were congruent with the therapeutic approach used, clients were more likely to remain in therapy and developed a stronger alliance early in treatment. More recently, research by Berg et al. (2008) examined the treatment outcomes of patients with generalized anxiety disorder and found that treatment preferences exerted a strong transference influence that can be an important component of improving therapy outcomes. Additionally, Elkin et al. (2008) noted that the beliefs and attitudes clients brought to therapy impacted the process and outcome of therapy. Moreover, in a study of clients with eating disorders, Clinton, Bjorck, Sohlberg, and Norring (2004) found that patient treatment preferences were related to treatment satisfaction even at follow-up reviews.

### **Preferences in Therapy**

While much research has investigated client preferences in therapy, the majority of this research examined preferences that were related to the extrinsic variables of race, ethnicity, and gender (Adamson, Sellman, & Dore, 2005; Baird, 1979; Barber, Connolly, Crits-Cristoph, Gladis, & Siqueland, 2000; Berg, Sandahl, & Clinton, 2008; Clinton, Bjorck, Sohlberg, & Norring 2004; Cabral & Smith, 2011; Devine & Fernald, 1973; Elkin et al., 1999; Glass, Arnkoff & Shapiro, 2001; Petronzi & Masciale, 2015; Proctor & Rosen, 1981; Swift & Callahan, 2010; Thompson & Cimboric, 1978). The rationale for examining preferences with regard to these extrinsic variables is that people often associate with others that they perceive to be similar to

themselves (Cabral & Smith, 2011). Moreover, from a sociological perspective, perceived similarity with others can reduce a client's concern that he or she will be stereotyped and can increase the chances that a client will feel comfortable being open with his or her therapist (Cabral & Smith, 2011). Nevertheless, as Cabral and Smith (2011) have pointed out, clients may be disappointed if they are matched to a therapist based upon extrinsic criteria, such as race, alone if, in fact, they have differing values. While perceived similarity can create higher client expectations of therapeutic efficacy, few studies have examined preferences as they relate to the intrinsic or dispositional qualities of people, such as personality traits and attachment styles (Arthur, 2001; Cabral & Smith 2011; Holler, 2007; Petronzi & Masciale, 2015).

Personality traits have been described in previous research in a multitude of ways. For example, a person's level of openness to new experiences, his or her level of honesty, emotionality, extraversion, agreeableness, and conscientiousness are measurable personality traits as defined by Lee and Ashton (2009). Costa (1991) defined personality traits in the five factor model and this definition overlaps with many of the traits listed by Lee and Ashton (2009). Additionally, attachment styles—initially categorized as secure, anxious-avoidant, and anxious-ambivalent—were first noted in research by Mary Ainsworth; who examined the nature of attachment between mothers and their infants (Wade, Tavris, & Garry 2012). At the present time there is a paucity of research that has examined the extent to which attachment styles and personality traits predict preferences for various psychotherapeutic orientations.

Arguably one of the most influential contributions that a therapist brings to the therapeutic dyad is his or her theoretical orientation. While very few clients know the distinctions between the various theories, a therapist's adherence to these diverse orientations—

whether integrated or orthodox—can influence treatment a great deal (Cabral & Smith, 2011). In spite of this important connection to applied practice, the extent to which a client may have a preference for one modality over another has been minimally investigated (Baird, 1979; Elkin et al., 1999; Glass et al., 2001). This may be due to the fact that it is difficult to assess clients' theoretical preferences since they tend to know very little about the distinctions between various modalities (Braaten, Otto, & Handelsman, 1993). While prior research has shown that treatment preference matching yields positive outcomes, few studies have examined what specifically predicts client preferences for various treatment orientations (Berg, Sandahl, & Clinton, 2008; Devine & Fernald, 1973; Glass, Arnkoff, & Shapiro, 2001; Holler, 2007; Joyce & Piper, 1998). Rather, the majority of past research on psychotherapy preferences has investigated the preferences of psychotherapists.

For example, Arthur (2001) conducted an extensive literature review and meta-analysis of studies that investigated how therapists' personalities and epistemological traits explained their theoretical selection (psychoanalytic and behavioral modalities). While his analysis revealed significant associations between dispositional qualities and preferences for one modality over another, these associations were only examined with psychotherapists. Bergin and Garfield (1994) pointed out the importance of examining dispositional or intrinsic client factors with regard to preference. Specifically, they stated, "Rather than argue over whether or not the 'therapy works' we could address the question of whether or not 'the client works'!" (p.826). It is important to note that these researchers were not suggesting an all or nothing interpretation of preference alignment to explain outcomes, but rather they were suggesting that the process of therapy is dynamic and collaborative in nature. Therefore, it would behoove applied researchers to examine the extent to which people's dispositional qualities (such as personality traits and

attachment styles) influence their therapeutic preferences. Cabral and Smith (2011) suggested that future research more systematically examine the constructs of cognitive matching (described further in Chapter II), rather than matching clients to therapists via more extrinsic variables such as race and ethnicity.

While Arthur (2001) and others have demonstrated the dispositional correlates of psychotherapy preferences in a sample of therapists, fewer studies have examined this line of inquiry using client (or potential client) populations (Scandell, Wlazelek, & Scandell, 1997). In a study by Ogunfowora and Drapeu (2008), significant associations were found between psychology students' personality traits and their preferences for three different psychotherapeutic orientations. Moreover, in a study by Holler (2007), personality factors were again found to be predictive of preferences for psychotherapeutic orientation. Holler's (2007) study, like the other studies, used a sample of students from two different universities; however, his sample differed from others in that the students were not specifically studying psychology. Only Petronzi and Masciale's (2015) investigated a representative community sample with no specific inclusion criteria (beyond being 18 years of age or older and English speaking). Interestingly, the findings with the non-professional populations revealed some results that overlap with the aforementioned studies with regard to the extent to which certain personality traits predicted preferences for various psychotherapeutic modalities. To date, no research has examined the preference characteristics that distinguish clinical from non-clinical populations (i.e. individuals in treatment versus individuals not in psychotherapy).

### **Statement of the Problem**

There are a few problems with the research regarding the dispositional correlates of people's psychotherapeutic preferences. In over 50 articles found searching psychinfo, using the keywords *psychotherapy* and *preference*, only the study by Holler (2007) specifically examined potential clients personality traits for their predictive associations with therapy preference. While Petronzi and Masciale (2015) extended this line of inquiry by adding attachment styles as a dispositional construct, the issue remains that across studies the associations of personality traits with preferences have been found to be small to medium (e.g.  $r = 0.10$  to  $.30$ ). Because only one study has examined attachment style as a dispositional construct, more research is needed to fully elucidate the extent to which attachment can be utilized in research to predict people's psychotherapy preferences.

While the present study utilized the wellness perspective of psychology—wherein all people could be potential clients—there has yet to be an examination of actual clients in therapy (or people thinking about entering). Recall that the participants in both Holler's (2007) and Ogunfowora and Drapeu's (2008) studies consisted of college students. In 2011, the National College Health Assessment (ACHA, as cited in Colloway, Kelly, & Ward-Smith, 2012) indicated that 46% of college students felt hopeless, 85% felt overwhelmed, and 61% felt depressed, and yet only 6.8% reported seeking mental health services. The following question is raised: If one chooses not to, or is unlikely to seek treatment, might he or she be as likely to express preference for one therapeutic modality over another? Perhaps the same or similar factors that hinder people from seeking professional psychological help might also hinder them from distinguishing their preferences for various psychotherapeutic modalities.

Research has shown that a lack of knowledge about therapy, an emphasis on self-reliance, negative perceptions of the efficacies of mental health professions, and even depression can act as barriers to professional help seeking (Gulliver, Griffiths, & Christensen, 2010; Kravitz et al., 2010; Oliver, Reed, Katz, & Haugh, 1999; Staniford, Dollard, & Guerin, 2009). While demographic information, cultural background, and prior experience with therapy, as well as prior study of psychology have all been examined as factors that could potentially influence a person's preference for various psychotherapies (Glass, 2001; Holler, 2007; Petronzi & Masciale, 2015; Sobel, 1979), research has yet to examine attitudes toward help-seeking in relation to therapy preferences.

### **Purpose of this Study**

The purpose of this study was twofold: First, to expand on research examining the extent to which people's dispositional characteristics—personality traits and attachment styles—predict their psychotherapeutic orientation preferences. Second, this study sought to determine if people's attitude toward help-seeking accounts for variance in their psychotherapeutic preferences above demographic and dispositional variables.

### **Research Questions and Hypotheses**

Research question 1. Do personality traits and attachment styles predict psychotherapeutic preference above variance accounted for by demographic variables?

Research question 2. Does attitude toward help seeking account for variance in psychotherapy preference over and above variance accounted for by demographic variables, attachment styles, and personality traits?

Hypothesis 1. Personality traits and attachment styles will significantly predict psychotherapeutic preference above demographic variables.

Hypothesis 2. Attitude toward help seeking will account for variance in psychotherapy preference over and above demographic variables, personality traits, and attachment styles.

### **Definitions**

*Demographic variables.* In this research the demographic variables consisted of age, gender, level of education, socioeconomic background, racial/ethnic background, prior experience with psychotherapy, rating of their psychotherapy experience, and prior study of psychology (see Appendix G for full demographics form).

*Psychotherapeutic preference distinction.* It is important to note that the present research asked not only if a person preferred one therapeutic modality over another, but also the strength of the preference. In this study, the extent to which one showed a significant preference for one therapeutic modality over another was referred to as *preference distinction*.

*Therapeutic modality.* Also referred to as *therapeutic orientation*—this construct encompasses key elements of theory as they pertain to case conceptualization and treatment approach in the practice of psychotherapy. For the purposes of this study, psychodynamic, humanistic, and cognitive-behavioral theoretical modalities were delimited for use because of their prevalence in the literature and in applied practice (Ogunfowora & Drapeu, 2008; Petronzi & Masciale, 2015).

According to Sharf (2011), psychodynamic psychotherapy aims at resolving unconscious conflicts within clients and encouraging insight by reconstructing, interpreting, and analyzing

childhood experiences. Humanistic therapy concentrates on human potential, creativity, and, in the person centered approach (which was utilized for this dissertation) emphasizes unconditional positive regard, empathy, and genuineness in the therapeutic process (Sharf, 2011; Wade, Tavis, & Garry 2012). Lastly, cognitive-behavioral therapy focuses on addressing faulty beliefs and or ways of thinking and behaving that lead to negative emotional and affective outcomes (Sharf, 2011; Wade, Tavis, & Garry 2012).

*Intrinsic qualities.* In this study, intrinsic qualities are the dispositional attributes of a person as defined by personality traits and attachment styles.

*Extrinsic qualities.* For the purposes of this study, extrinsic qualities are directly observable demographic groupings, often perceived as categorical qualities that can lead to stereotyping. For instance, gender and race are two qualities from which people may overestimate differences between different groups of people and underestimate differences within the same or similar groups of people. It is important to note that I am not suggesting that race and gender are not hugely influential multicultural elements that can influence dispositional variation in people, rather the examination of dispositional variables in this study were those pertaining to more covert characteristics than observable as extrinsic qualities.

*Personality traits.* For the purposes of this study, personality was defined as Honestly/Humility, Emotionality, Extraversion, Agreeableness, Conscientiousness, and Openness to Experience, which are dimensions of the HEXACO-60 (discussed in greater detail in Chapter III).

*Attachment styles.* In this study, attachment styles were defined by the extent to which one scored high on avoidance and or anxiety (Fraley, 2000). While the attachment styles were



statistically examined on continuous dimensional terms (described further in Chapter III), they are described theoretically and practically in terms of the four categorical quadrants defined by Bartholomew and Horowitz (1991) as: secure attachment (i.e. comfortable with intimacy and autonomy), dismissive attachment (i.e. dismissive of intimacy and strongly independent), preoccupied attachment (i.e. preoccupied with relationships), and fearful attachment (i.e. fear of intimacy and socially avoidant).

*Attitudes toward help seeking.* For the purpose of this research, attitudes toward help seeking were defined as the extent to which one is open to the idea of seeking professional psychological help.

## CHAPTER II

### REVIEW OF LITERATURE

Research shows a linear association between a person's preferences of theoretical orientation and therapy outcomes. However, to date a direct causal link has not been established in research. We know that a person's preferences for the extrinsic qualities of a therapist (e.g., race and gender) can influence therapy outcomes (Harrison, 1975; Swift & Callahan, 2013), however, a person's preference for therapeutic orientation has yet to be investigated in association with therapy outcomes. Before drawing conclusions about the extent to which psychotherapeutic orientation preferences effect therapeutic efficacy, it is essential to determine if different people do, in fact, prefer different therapeutic orientations and on what basis. This question has been minimally investigated (Holler, 2007; Ogunfowora & Drapeu, 2008; Petronzi & Masciale, 2015).

Determining if different people prefer different therapeutic orientations is important to counseling and clinical psychology for two reasons. First, such an understanding could be a valuable aid for referrals. Currently, there is no formalized process for the entry of prospective clients into therapy: There is no stepping-stone between seeking treatment and selecting a clinician. To ignore the differences various therapeutic modalities have on the therapeutic process and how those variations may or may not work optimally for different potential clients is arguably naïve or willfully ignorant. While fundamentalists of each theoretical framework may believe that their theoretical modality is the "right" one for all clients, psychotherapists know that not every client is the same, and likewise, not every theory espouses the same conceptual formulations and treatment techniques. Norcross and Wampold (2011, p. 131) aptly stated that

the identical psychological treatment for all clients is not only inappropriate but also potentially unethical. Accordingly, different clients require different treatments and relationships in therapy. Norcross and Wampold (2011) further stated that, “matching psychotherapy to a disorder is incomplete and not always effective...particularly absent from much of the research has been the person of the patient, beyond his or her disorder” (p. 127). By examining the client preferences for various psychotherapeutic modalities, this study examines and acknowledges the extent to which methodological and or theoretical differences impact the experience of therapy for different *people*, rather than for different *disorders*. This line of inquiry was an attempt to develop a deeper understanding of optimal client-therapist match by examining how a person’s intrinsic dispositional qualities (i.e. personality and attachment styles) predicted his or her preference for treatment modality.

It is important to acknowledge that some previous research has shown that regardless of theoretical orientation used, treatment outcomes are generally consistent across various modalities (Luborsky, Singer, & Luborsky, 1975; Wampold et al., 1997a). A study by Luborsky et al. (1975) made the “dodo bird conjecture” popular. This conjecture is essentially that all various therapies are about equally effective. Wampold et al. (1997a) further extended this line of inquiry when they stated, “when psychotherapies intended to be therapeutic are compared, the true difference among all such treatments are 0” (p. 203). The therapies they measured were what they called “bona fide psychotherapies” (p.205); meaning that they were delivered by psychologists in training, were based on psychological principles, contained specified components, and were offered to the psychotherapy community through books and or manuals (Wampold et al., 1997).

However, other researchers have debated the validity of the dodo bird conjecture and posited that methodological differences across theories do have varied consequences for different clients in therapy (Crits-Cristoph, 1997; Wampold et al., 1997). Howard et al. (1996) aptly pointed out that clinically meaningful treatment differences are unlikely to be revealed by heterogeneous meta-analyses, and that researchers should question the validity of studies that show no outcome differences across theories. That is to say that the effectiveness of each theory would need to be assessed separately with the same client and measured in a standardized way in order to draw strong comparative conclusions. Since it is impossible to return the same client to his or her baseline state before administering another form of therapy, there are obvious conceptual and pragmatic limitations that render drawing conclusions about the true nature of one effectiveness of one therapy over another impossible.

The second reason that this research is important for counseling and clinical psychology is because understanding whether different people prefer different therapeutic modalities (and on what basis) could be helpful for clinicians who subscribe to integrated theoretical models. For example, if at the beginning of treatment a clinician gives his or her client an assessment that displays the client's theoretical preferences, then the results could potentially aid the clinician's treatment planning and ability to more expediently form a therapeutic alliance with the client (Petronzi & Masciale, 2015).

In Chapter I, therapeutic alliance was discussed as a construct that accounts for successful therapy outcomes (Martin, Garske, & Davis, 2000). The question was put forth; what creates therapeutic alliance? This chapter discusses client preferences in therapy and how they have been linked to therapeutic alliance formation by previous research. One specific focus of this chapter

is to highlight the distinctions between intrinsic (dispositional) and demographic bases of preferences in research. Next, there is a review of literature on intrinsic preferences as measured by the trait constructs of personality and attachment styles, as well as a review of the literature on factors that account for both clinician and client therapy preferences. Finally, the role of attitude toward help seeking is discussed, and a rationale for its inclusion in research examining psychotherapeutic preferences is presented.

### **Intrinsic Versus Extrinsic Based Preferences**

As mentioned in Chapter I, for the purposes of this study, extrinsic characteristics of a person encompass those that are directly observable categorical qualities from which people may stereotype others such as race, ethnicity, and sex. While these qualities can very much define a person, at face value they are denoted mainly by external, physical characteristics. Extrinsic variables largely comprise the criteria in research that has examined client preferences in therapy. Namely, the majority of research concerning people's preferences in psychotherapy has examined their preferences with regard to the gender or racial similarity of client and therapist (Barber et al., 2000; Harrison, 1975). Beyond this, there is also a subset of research that has examined people's preferences for therapy with respect to psychotherapy as compared with psychopharmacological treatment (Barber et al., 2000; Mohlman, 2012). Fewer studies have examined intrinsic or dispositional criteria with regard to client preferences in therapy.

Intrinsic variables describe things that are internal and dispositional with regard to a person's unique characteristics. Specifically, an intrinsic characteristic is something that belongs to the essential nature or construction originating from within ([www.merriam-webster.com](http://www.merriam-webster.com), n.d.). Since intrinsic qualities tend to describe more enduring dispositional traits rather than transitory

characteristics, an examination of these qualities may present more practical implications with regard to the relational process of the therapeutic dyad. For the purposes of this study, intrinsic qualities of personality traits and attachment styles are constructs that are partially influenced by temperament and appear to be relatively stable and across a person's lifespan (Costa, 1991; Holler, 2007; Wade, Tavris & Garry, 2012).

### **Extrinsic Perspectives in Research**

As previously mentioned, research thus far has mainly examined people's preferences in terms of extrinsic characteristics of the therapist. In particular, race and ethnicity have been examined with regard to their influences on client preferences in therapy. Sue, Fujino, Hu, and Takeuchi (1991) investigated the extent to which ethnic match was related to length of time in treatment for clients from Mexican, African American, and Asian American descent. Their findings indicated that ethnic match between client and therapist was a predictor of both treatment duration and treatment outcomes. These findings supported what is referred to as the *cultural responsiveness hypothesis* (Sue et al., 1991, p. 533). Moreover, Atkinson, Ponce, and Martinez (1984) found that the more similar Mexican American immigrants perceived their therapists' attitudes to be to their own, the more they viewed their therapists as competent, and the more willing they were to engage in therapy. Similarly, these effects were found with Asian American clients (Atkinson, Maruyama, & Matsui, 1978). Atkinson et al. (1978) surveyed 52 Asian American university students and found that, for their sample, Asian American therapists were viewed as more credible and approachable than Caucasian therapists. Indeed, these findings are in line with other research that has highlighted the fact that clients tend to prefer therapists of

their own racial background (Harrison, 1975; Proctor & Rosen, 1981; Thompson & Cimboric, 1978).

Beyond the extrinsic variable of race, research has also demonstrated that clients tend to prefer therapists of their own gender. Pikus and Heavey (1996) conducted survey research with 41 male and 75 female therapy clients and found that the majority of these clients preferred therapists of their own gender. When asked why this preference was endorsed, most clients reported that they would feel more comfortable confiding in a therapist of the same gender because he or she would be more likely to understand their particular perspectives (Pikus & Heavey, 1996). Perhaps not surprisingly, the researchers concluded that future research would “benefit from a broader investigation of therapist characteristics that clients may prefer” (Pikus & Heavey, 1996, p. 41).

Cabral and Smith (2011) pointed out that people often presume similarity with others unless differences are brought to their attention. With regard to research that has examined racial matching, it has been found that people may be more likely to assume alignment with a therapist of their own race and gender than another. Further, Cabral and Smith (2011) reasoned that this assumed similarity might encourage greater therapeutic alliance and outcome efficacy as a whole. This assumption prompted a meta-analysis of (a) individuals’ preferences for ethnically matched therapists, (b) clients’ perceptions of ethnically matched therapists, and (c) therapeutic outcomes across ethnic match (p. 537). Their findings indicated that, across 52 studies of psychotherapy preferences, the average effect size (Cohen’s  $d = 0.63$ ) showed a moderately strong preference for therapists of the same race. Additionally, across 81 studies, the effect size ( $d = .32$ ) indicated a tendency for people to perceive therapists of their own race “more

positively than therapists whose race was different from one's own" (Cabral & Smith, 2011, p. 537). Lastly, and perhaps most interestingly, across 53 studies that examined treatment outcomes, there was almost no benefit from racial matching in terms of treatment outcomes ( $d = 0.09$ ) (Cabral & Smith, 2011, p. 537). These findings suggest that matching clients to therapists based on the extrinsic variable of race alone is, as Sue (1998) has stated, neither a necessary nor sufficient condition for positive treatment outcomes. Rather, Cabral and Smith (2011) pointed out that future research should focus on constructs that define "greater cognitive approximation and worldviews between clients and therapists" (p. 545). Arguably the constructs of cognitive match and worldview may be more representative of a person's intrinsic/dispositional characteristics. Albeit minimal, some research exists that more closely evaluates these intrinsic characteristics with regard to therapist/client matching.

### **Intrinsic Perspectives in Research**

Lyddon and Adamson (1992) studied the relationship between a person's dominant worldview (mechanistic or organistic) and preference for three counseling approaches (behavioral, rationalist, and constructivist). They found that a significant interaction existed between worldview and counseling approach. Namely, participants who identified as organists showed a significant preference for constructivist counseling ( $M = 4.81$ ),  $t(58) = 1.97$ ,  $p < .05$ , whereas mechanists significantly preferred behavioral counseling ( $M = 3.76$ ),  $t(58) = 1.88$ ,  $p < .05$  (Lyddon & Adamson, 1992, p. 45).

In addition to worldview alignment and treatment preference, Kelly and Stupp (1992) examined the extent to which client-therapist value alignment had an effect on therapy outcomes. They found that, across 36 therapist-client dyads, those whose values were more similar



demonstrated greater therapeutic alliance and positive overall treatment outcomes ( $r = .45, p < .001$ ), as assessed by improvement in interpersonal impairment (Kelly & Strupp, 1992). A major limitation in their study is the fact that value reports were retrospective. That is, participants reported their value similarity or dissimilarity after therapy was completed. This confound prompts some skepticism with regard to the validity of their results.

Zane et al. (2005) conducted a compelling study that tapped into the construct of intrinsic client characteristics by examining cognitive match between client and therapists prospectively. In their study, the construct of cognitive match between client and therapists was comprised of their perceptions of the presenting problem, coping orientation, and expectations about treatment goals. Zane et al. (2005) used separate and independent sources for their predictors and employed multiple outcome measures to increase the internal validity of their study. They found that cognitive match on treatment goals was predictive of session impact. Namely, cognitive match on avoidance coping was a significant predictor of client comfort in sessions ( $\beta = .21, p < .05$ ) (Zane et al., 2005). Additionally, clients whose views of their problem distress more closely approximated that of their therapists' at pretreatment were functioning better after short-term therapy than client-therapist dyads who held less similar perceptions ( $\beta = .20, p < .05$ ). In sum, Zane et al. (2005) found that higher levels of congruence for therapist-client dyads with regard to avoidant coping orientation and perceived problem distress were significant predictors of therapy outcomes (as measured by session depth, smoothness, and positivity) (p. 581).

Zane and colleagues (2005) posited that these findings furthered an understanding of factors in treatment that enhance our grasp of optimal client-therapist matching. While Zane et al. (2005) noted that, "clients with therapists who are mismatched may be more likely to

terminate and/or feel misunderstood” (p. 582), they did not suggest that therapists adapt their ways of thinking to match the clients’ thought processes (especially if those thought processes are dysfunctional). Rather, Zane et al. (2005) emphasized the extent to which client-therapist matches play an important role in therapy. In examining cognitive matches and worldviews, researchers have begun to more deeply consider the extent to which people’s dispositional characteristics may play a part in therapist-client dyad analysis.

### **Preferences in Therapy**

As per previous findings, it would appear that both intrinsic and extrinsic criteria have an impact in therapy with regard to client-therapist match. Specifically, the extent to which clients feel that therapy meets their intrinsic and extrinsic preferences appears to be of value in terms of therapeutic efficacy. Similar to the study by Zane et al. (2005), Elkin, Yamaguchi, Arnkoff, Glass, Sotsky, and Krupnick (1999) studied what they termed “patient-treatment fit” (p.437) or congruence between the ways in which clients thought about their problems and what form of treatment was most helpful to them (psychotherapy versus psychopharmacology). They found that when client preferences were met in therapy, clients remained in treatment longer and scored higher on measures of therapeutic alliance (Elkin et al., 1999).

Furthermore, Swift and Callahan (2013) examined the effect of client preferences ( $N = 6058$ ) in therapy by using a regression analysis of 33 studies. The result of their analysis was that when client preferences were met in treatment, dropout rates decreased and outcomes improved. Moreover, these effects were found to be consistent regardless of age, gender, ethnicity, educational level, and marital status of the clients (Swift & Callahan, 2013). In their study, treatment preferences extended beyond just comparing psychotherapy versus drug

treatment, but also included preference of therapist treatment modality, therapist role, and therapist extrinsic criteria such as race, age, and gender (Swift & Callahan, 2013). Swift and Callahan's (2013) results were particularly poignant because in controlling for demographic criteria, their findings suggested that "assessing and accommodating preferences in therapy is equally important" (p. 141) for a variety of clients regardless of multicultural elements potentially mediated by demographic variation. From this research, it can be concluded that meeting client preferences in therapy challenges the dodo bird notion that various treatment modalities will produce equivalent outcomes for different clients (Wampold, 1997).

Since client preferences have been shown to play an important role in psychotherapy treatment utilization and therapeutic alliance formation, a deeper understanding of these preferences—especially with respect to dispositional variables such as personality traits and attachment styles—could lead to greater insight on the dynamics of optimal client therapist matching (Petronzi & Masciale, 2015; Swift & Callahan, 2010). While some researchers have examined client dispositional constructs with regard to cognitive match and worldview, these constructs have some distinct limitations.

First, definitions of cognitive match appear to vary across studies (Carr, 1970; Hunt, Carr, Dagadakis, & Walker, 1985; Zane et al., 2005). For instance, in the case of Zane et al.'s (2005) research, cognitive match was not one construct but many. In their study, cognitive match was comprised of problem perception, coping orientation, and treatment goals (Zane et al., 2005). Second, the construct of cognitive match does little to characterize a person's stable and enduring dispositional traits over time. On the contrary, the factors listed by Zane et al. (2005) were said to be influenced by temporal state characteristics, such as change within a person's

immediate social and environmental context (Fraley, Vicary, Brumbaugh, & Roisman, 2011). Similar limitations also apply to worldviews; namely, that there appears to be varying definitions of worldviews in research (Hedlund-de Witt, de Boer, & Boersema, 2014; Rogers, 2011). Additionally, worldviews generally include values and attitudes, which can be shaped by contextual factors (Hedlund-de Witt et al., 2014). The lack of temporal stability and universally accepted descriptions of these constructs limits the extent to which conclusions can be drawn regarding how distinct types of people prefer distinct types of therapy using these constructs to measure preference.

Rather than examining transitory factors that describe the extent to which a person's dispositional characteristics play a role in their therapy preferences, it would behoove researchers to examine trait factors that describe generally enduring characterological patterns and ways of relating with others. Arguably, measuring dispositional constructs with higher temporal stability could lead to more fruitful and clinically significant results with regard to applied research. Indeed, since therapy is a relational process (Larner, 2004), examining personality traits and attachment styles has the potential to contribute more compelling findings because of (a) their extensive and established use in research on relationships, and (b) their ability to describe relatively stable dispositional qualities (Bartholomew & Horowitz, 1991; Chan et al., 2012; Costa & McCrae, 1992, 2006; Fraley 2002; Fraley, Vicay, Brumbaugh & Roisman, 2011; Fraley, Roisman, Booth-LaForce, Owen, & Holland, 2013; Wade, Tavris, & Garry 2012).

While questions have been raised about the stability of personality traits and attachment styles over time (Costa & McCrae, 2006; Fraley, 2002; Roberts, Walton, & Viechtbauer, 2006), by and large, these changes are developmental in nature across specific stages of the lifespan

(Costa & McCrae, 2006; Fraley 2002). It has been found that the greatest changes for personality traits happen from adolescence to adulthood (Costa & McCrae, 1992; Costa & McCrae, 2006; Fraley 2002; Fraley, Vicay, Bumbaugh & Roisman, 2011). For example, Chan et al. (2012) asked a large sample of participants ( $N = 3,323$ ) from 26 countries to rate their perceptions of personality traits across age groups (adolescents, adults, and older adults). They found that participants tended to share similar beliefs about developmental changes in personality traits. For example, adolescents were believed to be more impulsive and open to new experiences, whereas older adults were more conscientious and more agreeable (Chan et al., 2012). While Chan et al. (2012) were looking at people's perceptions of trait change, Costa and McCrae (2006) found that actual trait changes were predictable and consistent across cultures. Costa and McCrae (2006) posited that biologically based "intrinsic maturation" was most likely responsible for age-related personality trait changes and that once people enter adulthood, trait change is modest at best (p. 26). Research has demonstrated that personality traits are not only relatively stable over time, but they are also predictable with regard to dispositional development (Costa & McCrae, 1996, 2006).

Likewise, attachment styles have been found to be moderately stable dispositional constructs (Bartholomew & Horowitz, 1991; Fraley et al., 2011; Scharfe & Cole, 2006). In a study by Fraley et al. (2011), adults were placed in two longitudinal conditions and assessed on attachment. In the first condition, participants ( $N = 203$ ) were assessed daily over a 30-day period and in the second condition participants ( $N = 388$ ) were assessed weekly over a year-long period (Fraley et al., 2011, p. 974). Results revealed that a pattern of stability existed for adult attachment. Interestingly, Fraley et al. (2011) also investigated if the Big Five personality traits (Costa, 1991) explained patterns of attachment stability. They determined that while personality

traits demonstrated a pattern of stability over time they did not account for the stability observed in attachment styles. In other words, attachment styles and personality traits are distinct ways of measuring intrinsic, dispositional characteristics over time.

The idea of predicting people's preferences for something using dispositional trait characteristics is certainly not new to the field of counseling psychology; its roots being in vocational development (Munley, Duncan, McDonnell, & Sauer, 2004; Ott-Holland, Huang, Ryan, Elizondo, & Wadlington, 2013). Indeed, John Holland paved the way with his attempts to match various people with various careers by examining their personality traits (Nauta, 2010). His theory posits that people's congruence between their personality type and work environment type is a determinant of "job satisfaction, stability, and performance" (Nauta, 2010, p. 11). Over half a century later, Holland's work continues to influence counseling psychology and career development (Ott-Holland et al., 2013). As Nauta (2010) aptly noted, "by basing his theory on a limited number of types, operationalizing them with self-scorable instruments, and providing a parallel mechanism for linking person types with environment types, Holland helped to 'give away' an important part of counseling psychology's knowledge" (p. 19). If Holland (1973) was able to find an empirical link between personality types and environment types, why then should not a link be found between personality types and treatment modalities (which could arguably be an environmental change within therapy)?

### **Personality Traits Predicting Psychotherapeutic Preferences**

In describing the applied utility of personality traits measured by the Five Factor Model (FFM), Costa (1991) explained that personality traits could potentially be used to select optimal forms of psychotherapy. A few studies have been conducted with the intent of determining the

extent to which personality traits predicted people's preferences for various psychotherapeutic modalities. As Holler (2007) explained, research on the predictive nature of personality with regard to preference for therapeutic orientation is a "two-way street" (p. 14). One form of this examination looks at how the therapist's personality traits predict his or her preference of theory, whereas the other examination looks at how the client's (or potential client's) personality might predict his or her preference for psychotherapeutic modality (Holler, 2007). The review of literature that follows presents both investigations: how personality traits predict therapists' and clients' preference theoretical orientation.

### **Assessing Therapist Preference**

In the late 1970s researchers such as Walton (1978) began looking at the interaction between personality traits and psychotherapeutic orientation. Walton (1978) was not necessarily looking at predictive associations between these constructs. Rather, he simply looked to see if therapists who adhered to certain theoretical orientations (psychodynamic, rational-emotive, eclectic, and behaviorist) also tended to display specific personality trait themes. Analyses of variance among eight personality factors and the four orientations revealed some specific patterns; namely, psychodynamic therapists viewed themselves as more serious, RET practitioners viewed themselves as more humorous, and behavioral therapists rated themselves lower on intuition (Walton, 1978). Overall, the results led Walton (1978) to conclude that "self-concept variables are related to theoretical orientation" (p. 394).

Tremblay, Herron, and Schultz (1986) further developed this line of inquiry through their examination of the relationship between personality and psychotherapeutic orientation by looking at therapists that adhered specifically to behavioral, psychodynamic, or humanist

perspectives. Expanding on previous work, they explored this line of inquiry which offered a clear and definite focus on the association between a therapist's theoretical orientation and personality. They examined three orientations in particular and described each roughly as follows: (a) behavioral therapists stress objectivity and focus on the present, (b) psychodynamic therapists emphasize the unconscious motives and past experiences, and (c) humanist therapists stress spontaneous expression of feelings and personal relationships in therapy (Tremblay et al., 1978, p. 106). With regard to their personality assessment, they used the 150-item instrument called the Personal Orientation Inventory (Shostrom, 1964). Their results were in line with their hypothesis that separate personality profiles exist for each theoretical orientation (Tremblay et al. 1986). Tremblay et al. (1986) concluded that future research should aim to determine whether therapist-client personality matching affects the outcome of therapy when orientation is considered.

Scandell, Wlazelek, and Scandell (1997) were the first to utilize the Five-Factor Model (FFM) of personality, measured by the NEO-PI-R (Costa & McCrae, 1992), to examine the relationship between the personality traits of therapists and their theoretical orientations. Their findings indicated that the cognitive orientation was significantly correlated with the agreeableness trait ( $r = .42, p < .01$ ), and that humanistic and Gestalt orientations were significantly correlated with the openness trait ( $r = .31$  and  $.38, p < .05$ ). Their findings supported past research demonstrating that different therapists' personality traits were related to their choices of theoretical orientations (Kolevzon, Sowers-Hoagg & Hoffman, 1989; Tremblay et al., 1986; Walton, 1978). However, the extent to which these traits were predictive of psychotherapeutic selection was yet to be investigated.



Arthur (2001) investigated the extent to which cognitive-epistemological traits and personality style patterns were found in psychotherapists that had two different theoretical orientations (cognitive-behavioral and psychoanalytic). Arthur (2001) administered the Millon Index of Personality (MIPS; Millon, 1988) to assess the personality traits of 247 psychotherapists (134 psychoanalytic and 113 cognitive behavioral). Participants were also given the Organicism-Mechanism Paradigm Inventory (OMPI; Johnson, Germer, Efran, & Overton, 1988) and the Psychological Epistemological Profile (PEP; Royce & Mos, 1980) to assess their cognitive-epistemological traits (Arthur, 2001). After accounting for demographic variation, the results indicated that both personality traits and cognitive-epistemological views were significantly different across the two theoretical orientations. Specifically, Arthur (2001) stated that, “personality and cognitive-epistemological factors were found to distinguish various motivational aims, cognitive styles, epistemological beliefs, and, to a lesser extent, interpersonal behaviors” (p. 253). These findings were consistent—albeit with slightly weaker correlations—when experienced versus novice therapists were examined (Arthur, 2001).

Arthur (2001) took the examination of personality and epistemic differences across theories further by looking at how intrinsic, dispositional qualities were related to therapists’ choices of theoretical orientation. Arthur (2001) pointed out the circular importance of this line of inquiry by citing Barron (1978); “Without an understanding of theory we cannot practice knowledgeably. And without an understanding of personality, we cannot understand the source and development of theory” (Barron, as cited in Arthur, 2001, p. 46). Arthur (2001) concluded that because distinct and internally consistent patterns of personality and epistemic traits were found among practitioners who subscribed to different theoretical orientations, it is likely that these styles accounted for the choices of orientation. However, he also noted that some

methodological limitations in his study limited the extent to which firm conclusions could be generalized to all therapists. He suggested that future research be prospective and longitudinal before further, more concrete conclusions could be made regarding the extent to which intrinsic variables predict a therapist's choice of theoretical orientation (Arthur, 2001).

The most recent study to examine the relationship between personality styles and preferences for psychotherapeutic orientation specifically looked at the predictive power that personality traits had on preference of orientation. In their study, Ogunfowora and Drapeau (2008) utilized hierarchical multiple regression analyses to determine if personality traits—as measured by the HEXACO personality inventory (Lee & Ashton, 2004)—were predictive of psychology students' ( $n = 219$ ) and licensed practitioners' ( $n = 274$ ) preferences of orientation as measured by the Theoretical Orientation Profile Scale – Revised (TOPS-R; Worthington & Dillon, 2003). Using the TOPS-R, Ogunfowora and Drapeau (2008) assessed preference for “psychodynamic, humanistic/existential, cognitive-behavioral, family systems, multicultural, feminist, and psychopharmacological theories” (p.153).

After controlling for gender, profession, and degree type, their findings in the practitioner sample indicated that the cognitive-behavioral orientation was predicted by conscientiousness ( $\beta = .20, p < .01$ ); the humanistic/existential orientation was predicted by openness ( $\beta = .25, p < .001$ ) and negatively by conscientiousness ( $\beta = -.14, p < .05$ ); and the psychodynamic preference was predicted by openness ( $\beta = .13, p < .05$ ) and negatively by agreeableness ( $\beta = -.14, p < .05$ ). Multicultural and feminist orientations were both predicted by agreeableness ( $\beta = .19, p < .001$  and  $\beta = .13, p < .05$  respectively) and openness ( $\beta = .14, p < .05$  and  $\beta = .15, p < .05$  respectively). And lastly, the family systems orientation was predicted by agreeableness ( $\beta =$

.16,  $p < .01$ ) and the psychopharmacological perspective was predicted by honest-humility ( $\beta = .15, p < .05$ ) (Ogunfowora & Drapeau, 2008).

For the student sample, similar results were found to that of the practitioner sample. Namely, the cognitive-behavioral orientation was predicted by conscientiousness ( $\beta = .37, p < .001$ ), the humanistic orientation was predicted by openness ( $\beta = .29, p < .001$ ) and negatively by conscientiousness ( $\beta = -.14, p < .05$ ). The feminist orientation was predicted by openness ( $\beta = .23, p < .001$ ). Lastly, family systems orientation was predicted by extraversion ( $\beta = .18, p < .01$ ) and the psychopharmacological perspective was predicted by conscientiousness ( $\beta = .24, p < .001$ ) and emotionality ( $\beta = -.16, p < .05$ ). Ogunfowora and Drapeau (2008) pointed out that in spite of the modest effect sizes, consistent effects over demographic variation were observed across samples—in line with prior research—and thus, their results demonstrate the validity of using personality to predict preference of psychotherapeutic orientation.

Overall, the findings using the psychology student sample and the practitioner sample were congruent. Since personality factors accounted for more variance in preference for the student sample ( $\Delta R^2$  range from .02-.17) than they did for the practitioner sample ( $\Delta R^2$  range from .03-.08), Ogunfowora and Drapeau (2008) proposed that personality factors are more stable for those with more maturity and clinical experience.

As evidenced by the aforementioned results, several researchers have investigated the relationship between personality variables of therapists (or therapists in training) and theoretical orientation. Theoretical orientations, however, have varied across studies, as well as the methods used to assess personality (Arthur, 2000, 2001; Holler, 2007; Kolevzon et al., 1989; Ogunfowora & Drapeau, 2008; Scandell et al., 1997; Tremblay et al., 1986, Walton, 1978). While overall the

results demonstrate that different personality traits are, in fact, associated with different theoretical orientations, the strength of these associations is mixed, particularly when examined in non-practitioner samples (Hensley & Cashen, 1985). For example, Hensley and Cashen (1985) found that psychology students that had no previous experience as clients in psychotherapy did not exhibit significant preferences for one theoretical orientation over another. While this appears to be in direct contrast to Ogunfowora and Drapeau's (2008) findings, it is important to note that Ogunfowora and Drapeau (2008) did not list prior experience in therapy as an observed variable. Indeed, the distinction between how clients view therapy and how practitioners (and those studying to be practitioners) view therapy is of essential importance in this line of inquiry if practical assertions are to be implied.

### **Assessing Client Preference**

There is a paucity of research that has specifically examined the extent to which clients' (or potential clients') personality traits predicted their preferences for one psychotherapeutic modality over another. This section reviews the prior research in counseling and clinical psychology, as well as some analogous vocational psychology work, that specifically sought to examine psychotherapeutic preferences from non-clinician samples.

The earliest known study pertaining to the assessment of preferences for various psychotherapeutic approaches dates back to 1975. In a study by Holen and Kinsey (1975), 57 students were assessed with regard to their preferences and "believed effectiveness" of psychodynamic, client-centered, and behavioral therapy (p. 21). In their study, participants listened to three 15-minute audiotapes of psychotherapy sessions conducted in accordance with the three theories. A different therapist working with the same client—whose chief complaint

was a headache, did each therapy session. Their findings indicated that, overall, participants preferred behavior therapy and believed that it was more effective than both client-centered and psychodynamic therapies. This study had some limitations. The largest limitation, arguably, was the fact that the use of an audio tape of the different therapists for each vignette made it nearly impossible to know if the theory, and not some other confounding variable (e.g. therapist's tone of voice), led participants to make the judgments that they did. While this study began the line of inquiry into potential client preferences of psychotherapeutic modality, there were no assertions made regarding what may have accounted for this preference.

Baird (1979) extended this line of inquiry by using the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1940) in an effort to see whether a person's preference of psychotherapy correlated with personality factors identified by the MMPI. Baird's (1979) sample consisted of 50 undergraduate students (32 females, 18 males). No other demographic variables were listed in the publication of the study. After completing the MMPI, each participant wrote a description of a problem in his or her life, read summaries of five different therapeutic approaches, and lastly, were asked to consider which they thought might be most helpful with their problem. The modalities presented to the participants were behavioral therapy, chemotherapy (a method of therapy unexplained by the author), rational emotive therapy, person centered treatment, and psychoanalytic therapy). Findings were in line with Baird's (1979) hypothesis that people with more neurotic profiles would prefer therapist-directed modalities (e.g. behavioral and rational emotive therapy), whereas individuals with less neurotic profiles would prefer patient-directed approaches (e.g. person centered and psychoanalytic therapy). Of the many limitations in this study, the largest may be the limited generalizability due to the lack of demographic descriptions.

In 1998 personality traits were again examined with respect to treatment selection. Bishop (1998) was the first to utilize the Five-Factor Model (FFM) of the NEO FFI (Costa & McCrae, 1992) to examine if personality traits (measured by the FFM) correlated with preference for counseling approach. In his study, the theoretical approaches consisted of diagnostic interviewing, solution focused therapy, and rational emotive therapy. Bishop (1998) examined 183 university psychology students (57 males, 126 females). Like Baird (1979), the publication for this study failed to report race and ethnicity in demographic information. After completing the NEO FFI, participants viewed three, 5-minute, videotaped sessions of each modality. Lastly, participants were asked to rate their preference of each approach using the Therapeutic Questioning Scale (TQS) (Bishop, 1998). Bishop's (1998) findings indicated that openness was negatively correlated with preference of diagnostic interviewing ( $r = -.26, p < .001$ ) and solution-focused therapy ( $r = -.25, p < .001$ ) (p. 39).

Holler (2007) used a revised version of the NEO called the NEO-PI-R (Costa & McCrae, 1992) to investigate the extent to which personality traits predicted preference for psychodynamic, person centered, and cognitive approaches. Holler (2007) felt that using a more concise and statistically reliable instrument (NEO-PI-R) than Bishop (1979) (NEO FFI) would enable him to find stronger predictive associations between personality traits and preference of therapy.

Holler's (2007) sample consisted of 145 graduate and undergraduate students (107 females, 38 males). Unlike prior published studies in this area, Holler (2007) listed more detailed demographic information and also examined race as a variable that could predict preference. His sample was comprised of 74 African Americans (51%), 64 Caucasians (44.1%), 3 Latinos

(2.1%), and 4 reporting Other (2.8%). Participants began by completing the NEO-PI-R. Next, they completed the Preferences of Psychotherapy Approaches Scale (PPAS-R; Holler, 2007) that asked them to read three, one-page, scripts that described the various psychotherapy approaches and to rate each approach. The results indicated that, after controlling for age, gender, and race, extraversion predicted preference for psychodynamic psychotherapy ( $\beta = .259, p < .01$ ) (Holler, 2006). Interestingly, Holler (2007) also found that race was a predictor of preference. Specifically, “Caucasians were less likely to prefer psychoanalytic and person centered approaches than African Americans” ( $\beta = .280, p < .01$  and  $\beta = .194, p < .05$  respectively) (p. 5).

Petronzi and Masciale (2015) conducted a study that examined how personality traits predicted psychotherapeutic preferences (specifically examining psychodynamic, person centered, and cognitive-behavioral theories). In addition to personality traits, attachment styles were added as a dispositional construct for the first time in this line of inquiry. While attachment has been used extensively in psychotherapy research, it has primarily been examined with respect to therapeutic alliance and efficacy (Gelso, Palma, & Bhatia, 2013; Giannini, Gori, De Sanctis, & Schildberg, 2011; Levy, 2013; Norcross & Wampold, 2011), rather than for its ability to predict people’s preferences for various psychotherapeutic orientations. Interestingly, Petronzi and Masciale (2015) found that attachment styles, in addition to personality traits, predicted people’s preferences for psychotherapeutic modality over and above demographic variation.

Petronzi and Masciale (2015) obtained their sample of participants ( $N = 202$ ) by utilizing amazon.com’s Mechanical Turk survey research platform. Their sample consisted of 136 females (67.3%) and 66 males (32.7%). One hundred and fifty-eight participants identified as Caucasian (78.2%), 23 were African American (11.4%), 8 were Asian/Pacific Islander (4.0%), 6

were Latino/a (3.0%), 5 stated that they were multi-racial (2.5%), 1 was Native American (0.5%), and 1 declined to respond (0.5%). Participants were also asked if they had prior psychotherapy experience, and if they had studied psychotherapy before. Next, participants were asked to read three psychotherapy vignettes (presented in random order) from Holler's (2007) PPAS and to rate their preferences for each therapy vignette using the Counseling Approach Evaluation Form (CAEF; Lyddon, 1989). Following this, participants completed the HEXACO-60 (Ashton & Lee, 2009) and Bartholomew and Horowitz' (1991) Relationships Questionnaire to measure attachment.

The results of their hierarchical regression analysis indicated that openness ( $\beta = .178, p = .02$ ), emotionality ( $\beta = .010, p = .01$ ), extraversion ( $\beta = .102, p = .05$ ), and secure attachment ( $\beta = .228, p = .02$ ) were significant predictors of preference for psychodynamic psychotherapy. Additionally, previous study of psychology ( $\beta = .170, p = .03$ ) and fearful attachment ( $\beta = -.181, p = .05$ ) emerged as significant predictors of preference for cognitive-behavioral therapy. No demographic differences were found with regard to preference for therapy.

As is evident from this overview of studies that examined how personality traits predicted preferences for psychotherapeutic orientations, certain associations have consistently been found. However, different studies have had different results, with modest effect sizes, even when similar variables (e.g. psychodynamic preference) were examined. It is reasonable to conclude that if the problems with the data common to these studies are addressed, then reasons behind the identifiable inconsistencies will be elucidated.

### **Expanding on Prior Research**



The prior research that has measured client preferences has been principally conducted with samples of university students and or self-selected survey participants (e.g., Baird, 1979; Bishop, 1998; Holen & Kinsey, 1975; Holler, 2007; Kivlighan, Hageseth, Tipton & McGovern, 1981; Petronzi & Masciale, 2015; Sobel, 1979). Using potential clients to draw conclusions about how “real” clients might demonstrate preferences in therapy, presents a notable limitation in terms of the validity of these findings. The failure to distinguish between people who are open to the idea of seeking treatment and those who are not is a limitation across all of the studies in this line of inquiry. It is reasonable to assume that if a person is not open to the idea of seeking professional psychological help, then he or she may not be as discerning with regard to distinguishing his or her psychotherapeutic preference.

Interestingly, one trait in particular that accounted for variance in several theoretical preferences across studies was that of openness (Bishop, 1998; Ogunfowora & Drapeau, 2008; Petronzi & Masciale, 2015; Scandell et al., 1997). Research has shown that people who are more open to the idea of psychotherapy are more likely to seek professional treatment for psychological problems than those who are not (Komiya, Good, & Sherrod, 2000; Kravitz et al., 2011; Wilson & Deane, 2001). A good amount of research has explored people’s willingness to seek professional psychological help (see Calloway, Kelly, & Ward-Smith, 2012; Cole, 2014; Gulliver, Griffiths, & Christensen, 2010; Jackson et al., 2007; Komiya et al., 2000; Kravitz et al., 2011; Vanheusden et al., 2008; Vogel, Wade, & Haake, 2006). Some of this work has produced a way of measuring the extent with which a person demonstrates willingness to seek help, or conversely, is averse to seeking treatment (Fischer & Turner, 1970; Vogel et al., 2005).

The Attitude Toward Seeking Professional Psychological Help Scale (ATSPPH; Fischer & Turner, 1970) and the Self-Stigma of Seeking Help (SSOSH; Vogel et al., 2006) are two of

many instruments that tap into this construct. Since openness is a personality trait that has repeatedly accounted for variance in research on psychotherapeutic preference, it would be interesting to see to what extent this trait explains one's psychotherapeutic preference in association with attitude toward help seeking. Particularly as Komiya et al. (2000) have demonstrated, emotional openness is a strong predictor of a person's attitude toward seeking psychotherapy.

To date, the extent to which a person's attitude toward help seeking influences the way he or she demonstrates psychotherapeutic preference has yet to be examined. This appears to be an important piece of the puzzle that is missing from current research. If, for instance, a person is disinclined to seeking treatment, it may be difficult for him or her to distinguish which theory he or she prefers in the first place.

Recall that Hensley and Cashen (1985) found that psychology students who had no previous experience as clients in psychotherapy did not exhibit preference for one theoretical orientation over another, while students who did have some therapy experience showed significant preferences. It may be that the same motivation and or interest prompting people to study psychology might also account for their ability to discern which theory they preferred. By not taking into account a person's attitudes toward seeking treatment in the first place, past studies may not have been as able to adequately assess the variance accounted for in people's preferences for different therapies. In sum, the present study aimed to (a) expand on research examining the extent to which people's dispositional characteristics predict their psychotherapeutic orientation preferences and (b) to determine if people's attitude toward help-seeking accounts for variance in their psychotherapeutic preferences above demographic and dispositional variables.

## CHAPTER III

### METHOD

This chapter describes the inclusion criteria for participants, data screening procedures, and descriptive statistics. Next, operational definitions are provided with a review of the selected instruments. Reliability and validity estimates for each instrument are presented, followed by the procedure participants followed during the study.

#### Participants

In order to participate in this study, participants had to be 18 years of age or older and fluent in the English language. Moreover, upon the recommendation of quality control set by Mechanical Turk (see below), participants needed to have a Human Intelligence Task (HIT) rating of 80% or higher to assure that their work had been consistently validated and approved from their prior participation in work completed on Mechanical Turk.

A non-random sample of self-selected participants was recruited through Amazon.com's Mechanical Turk (MTurk; [www.mturk.com](http://www.mturk.com)). Mechanical Turk is an online labor market for experimental research (Berinsky, Huber, & Lenz, 2012). More specifically, it is a web-based platform for recruiting and paying participants to perform tasks—most often, survey research (Berinsky et al., 2012). Initially intended for political science, MTurk has been increasingly utilized by social scientists (Berinsky et al., 2012).

Once a researcher signs up for an account with MTurk, he or she becomes a *requestor* and can then either create a survey within the MTurk website, or embed a survey from another online survey platform, such as [surveygizmo.com](http://surveygizmo.com) or Qualtrics. Once the survey (or a link to the

survey) is created, the researcher then deposits a bulk sum of money into his or her MTurk account. MTurk then manages the distribution of funds (in the form of credit for purchases on the amazon.com website) to *workers* (participants) once they complete the survey. Thus, participants are remunerated for their participation while retaining their anonymity to the researchers.

Once on MTurk as a worker, participants have the ability to select from lists of multiple jobs or what MTurk calls *HITS*. This study was only one of hundreds of HITs available on MTurk at a given time. This research had a recruitment flier from which participants were presented with the nature of the research and the approximate length of time that they could expect the survey to take them. After reading the recruitment flyer, participants clicked on the web-based survey link, hosted on Surveygizmo.com, where they were directed to study information, including IRB approval and a request for informed consent (see Procedures section that follows). Participants were paid \$0.50 through MTurk for their participation in the study.

Berinsky et al. (2012) validated MTurk as a means of recruitment for use with web-based survey research. They described it as a “promising vehicle for performing low-cost and easy-to-field experiments” (p. 1). Berinsky et al. (2012) assessed the internal and external validity of MTurk first by investigating characteristics of samples drawn from the MTurk population. They found that participants recruited with MTurk, “were often more representative of the U.S. population than in-person convenience samples” (p. 1). Moreover, by replicating findings of previously published experimental research Berinsky et al. (2012) were able to find good concurrent validity using MTurk. Overall, Berinsky et al. (2012) concluded that, relative to convenience samples, MTurk is more representative of the general population, and participants

recruited via MTurk respond to experimental stimuli in a manner consistent with previous in-person research. Because, MTurk has been shown to produce a good representative sample of the general population and preserves the anonymity of participants while still compensating them for their participation, MTurk was a useful recruitment tool for this study. Notably, Petronzi and Masciale (2015) used MTurk to recruit over 200 participants for their study in which Cronbach's alpha scores for several instruments were consistently over .80, demonstrating a high degree of internal consistency in the data.

The planned number of participants was based on an a priori power analysis for regression, which was described by Green (1991) as when the sample size is greater than or equal to  $50 + 8m$ , with  $m$  being the number of predictors. For the present study there were 22 predictors (age, gender, race/ethnicity, sexual orientation, level of education, currently psychotherapy experience, past psychotherapy experience, currently seeking psychotherapy, previous study of psychology, six attachment styles, six personality traits, and finally, attitude toward seeking professional psychological help). Thus, accordingly to Green's (1991) equation, a minimum of 226 participants were needed to achieve ample power.

In addition to Green's (1991) equation, an a priori power analysis was also conducted using G\*Power (Faul, Erdfelder, Lang, & Buchner, 2007) with an alpha level of .05, a small effect size of .09 (consistent with previous findings), and  $1-\beta$  error probability of .80 using linear multiple regression. The total sample size suggested was 259 participants.

### **Data Screening**

As mentioned, inclusion criteria for participation required participants to be over 18 years of age, English speaking, and to reside in the United States. Any surveys completed from domains indicating that people were outside of the US were eliminated ( $n = 7$ ). Additionally, built into the survey's design were three validity check indicators that required participants to click on a specific option at different points throughout the survey. Participants answering any of the validity questions incorrectly (i.e. were asked to click option two of four and clicked three) were eliminated from the final sample ( $n = 4$ ).

Surveygizmo's automated platform indicated that based on the survey length, participants should have taken roughly 18 minutes to complete the study with a minimal fatigue factor. The total sample of  $N = 312$  participants, obtained over a 2-month period, demonstrated a mean completion time of 17.71 minutes with a standard deviation of 10.82 minutes. Time in minutes was converted to standard scores and a positive skew became apparent. Participants completing the survey above or below 3 standard deviations from the mean were removed twice until there were no time-specific outliers ( $\pm 3$  SD from the mean). This was done in order to exclude outliers who may have provided inaccurate data due to either completing the survey much faster or much longer than required for the provision of accurate responses. People who completed the survey too quickly may have answered questions at random, whereas people who took too long may have not been answering with their immediate reaction or feelings in response to the questions as prompted. After the time-based outlier trimming the total sample consisted of 240 participants with a mean survey completion time of 17.65 minutes and a standard deviation of 5.76 minutes. The minimum completion time went from 2.22 minutes to 9.78 minutes, and the maximum completion time went from 100 minutes to 34.53 minutes after the data trimming. Comparing Cronbach's alpha coefficients pre and post data trimming revealed that the reliability

indicators increased across all instruments used in the survey (more specific information on reliability estimates will be presented shortly). Two hundred and forty participants were roughly within the target sample size according to the aforementioned a priori power analyses, therefore data analytic procedures were run with relative confidence that the hypotheses would be tested. After data screening, post hoc observed power as calculated by G\*Power was fairly high for this study; at  $1 - \beta = .95$  with a critical  $F$  of 1.59.

### **Descriptive Statistics**

The final sample consisted of 240 participants: 151 females (62.9%) and 89 males (37.1%). Participants ranged in age from 19 to 75 ( $M = 39.21$ ,  $SD = 13.35$ ). Two hundred and nineteen participants identified as heterosexual (91.3%), 12 identified as bisexual (5%), 8 identified as gay or lesbian (3.3%), and 1 answered other (0.4%). The sample was fairly well educated: 76 participants stated that they had a bachelor's degree (31.7%), 54 had some college experience (22.5%), 35 possessed a master's degree (14.6%), 34 had a high school equivalency (14.2%), 32 had an associate's degree (13.3%), 8 had a doctorate (3.3%), and 1 had less than high school (0.4%). One hundred and eighty-nine participants were Caucasian (78.8%), 16 were African American (6.7%), 13 were Asian American (5.4%), 10 identified as multi-racial (4.2%), 8 were Latino/a (3.3%), 2 were Native American/Alaska Native (0.8%), and 2 did not specify (0.8%).

Included in the demographic information were questions pertaining to participants' experiences with psychology (either as a field of study or as a client of mental health services). Out of the 240 participants, 225 stated that they were not currently in psychotherapy (93.8%), 9 reported that they were currently in treatment (3.8%), and 6 declined to respond (2.5%). One

hundred and forty-two participants endorsed having never previously been in psychotherapy (59.2%), 93 stated that they had previously been in psychotherapy (38.8%) and 5 declined to respond (2.1%). When asked if they were currently seeking treatment, 230 stated that they were not (95.8%) and 10 stated that they were seeking treatment (4.2%). Lastly, when asked if they had ever studied psychology, 101 participants stated that they had not (42.1%), 94 endorsed *yes, a little* (39.2%), 27 endorsed *yes, some* (11.3%), and 18 endorsed *yes, a lot* (7.5%).

## Measures

### Preferences for Psychotherapy Approaches Scale-Revised (PPAS-R)

To assess preference for therapy (or therapeutic preference distinction), this study utilized the combination of two instruments, the first of which is the revised Preferences for Psychotherapy Approaches Scale (PPAS-R; Holler 2007 Petronzi & Masciale, 2015). The PPAS-R consists of three, one-page descriptions of psychotherapy written in the second person by a therapist describing his or her therapeutic orientation (utilizing psychodynamic, person-centered, and cognitive-behavioral theories). The original PPAS (Cheng, 2000) described a psychodynamic, a person-centered, and a behavioral approach to treatment, however, Holler (2007) revised the scale and included a cognitive rather than strictly a behavioral paradigm.

Cheng (2000) validated the original PPAS by asking five licensed clinical psychologists to label the theory presented in each vignette. All psychologists agreed on the theory each vignette represented. Moreover, how well each theory was represented was rated on a 1 to 10 point scale (*1 = lowest, 10 = highest*) (Holler, 2007). The average agreement among the psychologists was 8.4 for the person-centered paradigm and 8.2 for the psychodynamic vignette (Cheng, 2000). In Holler's (2007) revised version, five licensed therapists (three psychologists



and two mental health counselors) rated each of the scripts again (this time with the inclusion of the cognitive vignette). Results for the psychodynamic script averaged 9.0, person-centered 8.6, and cognitive, 9.6). Since the pre-established criterion for acceptable validity was 8.0, the revised version of the PPAS demonstrated both good internal consistency and face validity (Holler, 2007).

Petronzi and Masciale (2015) used the same PPAS-R vignettes in their study, however, they modified the measure to include a total of four questions regarding each preference, whereas the original scale only had one question per theory that asked clients to “rate their preference of each therapist” on a 10-point Likert scale: 1 (*Definitely not prefer*) to 10 (*Strongly prefer*) (p. 8). Petronzi and Masciale (2015) noted that the decision to add additional questions was made with the intent to account for more variance in the psychotherapy preference construct. Thus, the PPAS-R (see Appendix A) used for this study was the same instrument used in Petronzi and Masciale’s (2015) study; it consisted of four items per theory (20 items total) on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*).

Petronzi and Masciale (2015) found their scale revision to be internally consistent with Cronbach’s alpha values of .88 for preference of psychodynamic psychotherapy, .89 for preference of client-centered psychotherapy, and .92 for preference of cognitive therapy (p. 8). Their scale items are comprised of “I like this therapist’s style,” “I dislike this therapist’s approach to working with people,” “This therapist is right for me,” and “I would willingly pay to see this therapist” (Petronzi & Masciale, 2015, p. 9). In the current study, adequate internal consistency ( $\alpha = .69$ ) was found within the PPAS.

### **Counseling Approach Evaluation Form (CAEF)**

The second scale used to assess people's psychotherapeutic preference was the Counseling Approach Evaluation Form (CAEF; Lyddon, 1989). The CAEF is comprised of two subscales. The first subscale contains three items that pertain to participants' evaluations of the therapy in relation to themselves (e.g. "What is the likelihood that you would seek out this counseling approach if you desired counseling in the future?"), whereas the second subscale contains items that assess participants' evaluations of the therapeutic approach in relation to other approaches (e.g. "How optimistic are you that this approach would be beneficial for most people?") (Lyddon, 1989, p. 425). The six questions of the CAEF are answered on a 7-point Likert scale (1 = *low preference*, 7 = *high preference*). Scores are summed to obtain the total.

Lyddon (1989) normed the CAEF using 92 college students (59 women and 33 men) at a diverse, urban university. Internal consistency was high, with a Cronbach's alpha of .96 for the first subscale and .93 for the second subscale. Petronzi and Masciale (2015) found identical subscale values (Cronbach's alpha of .96 and .93 respectively) in their sample of 209 participants. Similar internal consistency was found in the present study, with  $\alpha = .80$ .

In addition, Petronzi and Masciale (2015) combined scores from both the PPAS-R and the CAEF to create one large measure of psychotherapeutic preference. The combined scale consisted of 10 items and demonstrated excellent internal consistency: psychodynamic,  $\alpha = .89$ ; person-centered,  $\alpha = .89$ ; and cognitive,  $\alpha = .90$ ; all significant at  $p < .001$ ). The present study utilized the same methodology, combining the total scores of both the PPAS-R and CAEF, to produce one main criterion variable for each psychotherapy preference. The Cronbach's alphas were found to be:  $\alpha = .91$  for psychodynamic preference,  $\alpha = .89$  for person-centered preference, and  $\alpha = .92$  for cognitive-behavioral preference, thus, strong internal consistency for

psychotherapeutic preference discernment was found among the participants in this study. Given the consistency across measures for this sample and that of previous work (see Petronzi & Masciale, 2015), it would appear that the measures in this study demonstrated good concurrent validity.

### **HEXACO-60**

Personality traits were measured using the HEXACO-60; a shortened version of the HEXACO Personality Inventory—Revised (Ashton & Lee, 2009). The HEXACO Personality Inventory mirrors Costa and McCrae's (1992) NEO and Five Factor Model, however, it is the result of a more recent factor analysis of large sets of personality-descriptive adjectives, from a multitude of languages, that were used in personality research (Ashton & Lee, 2009). The HEXACO personality inventory assesses six cross-language personality factors using both self-report and peer-report formats. Because the six dimensions emerged from research that used multiple linguistic descriptions of personality, it is thought that the HEXACO offers a more multiculturally representative personality structure than that of the Five Factor Model (Ashton & Lee, 2005, 2007, 2009). The six personality constructs are defined as follows:

**Honest-Humility:** Those who score high on this scale do not manipulate others, are not rule breakers, are disinterested in material things, and have a lack of entitlement.

**Emotionality:** People who score high on this trait scale tend to experience fear of danger, anxiety in response to stressful life events, need emotional support from others, and demonstrate empathy towards others.

Extraversion: People who score high on this trait scale tend to be more positive about themselves and demonstrate confidence leading others, addressing groups, and generally enjoy social settings.

Agreeableness: People who score high on this trait scale tend to be more forgiving, less judgmental, more cooperative, and better at compromising with others.

Conscientiousness: People who score high on this trait scale tend to be more perfectionistic and deliberate more when decision-making.

Openness to Experience: People who are high on this trait scale tend to be more appreciative of art and nature, are more inquisitive about learning and ideas, are more imaginative, and demonstrate interest in other people (Ashton & Lee, 2009).

The HEXACO-60 is comprised of these six subscales that have 10 items each. Each item is rated on a 5 point Likert scale (1 = *strongly disagree*, 5 = *strongly agree*). Item scores are summed for each subscale. Inter-item correlations ranged from .25 to .29 in the college sample ( $N = 936$ ) and .21 to .28 in the community sample ( $N = 734$ ), and this demonstrates good discriminant validity across samples. Demographic variation beyond gender was not provided for the normative sample of the 60-item version. The internal consistency reliabilities ranged from .77 to .80 in the college sample and .73 to .80 in the community sample. Similar findings were found by Petronzi and Masciale (2015) who reported Cronbach alpha ranges from .75 to .83 for their sample ( $N = 202$ ). In addition, convergent validity was shown to be high, with self-report and observer report measure correlations that averaged above .50 (Ashton & Lee, 2009). The present study found internal consistency similar to that reported by Ashton and Lee (2009), as well as Petronzi and Masciale (2015). Cronbach's alpha from the six subscales of the HEXACO-

60 ranged from  $\alpha = .77$  for Honesty/Humility to  $\alpha = .86$  for Extraversion with an overall internal consistency of  $\alpha = .82$ .

Ashton and Lee (2009) recommended the use of the HEXACO-60 as a short personality inventory in research in which “assessment is time limited” (p. 340). The measure is free of charge for academic research purposes and can be obtained from the authors at their website (website should be noted here). Additionally, the HEXACO-60 was selected to measure personality because it is arguably a more multiculturally valid representation of personality than the older NEO FFM-based instruments. Finally, because participants in the present study were asked to complete several measures, the HEXACO-60 was selected for pragmatic purposes: to keep the overall survey to a reasonable length that would avoid or minimize participant fatigue.

### **Relationships Questionnaire**

The Relationships Questionnaire (RQ), which was used as one of two measures to assess attachment, presented the participants with four short descriptions of attachment styles and asked them to rate which of the styles most closely approximated their own using a 6-point Likert scale (1 – *Not at all like me* to 7 – *Very much like me*), and finally, to select one attachment style that best described them (although this final selection was not utilized for analysis). The four attachment styles presented to the participants were as follows: (a) secure, defined as being comfortable with intimacy and autonomy; (b) preoccupied, defined as being preoccupied with relationships and uncomfortable being without close relationships; (c) fearful, defined as a fear of intimacy and being socially avoidance; and (d) dismissive, defined as “counter-dependence” or being comfortable without close relationships (Bartholomew & Horowitz, 1991, p. 227).

The scale was normed on a sample of 77 undergraduate college students (40 female, 37 male) who ranged in age from 18-22. Participants in the normative sample were reported to be 67% Caucasian, 16% Asian American, 5% Latino, 8% African American, and 4% other (Bartholomew & Horowitz, 1991, p. 228). Bartholomew and Horowitz (1991) found the RQ to have adequate construct validity, evidenced in the Cronbach's alpha for self-report ( $\alpha = .66$  to  $.88$ ) and friend-report ( $\alpha = .71$  to  $.89$ ) ratings, as well as adequate discriminant validity, with inter-item correlations found to range from  $-.26$  to  $-.14$ . Inter-item correlations in Petronzi and Masciale's (2015) study also demonstrated adequate discriminant validity, with correlations that ranged from  $.02$  to  $-.46$ . In the present study, the RQ demonstrated adequate discriminant validity, with intercorrelations that ranged from  $r = -.25$  to  $-.43$  ( $p < .01$ ).

### **Experience in Close Relationships Scale—Short Form**

In addition to the Relationships Questionnaire, the present study also utilized the Experience in Close Relationships Scale –Short form (ECR-S; Wei, Russell, Mallinckrodt, & Vogel, 2007) to assess attachment style. The ECR-S is a shortened version of the original Experience in Close Relationships (ECR; Brennan, Clark, & Shaver, 1998). The ECR was developed because of the psychometric problems associated with having a single-item measure (i.e. Relationships Questionnaire) per factor (Wei et al., 2007). In creating the ECR, Brennan et al. (1998, as cited in Wei et al., 2006) took 323 items from 14 self-report measures of adult attachment, administered the items to 1100 undergraduate students, and performed a factor analysis on the data. The results revealed two orthogonal dimensions that were labeled Anxiety and Avoidance (Brennan et al., 1998). The original ECR consisted of 36 items that demonstrated strong internal consistency. Cronbach's alpha for the Anxiety subscale ranged from  $.89$  to  $.92$

and for the Avoidance subscale the range was .91 to .95. Test-retest reliability was assessed at 3 week and 6-month intervals, and the reliabilities were reported to be of .70 and .68 respectively (Wei et al., 2007).

In an effort to create a shorter version of the instrument that could be used more easily in survey research, Wei et al. (2007) developed a 12-item measure by using a “principal axis factor extraction with a promax rotation” (p. 189). Like the 36-item measure, the questions asked participants to rate how well each statement described their feelings in relationships on a 7-point Likert scale that ranges from 1 (*strongly disagree*) to 7 (*agree strongly*). Wei et al. (2007) conducted six studies with the 12-item ECR-S and found that the short form retained acceptable internal consistency ( $\alpha = .77$  to  $.88$ ), test-retest reliability ( $r = .80$  to  $.86$ ), and discriminant ( $r = .28$ ) and construct validity across the six samples of undergraduate students (p. 201). The present study found the ECR, as a whole, to demonstrate adequate internal consistency ( $\alpha = .79$ ), as did its two subscales (anxiety,  $\alpha = .78$ ; and avoidance,  $\alpha = .87$ ).

### **Attitude Toward Seeking Professional Psychological Help**

To measure the extent to which a person’s attitude toward seeking psychological help accounted for his or her psychotherapeutic preference distinction, the Attitude Toward Seeking Professional Psychological Help Scale—Short Form (ATSPPH-SF; Fischer & Farina, 1995) was used.

The ATSPPH-SF is the most widely used instrument in research that has assessed people’s attitudes about seeking mental health treatment (Elhai, Schweinle, & Andersn, 2008). The ATSPPH-SF consists of 10 items (the original had 29) that are responded to on a 4-point

Likert scale ranging from 0 (*disagree*) to 3 (*agree*) (Fischer & Farina, 1995). Higher scores on the instrument indicate more positive attitudes towards seeking psychological treatment. Specifically, those who score higher on the instrument have been shown to espouse less stigma regarding mental health, are more open to emotional disclosure, and are more likely to see value in seeking psychological treatment (Elhai et al., 2008; Komiya, Good, & Sherrod, 2000). The ATSPPH-SF has demonstrated internal consistency with a Cronbach's alpha of .84 and test-retest reliability of .80 over 1 month (Fischer & Farina, 1995).

Although both the original ATSPPH and the short form version had been normed on a principally Caucasian college student population, Elhai et al. (2008) reassessed the reliability and validity of the ATSPPH-SF with a college student sample ( $n = 296$ ), as well as a sample of patients in primary care clinic ( $n = 395$ ). The college student sample consisted of 201 women (67%) and 98 men (32%), and the primary care patient sample was comprised of 280 women (70%) and 111 men (28%). Both student and patient samples were largely homogeneous, with 93% and 92% Caucasian respectively (Elhai et al. 2008, p. 322). Their results mirrored those of Fischer and Farina (1995). Namely, they found good internal consistency, with a Cronbach's alpha of .77 to .78 in both samples. Discriminant validity was demonstrated by inter-item correlations of 0.3 or less. Construct validity was demonstrated as higher scores on the ATSPPH-SF correlated with greater intentions to seek mental health treatment at a one-month ( $r = .24, p = .001$ ) and 6-months ( $r = .26, p < .001$ ) (Elhai et al. 2008). Lastly, while Elhai et al. (2008) found some slight differences in age (that older participants had more favorable treatment attitudes), they did not find any other variation related to demographic variables in their sample. Since the ATSPPH-SF has proven to be both a reliable and valid instrument across multiple studies, it was used to assess the extent to which a person's attitude towards help seeking may



account for variance in his or her psychotherapy preference distinction. In line with reports by Fischer and Farina (1995), the present study found good internal consistency, with a Cronbach's alpha of  $\alpha = .88$ .

### **Demographics**

In the present study, the requested demographic information included the following: age, gender, level of education, socioeconomic background, and race/ethnicity. In addition, participants were asked if they were currently or had ever been in psychotherapy before and, if so, to rate the experience (*positive, neutral, or negative*). Lastly, participants were asked if they had ever studied psychology before and, if so, to what extent.

One of the notable limitations in previous studies is the lack of descriptive demographic information regarding the samples (Bishop, 1998; Ogunfowora & Drapeau, 2008; Scandell et al., 1997). In order to be able to make assertions about the ecological validity of findings, it is essential that generalizability be discussed with relation to the variance accounted for by demographic differences. As such, the above information was deemed minimally appropriate for inclusion in the demographic section. Additionally, since Petronzi and Masciale (2015) found that level of education was significantly predictive of cognitive behavioral preference, further examination of this variable as a predictor of psychotherapy preference was merited for replication purposes.

### **Procedure**

After receiving approval from the Seton Hall University Institutional Review Board, a solicitation flyer for the study was posted on amazon.com's Mechanical Turk. The flyer

contained basic information about the study with regard to the approximate length of time for completion, as well as the purpose of the study (e.g. rate your favorite psychologist and take some brief measures assessing your characteristics). Interested M-Turk users clicked the link to the survey and were then directed to the online survey hosted by Surveygizmo's Internet-based survey platform.

The first page of the survey contained the informed consent, which described the voluntary nature of their participation, as well as the potential risks and benefits of participation. After reading the informed consent, prospective participants had the option to participate in the study or to opt out. Additionally, participants could have opted out of the study at any later point if they had chosen. After selecting to continue with the study, participants were presented with the three psychotherapy description vignettes of the PPAS-R, in random order to control for order effects. After reading each vignette, the participants filled out the PPAS-R and CAEF questionnaires. After completing the preference assessment portion of the survey, participants were prompted to complete the HEXACO-60, the Relationships Questionnaire, the ECR-S, and ATSPPH-SF. Lastly, participants were asked to fill out demographic information. This section was specifically placed at the end of the survey to avoid any potential stereotype threat confounds (Steele & Aronson, 1995). Upon completion of the survey, a random number generator produced a code in M-Turk signaling the completion of the survey. Participants were then awarded their Amazon.com remuneration.

### **Statistical Analysis**

Because this study was designed to examine the predictive associations between more than one continuous predictor variable and one (for each theory) continuous criterion variable a

hierarchical regression data analytic approach was selected. Within this model, in order to determine whether or not attitude toward help seeking accounted for variance in psychotherapeutic preference over and above demographic variables, personality traits, and attachment styles, three hierarchical multiple regressions (one for each psychotherapeutic orientation) were performed containing 3 step equations. The variables entered into the first step of the equations were demographic variables. In the second step, attachment variables and personality traits were entered. For the third and final step attitude toward help seeking was entered. Significance at this step indicated whether or not attitude toward help seeking accounted for variance in psychotherapy preference above and beyond demographic variation, personality traits, and attachment styles.

## CHAPTER IV

### RESULTS

This chapter will first summarize the results of the multivariate analysis of variance (MANOVA) to examine systematic variation in the sample. Second, zero order correlation analyses between the predictors and criteria are presented. Finally, results of the multiple hierarchical regression analyses are presented to address the research questions and hypotheses.

#### MANOVA of Demographic and Predictor Variables

This study utilized SPSS version 22.00 for data analysis. A one-way multivariate analysis of variance (MANOVA) was conducted with all demographic items and predictor variables. In terms of significant differences for gender, it was found that women in this sample ( $N = 145$ ,  $M = 31.96$ ) scored higher on honesty/humility as measured by the HEXACO-60, as compared to men ( $N = 86$ ,  $M = 28.99$ ,  $F(1, 239) = 8.97$ ,  $p = .003$ ,  $\eta^2 = .04$ ). Women ( $N = 145$ ,  $M = 35.02$ ) also scored higher on emotionality as compared to men ( $M = 29.32$ ,  $F(1, 239) = 34.84$ ,  $p < .001$ ,  $\eta^2 = .14$ ); a finding that mirrors that of Petronzi and Masciale's (2015). With regard to attitude toward seeking professional psychological help, men ( $M = 18.85$ ) scored significantly lower than women ( $M = 21.70$ ,  $F(1, 239) = 9.86$ ,  $p = .002$ ,  $\eta^2 = .05$ ), meaning that men demonstrated a higher resistance to seeking professional psychological help than women in this sample. Lastly, it was found that men scored higher ( $M = 3.99$ ) than women ( $M = 3.41$ ,  $F(1, 239) = 4.38$ ,  $p = .038$ ,  $\eta^2 = .02$ ) on dismissive attachment.

Significant mean differences were also found for sexual orientation. Namely, it was found that participants who described themselves as bisexual ( $N = 12$ ,  $M = 31.02$ ) scored significantly lower in conscientiousness than did those who endorsed being straight ( $N = 212$ ,  $M$

= 36.46), gay or lesbian ( $N = 6, M = 32.57$ ), or other ( $N = 1, M = 40.08, F(3, 237) = 3.06, p = .029, \eta^2 = .04$ ). Additionally, the participant who endorsed other ( $N = 1, M = 39.05$ ) scored significantly higher in avoidance than those who endorsed being straight ( $M = 18.86$ ), gay or lesbian ( $M = 19.82$ ), and bisexual ( $M = 21.19, F(3, 237) = 2.72, p = .046, \eta^2 = .04$ ).

Significant differences were also found for education in the criterion of psychodynamic therapy preference. Specifically, it was observed that the person who endorsed having less than a high school education ( $N = 1, M = 70.40$ ) rated his or her preference for psychodynamic psychotherapy significantly higher than did those who had a high school equivalent ( $N = 33, M = 49.33$ ), some college ( $N = 51, M = 50.27$ ), an associate's degree ( $N = 31, M = 42.620$ ), a bachelors degree ( $N = 73, M = 46.04$ ), a masters degree ( $N = 34, M = 43.27$ ) and lastly, a doctoral degree ( $N = 8, M = 30.09, F(6, 234) = 4.83, p < .001, \eta^2 = .24$ ).

In addition, participants who stated that they were in psychotherapy at the time they completed the survey demonstrated significantly higher scores for avoidant attachment style ( $N = 8, M = 28.10$ ) than those who stated that they were not currently in psychotherapy ( $N = 223, M = 21.37, F(1, 239) = 5.05, p = .026, \eta^2 = .12$ ). Moreover, those in treatment scored higher in fearful attachment ( $M = 6.70$ ) than those who were not in psychotherapy ( $M = 4.96, F(1, 239) = 5.05, p = .029, \eta^2 = .02$ ). Lastly, participants in psychotherapy ( $N = 8, M = 32.23$ ) demonstrated a smaller mean preference score for cognitive-behavioral therapy than did those who were not in treatment ( $N = 223, M = 43.87, F(1, 239) = 3.96, p = .048, \eta^2 = .02$ ).

Participants with previous psychotherapy experience ( $N = 92, M = 33.52$ ) rated higher for emotionality than those that did not ( $N = 139, M = 30.82, F(1, 239) = 7.47, p = .007, \eta^2 = .04$ ). Additionally, those with previous therapy experience rated lower for extraversion ( $M = 29.41$ ) than those with no experience ( $M = 31.84, F(1, 239) = 4.57, p = .034, \eta^2 = .02$ ). Lastly, and not

surprisingly, those with prior therapy experience ( $M = 22.79$ ) demonstrated less negative attitudes toward seeking psychological help, as evidenced by higher mean scores than those without therapy experience ( $M = 17.76$ ,  $F(1, 239) = 29.51$ ,  $p < .001$ ,  $\eta^2 = .13$ ).

Finally, the MANOVA revealed significant mean differences in theoretical preference between those who have studied psychology *a lot* ( $N = 18$ ,  $M = 38.99$ ) and those who had only *some* experience studying psychology ( $N = 26$ ,  $M = 50.66$ ,  $F(3, 237) = 2.82$ ,  $p = .040$ ,  $\eta^2 = .04$ ). This demonstrates that those who had more experience studying psychology tended to prefer person-centered treatment less. The final mean difference found in the MANOVA pertained to the extent to which previous study of psychology yielded different levels of honesty/humility. It was found that those with *a little* study of psychology ( $N = 92$ ,  $M = 33.02$ ) scored higher on honesty/humility than did those with *some* study of psychology ( $N = 26$ ,  $M = 27.71$ ,  $F(3, 239) = 4.06$ ,  $p = .008$ ,  $\eta^2 = .06$ ). No other systematic variation was found in the data.

It should be noted that while significant mean differences were found in the MANOVA analysis, some group means were calculated based upon as few as one individual, and the largest effect size overall was small,  $\eta^2 = .14$  (which was for gender difference in emotionality). While it is important to list the systematic variation within the data as found through the MANOVA prior to interpreting the main analyses, based on the above statistics, it would not appear that these variations in the data merit cautious interpretation of subsequent analyses to test the hypotheses.

### **Correlations of Predictors with Criterion Variables**

For a preliminary analysis, zero-order correlations were run to examine the associations between psychotherapy preferences and the following: demographic variables, personality traits, and attachment styles. Table 1 presents the results of this two-tailed bivariate analysis. The results reveal that secure attachment ( $r = .235$ ,  $p < .001$ ), education ( $r = -.275$ ,  $p < .001$ ),

avoidance ( $r = -.133, p = .044$ ), emotionality ( $r = .129, p = .049$ ), and extraversion ( $r = .157, p = .017$ ) were significantly correlated with psychodynamic therapy preference. Additionally, education ( $r = -.132, p = .045$ ), anxiety ( $r = .169, p = .010$ ), emotionality ( $r = .163, p = .013$ ), and conscientiousness ( $r = -.137, p = .037$ ) were significantly correlated with person-centered therapy preference. Finally, it was found that being in psychotherapy (at the time the study was conducted) ( $r = -.168, p = .010$ ), currently seeking psychotherapy ( $r = -.135, p = .041$ ), and attitude toward seeking professional psychological help ( $r = .201, p = .002$ ) were significantly correlated with cognitive-behavioral therapy preference.

Table 1

*Zero-Order Correlations of Outcome Variables With Predictor Variables*

Predictors	Psychodynamic	Person-centered	CBT
1. Age	-.08	-.11	-.02
2. Gender	-.03	.07	.01
3. Education	-.28**	-.13*	.01
4. Race/Ethnicity	-.12	-.06	.00
5. Sexual orientation	-.08	-.10	-.04
6. Gay or lesbian ( $n = 8$ )	-.18**	-.06	.08
7. Heterosexual ( $n = 219$ )	-.13	-.01	-.12

Predictors	Psychodynamic	Person-centered	CBT
8. Bisexual ( $n = 12$ )	-.07	.02	.07
9. Level of Study in Psychology	-.06	.00	.03
10. Currently in Treatment	.09	.02	-.17*
11. Previous Treatment	.01	.07	.07
12. Currently Seeking Treatment	.04	.12	-.14*
13. Anxiety	.10	.17*	-.07
14. Avoidance	-.13*	.02	-.11
15. Honesty/Humility	.00	-.12	-.05
16. Emotionality	.13*	.16*	.04
17. Extraversion	.16*	-.05	.02
18. Agreeableness	.13	-.02	.03
19. Conscientiousness	.08	-.14*	-.01
20. Openness	-.01	-.04	.12
21. Secure Attachment	.24**	.03	.09
22. Fearful Attachment	-.12	.08	.01

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Predictors	Psychodynamic	Person-centered	CBT
23. Preoccupied Attachment	.08	.12	-.03
24. Dismissive Attachment	-.12	-.03	-.02
25. ATSPPH-SF	.00	.02	.20**

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*Note:* \* $p < .05$ ; \*\* $p < .01$ . Attitude Toward Seeking Professional Psychological Help scale- Short Form (ATSPPH-SF).

### Hierarchical Regression Analyses

To test the main hypotheses, a hierarchical regression analysis was conducted in three steps using the enter method for each psychotherapeutic orientation (psychodynamic, person-centered, and cognitive-behavioral therapies). The data across all regression analyses indicated that multicollinearity was not a concern. Sexual orientation (Tolerance = .30, VIF = 3.29) presented the highest variance inflation factor, however, no other variables across all regressions had variance inflation factors over 2.4. Even with a VIF of 3.29 sexual orientation is within acceptable limits (Field, 2013).

### Hypothesis 1

To test if personality traits and attachment styles significantly predicted psychotherapeutic preference above demographic variables a hierarchical regression analysis was calculated. Step 1 for each psychotherapy regression included only demographic variables (age, gender, sexual orientation—dummy coded into three variables for gay or lesbian, straight and bisexual—highest level of education, race/ethnicity, current psychotherapy treatment, past

psychotherapy treatment, currently seeking psychotherapy, and previous study of psychology). In step 2 personality traits and attachment styles were added. Significant beta weights at step 2 indicated which personality traits and attachment styles predict people's psychotherapy preferences above demographic variables.

## **Hypothesis 2**

To test if attitude toward help seeking accounted for variance in psychotherapy preference above demographic variables, personality traits, and attachment styles, a third step was added to the regression, which added only the attitude toward help seeking variable. Significant beta weights at step 3 indicate the degree to which attitude toward help seeking accounts for variance in one's psychotherapy preference above demographic variables, personality traits, and attachment styles.

Table 2 summarizes the results of the hierarchical regression analysis for psychodynamic psychotherapy preference. The first step, which tested the degree to which demographic variables predicted preference for psychodynamic psychotherapy, was statistically significant ( $R = .34$ ,  $R^2 = .12$ ,  $F(10, 220) = 2.90$ ,  $p = .002$ ). The second step of the equation, which added personality traits and attachment styles, predicted an additional 12% of the variance in psychodynamic preference ( $R = .49$ ,  $R^2 = .24$ ,  $F(22, 208) = 2.93$ ,  $p < .001$ ,  $\Delta R^2 = .12$ ,  $\Delta F(12, 208) = 2.72$ ,  $p = .003$ ). While the model itself was statistically significant, the third step in the equation, which added only attitude toward seeking professional psychological help, did not add significant variance for psychodynamic preference over and above previous steps ( $R = .49$ ,  $R^2 = .24$ ,  $F(23, 207) = 2.87$ ,  $p < .001$ ,  $\Delta R^2 = .005$ ,  $\Delta F(1, 207) = 1.47$ ,  $p = .230$ ).

Based on significant standardized Beta weights, education ( $\beta = -.231$ ,  $p = .001$ ) and gay identity ( $\beta = -.388$ ,  $p = .025$ ) emerged as significant negative predictors of psychodynamic

preference such that the higher one rated his or her education, as well as those who identified as gay or lesbian, the less he or she tended to prefer psychodynamic psychotherapy. In addition, individuals who scored higher in agreeableness ( $\beta = .162, p = .016$ ) tended to prefer psychodynamic psychotherapy. Lastly, positive associations were found for psychodynamic preference for those who endorsed being anxiously attached ( $\beta = .174, p = .065$ ) as well as those who scored higher in conscientiousness ( $\beta = .127, p = .071$ ). However, while the associations found were in expected directions, considering previous research, they were not significant.

Table 2

*Predictors of Preference for Psychodynamic Psychotherapy*

Source	Unstandardized (b)	Standardized( $\beta$ )	t	p	R <sup>2</sup>
Step 1 – Controls					.12**
Constant	63.06	---	4.55	.001	
Age	-.06	-.06	-.92	.361	
Previous Study	.175	.01	.18	.857	
Previous Treatment	.11	.00	.06	.952	
Level of Education	-2.22	-.25	-3.63	.001	
Current Treatment	4.22	.06	.87	.384	
Seeking Treatment	.985	.02	.22	.826	
Gay or lesbian	-27.25	-.34	-2.05	.042	
Heterosexual	-15.94	-.34	-1.29	.199	
Bisexual	-20.68	-.36	-1.61	.109	
Step 2 – Predictors					
Constant	29.16	---	1.55	.123	

Source	Unstandardized (b)	Standardized( $\beta$ )	t	p	$R^2$
Age	-.07	-.07	-1.08	.282	
Previous Study	.48	.03	.505	.614	
Previous Treatment	.10	.00	.05	.956	
Level of Education	-2.08	-.23	-3.52	.001	
Current Treatment	7.29	.11	1.63	.127	
Seeking Treatment	2.90	.04	.63	.597	
Gay or lesbian	-31.11	-.38	-2.30	.022	
Heterosexual	-19.40	-.42	-1.54	.125	
Bisexual	-22.09	-.38	-1.70	.090	
Honesty/Humility	-.11	-.06	-.83	.409	
Emotionality	.22	.12	1.54	.124	
Extraversion	.14	.09	.96	.339	
Agreeableness	.30	.16	2.31	.022	
Conscientiousness	.28	.18	1.82	.071	
Openness	-.06	-.03	-.49	.627	
Secure Attachment	.84	.14	1.55	.123	
Fearful Attachment	-.62	-.10	-1.21	.228	
Preoccupied	-.28	-.04	-.45	.655	
Dismissive	.07	.01	.16	.875	
Anxiety	.29	.17	1.85	.065	
Avoidance	-.04	-.02	-.27	.782	
Step 3 --Add ATSPPH					.24**
Constant	26.70		1.41	.159	
Age	-.06	-.07	-.99	.323	

Source	Unstandardized (b)	Standardized( $\beta$ )	t	p	$R^2$
Previous Study	.56	.04	.59	.557	
Previous Treatment	.98	.04	.52	.603	
Seeking Treatment	2.75	.04	.63	.528	
Current Treatment	7.77	.11	1.63	.104	
Level of Education	-1.99	-.22	-3.37	.001	
Gay or lesbian	-.30.54	-.38	-2.26	.025	
Heterosexual	-19.37	-.42	-1.54	.126	
Bisexual	-21.99	-.38	-1.70	.091	
Honesty/Humility	-.11	-.06	-.85	.398	
Emotionality	.26	.15	1.78	.077	
Extraversion	.16	.10	1.12	.265	
Agreeableness	.31	.17	2.44	.016	
Conscientiousness	.26	.12	1.71	.088	
Openness	-.04	-.02	-.28	.777	
Anxiety	.29	.17	1.84	.067	
Avoidance	-.05	-.03	-.37	.715	
ATSPPH	-.17	-.09	-1.21	.227	

Note: \* $p < .05$ ; \*\* $p < .01$ . Attitude Toward Seeking Professional Psychological Help scale-Short Form (ATSPPH-SF)

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Table 3 summarizes the results for the hierarchical regression analysis of preference for person-centered psychotherapy. As indicated, the model was not significant at any steps in the equation. The results for step 1 were ( $R = .27$ ,  $R^2 = .07$ ,  $F(10, 220) = 1.66$ ,  $p = .092$ ), step 2 ( $R = .36$ ,  $R^2 = .13$ ,  $F(22, 208) = 1.37$ ,  $p = .130$ ) and step 3 ( $R = .36$ ,  $R^2 = .13$ ,  $F(23, 207) = 1.31$ ,  $p =$

.163). Therefore, the beta weights for each of the predictor variables were not interpretable for person-centered preference.

Table 3

*Predictors of Preference for Person-Centered Therapy*

Source	Unstandardized (b)	Standardized( $\beta$ )	t	p	R <sup>2</sup>
Step 1 – Controls					.07
Constant	63.06	---	4.55	.001	
Age	-.09	-.09	-1.34	.183	
Previous Study	.22	.01	.20	.841	
Previous Treatment	2.49	.09	1.28	.202	
Level of Education	-1.22	-.13	-1.81	.071	
Current Treatment	-4.25	.06	.79	.426	
Seeking Treatment	.8.54	.12	1.73	.085	
Gay or lesbian	-29.31	-.34	-1.99	.047	
Heterosexual	-26.15	-.52	-1.92	.057	
Bisexual	-26.29	-.43	-1.86	.064	
Step 2 – Predictors					
Constant	49.31	---	2.28	.024	
Age	-.04	-.04	-.51	.612	
Previous Study	.62	.04	.57	.568	
Previous Treatment	1.69	.06	.84	.401	
Level of Education	-1.16	-.12	-1.71	.089	
Current Treatment	-4.56	.06	-.84	.405	
Seeking Treatment	7.97	.11	1.60	.111	

Source	Unstandardized (b)	Standardized( $\beta$ )	t	p	$R^2$
Gay or lesbian	-33.29	-.39	-2.14	.033	.13
Heterosexual	-31.22	-.63	-2.16	.032	
Bisexual	-32.24	-.52	-2.17	.031	
Honesty/Humility	-.07	-.04	-.48	.623	
Emotionality	.37	.20	2.27	.024	
Extraversion	.09	.05	.55	.582	
Agreeableness	.12	.06	.80	.425	
Conscientiousness	-.20	-.09	-1.13	.260	
Openness	-.07	-.03	-.49	.625	
Secure Attachment	.34	.05	.55	.582	
Fearful Attachment	-.29	-.04	.49	.623	
Preoccupied	.07	.01	.10	.921	
Dismissive	.50	.07	.93	.353	
Anxiety	.12	.07	.67	.502	
Avoidance	-.04	-.02	-.22	.827	
Step 3 – Adding					
Constant	48.87		2.24	.026	
Age	-.04	-.04	-.49	.623	
Previous Study	.64	.04	.58	.561	
Previous Treatment	1.85	.07	.08	.397	
Seeking Treatment	8.05	.11	1.61	.109	
Current Treatment	-4.47	-.06	-.81	.417	
Level of Education	-1.14	-.12	-1.67	.096	
Gay or lesbian	-33.19	-.39	-2.13	.034	
Heterosexual	-31.21	-.63	-2.15	.033	
Bisexual	-32.22	-.52	-2.16	.032	

Source	Unstandardized (b)	Standardized( $\beta$ )	t	p	$R^2$
Honesty/Humility	-.07	-.04	-.48	.631	
Emotionality	.37	.19	2.25	.025	
Extraversion	.09	.06	.57	.568	
Agreeableness	.12	.06	.82	.416	
Conscientiousness	-.20	-.09	-1.14	.256	
Openness	-.07	-.03	-.45	.653	
Anxiety	.12	.07	.67	.504	
Avoidance	-.04	-.02	-.23	.817	
ATSPPH	-.03	-.02	-.19	.848	

Note: \* $p < .05$ ; \*\* $p < .01$ . Attitude Toward Seeking Professional Psychological Help scale-Short Form (ATSPPH-SF)

Finally, Table 4 summarizes the results for the hierarchical regression analysis of cognitive-behavioral therapy preference. The first step, which included all demographic variables, was not significant ( $R = .26$ ,  $R^2 = .07$ ,  $F(10, 220) = 1.61$ ,  $p = .110$ ). The second step, adding all personality traits and attachment styles, was also not significant ( $R = .38$ ,  $R^2 = .14$ ,  $F(22, 208) = 1.55$ ,  $p = .062$ ). However, the third step, which added only attitude toward help seeking, was statistically significant ( $R = .42$ ,  $R^2 = .17$ ,  $F(23, 207) = 1.88$ ,  $p = .011$ ,  $\Delta R^2 = .03$ ,  $\Delta F(1, 207) = 8.10$ ,  $p = .004$ ). Significant standardized beta weights at the third step indicated that individuals who were in psychotherapy at the time of the study ( $\beta = -.176$ ,  $p = .014$ ), those seeking psychotherapy ( $\beta = -.137$ ,  $p = .048$ ), and lastly, those indicating a more positive attitude



toward seeking professional psychological help ( $\beta = .241, p = .001$  tended to prefer the cognitive-behavioral orientation more.

Table 4

*Predictors of Preference for Cognitive Behavioral Psychotherapy*

Source	Unstandardized (b)	Standardized( $\beta$ )	t	p	R <sup>2</sup>
Step 1 – Controls					.07
Constant	69.37	---	4.30	.000	
Age	-.02	-.02	-.29	.824	
Previous Study	.26	1.13	.23	.822	
Previous Treatment	3.85	.13	1.88	.062	
Level of Education	-.21	-.02	-.29	.769	
Current Treatment	-12.96	-.16	-2.30	.022	
Seeking Treatment	-7.60	-.10	-1.50	.146	
Gay or lesbian	-9.46	-.10	-.61	.543	
Heterosexual	-17.12	-.33	-1.19	.236	
Bisexual	-12.64	-.19	-.85	.399	
Step 2 – Predictors					.14
Constant	77.50	---	3.42	.001	
Age	-.00	-.00	-.03	.974	
Previous Study	.46	.03	.40	.689	
Previous Treatment	4.06	.14	1.94	.054	
Level of Education	-.32	-.03	-.45	.655	
Current Treatment	-12.60	5.72	-2.20	.029	

Source	Unstandardized (b)	Standardized( $\beta$ )	t	p	$R^2$
Seeking Treatment	-8.95	-.12	-1.72	.087	
Gay or lesbian	-17.03	-.19	-1.05	.296	
Heterosexual	-19.40	-.42	-1.54	.905	
Honesty/Humility	-.17	-.08	-1.05	.284	
Emotionality	.11	.17	.64	.202	
Extraversion	-.26	-.14	-1.49	.278	
Agreeableness	.02	.01	.11	.648	
Conscientiousness	-.13	.18	-.73	.467	
Openness	.30	.15	1.96	.052	
Secure Attachment	.95	.13	1.45	.148	
Fearful Attachment	.80	.61	1.30	.194	
Preoccupied	-.30	.76	-.40	.693	
Dismissive	.36	.56	.65	.520	
Anxiety	-.34	.19	-1.81	.072	
Avoidance	-.26	.17	-1.55	.123	
Step 3 – Adding					.17*
Constant	84.33		3.77	.000	
Age	-.02	-.08	-.24	.814	
Previous Study	.24	1.13	.21	.835	
Previous Treatment	1.59	2.24	.71	.477	
Seeking Treatment	-10.23	-.14	-1.99	.048	
Current Treatment	-13.95	-.18	-2.47	.014	
Level of Education	-.54	-.05	-.77	.443	
Gay or lesbian	-18.63	-.21	-1.16	.246	
Heterosexual	-25.52	-.49	-1.71	.088	
Bisexual	-19.87	-.31	-1.30	.196	

Source	Unstandardized (b)	Standardized( $\beta$ )	t	p	$R^2$
Honesty/Humility	-.17	-.06	-.85	.295	
Emotionality	.11	.17	.64	.524	
Extraversion	-.26	-.14	-1.49	.138	
Agreeableness	.02	.01	.11	.911	
Conscientiousness	-.09	-.04	-.50	.616	
Openness	.23	.10	1.50	.135	
Anxiety	-.33	-.18	-1.81	.072	
Avoidance	-.22	-.12	-1.36	.175	
ATSPPH	.50	.241	2.85	.005	

*Note:* \* $p < .05$ ; \*\* $p < .01$ . Attitude Toward Seeking Professional Psychological Help scale-Short Form (ATSPPH-SF).

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## **CHAPTER V**

### **DISCUSSION**

This chapter discusses the findings of the statistical analyses that tested the research questions and hypotheses. Next, the findings of this study are compared to relevant literature and, in particular, the most recent research in this line of inquiry. Overlapping and or dichotomous findings are presented along with theoretical propositions for their occurrences. Next, limitations of this research are discussed followed by recommendations for future research.

#### **Summary of Findings**

This study examined the extent to which different people might prefer different forms of psychotherapy based on a clinician's theoretical orientation. Moreover, this research sought to understand if a person's attitude toward help seeking accounted for variance in their psychotherapy preference above and beyond their dispositional characteristics. In order to do this, personality traits and attachment styles were selected as measurable dispositional constructs using previous research as a guide (Holler, 2007; Ogunfowora & Drapeus, 2008; Petronzi & Masciale, 2015). Three psychotherapeutic orientations were presented to the participants in this study: psychodynamic psychotherapy, person-centered psychotherapy, and cognitive-behavioral. Each theoretical orientation was represented via a short vignettes in which a therapist of that respective theory explained his or her way of working with clients. Participants rated their preferences of each theory (presented in random order), took one short personality inventory (HEXACO-60) followed by two short attachment style instruments (RQ and ECR), completed the attitude toward help seeking questionnaire, and finally answered some questions about their previous experience with psychotherapy before filling out demographic information.

The initial sample consisted of 312 participants. After screening, the final sample was reduced to 240 participants. Data from these participants was then analyzed using IBM's SPSS version 22.0. As this line of inquiry is still largely exploratory, a bivariate zero order correlation analysis was calculated, which revealed that there were significant correlations between some of the predictor variables and the outcome variables (psychotherapy preferences).

Notably, secure attachment as measured by the RQ was significantly correlated with psychodynamic preference in this research as it was in Petronzi and Masciale's (2015) study. Additionally, anxious attachment as measured by the ECR was significantly correlated with person-centered preference in this study. Fearful attachment, as measured by the RQ was, significantly correlated with person-centered preference in prior research (Petronzi & Masciale, 2015). No other significant overlapping correlations were found across studies.

## **Results by Hypotheses**

### **Hypothesis 1**

Hypothesis 1 states that personality traits and attachment styles significantly predict psychotherapeutic preference above demographic variables. The results of the hierarchical regression analysis support hypothesis 1 for psychodynamic therapy preference, indicating that personality traits and attachment styles significantly predicted people's psychotherapy preferences above variation accounted for by demographic variables. This finding mirrors that of previous research (e.g. Holler, 2007; Ogunfowora & Drapeu, 2008; Petronzi & Masciale, 2015; Scandell et al., 1997). However, this hypothesis was not supported for person-centered and cognitive-behavioral preferences.

More specifically, it was found that agreeableness significantly predicted psychodynamic psychotherapy preference. Interestingly, agreeableness was also significantly correlated with

psychodynamic preference in Petronzi and Masciale's (2015) study. As such, it would appear that the agreeableness personality trait demonstrates a specific and somewhat consistent relationship for people's preference of psychodynamic psychotherapy, such that the more agreeable a person is, the more he or she tends to prefer psychodynamic therapy.

With regard to person-centered preference, it is notable that no personality traits or attachment styles were significant predictors of this therapy preference. This finding is not unique to this study, as it was also found in Petronzi and Masciale's (2015) research. It may be that the dispositional variables chosen failed to adequately account for variance in person-centered preference, or the lack of significant results could be representative of a problem inherent with the person-centered vignette within the PPAS-R measure. In either case, this is certainly an area for continued examination in future research.

Lastly, no personality traits or attachment styles significantly predicted cognitive-behavioral preference in this study. However, it should be noted that in previous research, Petronzi and Masciale (2015) found fearful attachment (as measured by the RQ) to be a significant negative predictor of preference for CBT. Likewise, in the current study, although not statistically significant, anxious attachment (as measured by the ECR) negatively predicted cognitive-behavioral therapy preference. Thus, there does appear to be a relationship between CBT preference and anxious attachment styles that is worth further investigation.

In sum, the results supported hypothesis 1 only for the psychodynamic psychotherapy preference. Other predictors, such as level of education and gay identity, were found to be significant negative predictors of psychodynamic therapy, however, these findings should be interpreted cautiously given the limited representation of subsamples in the overall sample.

## **Hypothesis 2**

Hypothesis 2 states that a person's attitude toward help seeking accounts for variance in psychotherapy preference above demographic variables, personality traits, and attachment styles.

With regard to the psychodynamic and person-centered preferences, scoring lower or higher in attitude for help seeking (as measured by the ATSPPH-SF) did not significantly account for variance in preferences for those psychotherapies in either direction. However, it was found that the more positive a person's attitude toward seeking professional psychological help, the more he or she demonstrated a preference for cognitive-behavioral psychotherapy. Concordantly, the other two significant predictors of cognitive-behavioral preference were the variables: currently being in psychotherapy and currently seeking psychotherapy.

Based on this information, it would appear that the sample in this research had a somewhat positive view of cognitive-behavioral therapy, such that those more open to seeking treatment, those seeking therapy at the time of the study, and those in treatment were more likely to prefer CBT. It may be that CBT is more commonly practiced across the country and therefore individuals who have experienced this type of therapy were able to demonstrate greater preferential distinction, as informed by their first-hand experiences. Unfortunately, this is only speculative. Future research could include a question asking participants' (who are currently in or have been in psychotherapy) which vignette most closely approximates their psychotherapy experiences. Nevertheless, findings for CBT preference support hypothesis 2, and this suggests that attitude toward help seeking merits further investigation in accounting for psychotherapy preferences.

### **Implications**

Results of the main analyses revealed partial support for both hypotheses. It should be noted that while only certain dispositional variables significantly predicted psychotherapeutic

preferences, each personality trait or attachment style need not demonstrate a significant predictive association in order to be clinically relevant. Rather, this research serves as a basis from which to begin understanding the extent to which different people may prefer various psychotherapies and how this preference occurs. Notably, the variance accounted for in the regressions, as measured by the *R* squared statistic, increased over a previous study in this line of inquiry. Where Petronzi and Masciale's (2015) findings accounted for roughly 9% of the variance in psychotherapeutic preference, whereas the variables in the current study accounted for 24% of the variance in psychodynamic therapy preference and 17% of the variance in cognitive behavioral preference in the third step equations.

In addition, the effect sizes in this study (as demonstrated by significant standardized beta weights) ranged from .14 to .39, with an average aggregate absolute value of  $\beta = .21$ . How can this be interpreted in terms of clinical utility? As Hunsley and Lee (2014) pointed out in their examination of the clinical utility of self-report and projective assessment measures as compared with other health care research, electrocardiogram stress tests and diagnosis of coronary heart disease correlated at  $r = .22$ , mammogram screening results and detection of breast cancer within a year correlated at  $r = .32$ , and finally, dental X-rays and diagnosis of tooth cavities correlated at  $r = .43$ . Given the comparatively more abstract nature of the constructs measured in the current study than those in the aforementioned health care fields, further research in this line of inquiry appears to be both reasonable and merited.

While the implications of this research for psychologists are yet to be realized, the results of this study may be helpful to theoretically integrative clinicians as an adjunct to their early treatment planning. Specifically, clinicians might find it helpful to give their clients the HEXACO-60, the RQ, the ECR, and the ATSPPH-SF at the onset of treatment. Based on the



significantly predictive associations found in this study, clinicians may find that clients scoring higher in agreeableness may tend to prefer psychodynamic psychotherapy, whereas more educated individuals and those who are gay-identified may be less enthusiastic about psychodynamic psychotherapy. Lastly, cognitive behavioral treatments may appeal more to people who are less resistant to seeking professional psychological help.

### **Limitations**

This study has several limitations. First, the use of self-report measures presents a mono-method bias in quantifying dispositional variables, thus limiting the thoroughness of the assessed predictor variables. For instance, some have argued that to have a complete understanding of one's attachment style, a clinical interview and observer reports are important in addition to self-report measures (Levy, Meehan, Temes, & Yeomans, 2012).

Next, this research intentionally selected a representative non-clinical sample for which the results are applicable. However, one possible limitation of this study—shared by previous research in this line of inquiry—is that there is an implied association between this sample and individuals who are clients in psychotherapy. It may be, however, that the results from this sample are not generalizable to potential or actual psychotherapy clients. Note that while this study did query about current psychotherapy status, questions about psychotherapy treatment in this study were optional in order to comply with Institutional Review Board requirements. Moreover, the combined number of individuals that endorsed being in psychotherapy and seeking treatment represented was only a small portion of the overall sample ( $n = 19$ ; 7.9%). It is reasonable to assume that while attitude toward help seeking was assessed, the results of this assessment may not be as representative of individuals who utilize psychotherapeutic services. Moreover, since the majority of the sample had no prior experience with psychotherapy ( $n = 142$ ;

59.2%), the generalizability of these findings to populations of individuals who are or would be psychotherapy clients is limited. For example, it may be that people who are not currently in psychotherapy may not have the intrinsic motivation to adequately delineate their psychotherapy preferences. While the MANOVA did, in fact, reveal some systematic variation in the sample with regard to people in current treatment as well as those who endorsed prior psychotherapy experience, since the number of these individuals was so small relative to the total sample, it is difficult to gauge the magnitude of these variations.

Another limitation of this study is that the psychotherapeutic orientations were presented to the participants in the form of three, one to two paragraph vignettes that described the therapy written in the first person by a psychologist who described his or her approach to therapy. The extent to which these vignettes adequately informed the participants of the theoretical/practical distinctions across paradigms may vary from person to person and may have acted as a confound in the calculation of the variance accounted for by the outcome measures.

Lastly, the representativeness of the sample poses some limitations in terms of how generalizable the findings are to a larger population. While samples from M-Turk have been shown to be fairly representative of the U.S. population at large, the sample used in this study was largely comprised of well-educated Caucasians. In addition, if CBT is viewed as a more contemporary representation of psychotherapy, then people's biases about therapy—be they good or bad—may influence the directionality of their preferences specifically regarding CBT. This could be better addressed in future research by including questions that ask which of the theoretical vignettes most closely resembles their experience or presupposition of what psychotherapy is like. Finally, although this study considered participants' formal educational attainment, which is sometimes used as proxy for socio-economic status, this study did not fully

consider other aspects of socioeconomic status that could have played a role in people's perceptions of psychotherapy. For instance, if one does not have the means to pay for psychotherapy, one might not even consider it a viable treatment option, and this could limit his or her preference discernment. Future research would therefore benefit from assessing participant socioeconomic status in addition to obtaining a more culturally diverse sample.

### **Future Directions for Research**

As both this study and prior research have revealed no significant associations for person-centered psychotherapy, it may be helpful to re-examine the extent to which the person-centered vignette is a valid representation of this therapeutic orientation. As the PPAS-R created each vignette by having nine different licensed mental health professionals rate the representativeness of each vignette, this may simply not be enough to reliably and confidently say that these vignettes sufficiently represent each theory described.

Additionally, it may be possible to tap into people's therapy preference better if they "see the therapy in action." Perhaps future research could present participants with a video of practitioners demonstrating each theory. It may be that reading short vignettes is not enough to enable the layperson to form an adequate conceptualization of each theoretical distinction. Moreover, it stands to reason that because there were differences found in the way individuals rated each therapy based on prior experience with psychology (via both study and experience; see MANOVA results), it may be helpful for future research to obtain adequately sized samples of people who have no prior experience with psychology and those that do, in order to examine differences across patterns of preferences more precisely.

While examining attitude toward seeking professional psychological help was an attempt at elucidating the potential differences in preference ratings between individuals with varied

experiences with psychology, only in the cognitive-behavioral preference was a strong predictive association found. In the present study, attitude toward help seeking was only used insofar as to examine variance accounted for by the construct of one's psychotherapy preferences (essentially using attitude toward help seeking as a dispositional construct). Future research could specifically examine attitude toward help seeking as a moderator of people's ability to demonstrate preference for one therapy over another (especially for cognitive-behavioral preference).

Lastly, future research in this line of inquiry could more effectively understand the clinical utility of people's psychotherapy preferences by using in an intent-to treat paradigm. Using this method, researchers could first assess people's personality traits and attachment styles and then randomly assign them to therapists using different theoretical orientations. Pre and post measures of distress (e.g. using Beck Depression Inventory scores or the like) could reveal the respective efficacy of each theoretical orientation for persons of different dispositional qualities. Results could then be compared to prior studies on preferential predictions to see whether or not overlap exists between a client's theoretical preferences and treatment efficacy.

### **Summary and Concluding Remarks**

This study examined the extent to which people's dispositional qualities (as measured by their personality traits and attachment styles), as well as their attitude towards seeking professional psychological help, accounted for variance in their preferences for three different psychotherapeutic orientations. In line with previous research, the results revealed some significant predictive associations between people's dispositional qualities and their preferences for various psychotherapies. While not true equally of all psychotherapeutic orientations

presented, results partially supported both hypotheses. Additionally, results pointed out ways in which this line of inquiry must be refined.

While this research remains largely exploratory, the findings indicate that further investigation is merited. As Hunsley and Lee (2014) pointed out, a clinician's theoretical orientation plays a central role in assessment, conceptualization, and treatment planning in the delivery of psychotherapy. It is therefore essential that clinicians become more aware of the ways in which various theoretical orientations may or may not work optimally for various clients based on empirically validated research. Accordingly, the development and refinement of this line of inquiry has important implications for the provision of psychotherapy. A deeper and more comprehensive understanding of which theory is right for what person could provide the first empirically supported basis for referrals. Finally, as clinicians increasingly utilize integrated theoretical frameworks in their practice, this research could provide an empirical basis for the treatment planning process.

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Appendix A

Preferences for Psychotherapy Approaches Scale-Revised

(Holler, 2007)

Preferences for Psychotherapy Approaches Scale-Revised  
(PPAS-R; Holler, 2007)

The PPAS-R, including permission for use, is available from:

Timothy Holler  
Victory University  
255 N. Highland Avenue, Memphis, TN 38111  
Phone: (901) 320-9700, ext. 1402  
Fax: (901) 320-9709



Appendix B

Counseling Approach Evaluation Form

(CAEF; Lyddon, 1989)

Counseling Approach Evaluation Form  
(CAEF; Lyddon, 1989)

The CAEF, including permission for use, is available from:

William J. Lyddon  
Department of Counseling Psychology and Counselor Education  
University of Southern Mississippi, Box 5012  
Southern Station, Hattiesburg, Mississippi 39406- 5012.

## Appendix C

HEXACO-60 Personality Inventory

(HEXACO-60; Lee & Ashton, 2009)

HEXACO-60 Personality Inventory  
(HEXACO-60; Lee & Ashton, 2009)

The HEXACO-60, including permission for use, is available from:

<https://hexaco.org/>

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Appendix D

Relationship Questionnaire

(RQ; Bartholomew & Horowitz, 1991)

Relationships Questionnaire  
(RQ; Bartholomew & Horowitz, 1991)

The Relationships Questionnaire, including permission for use, is available from:

Kim Bartholomew  
Department of Psychology  
Simon Fraser University  
Burnaby, British Columbia, Canada V5A 1S6

## Appendix E

Experiences in Close Relationship Scale-Short Form

(ECR-SF; Wei, Russell, Mallinckrodt, & Vogel, 2007)

Experiences in Close Relationships Scale-Short Form  
(ECR-SF; Wei, Russell, Mallinckrodt, & Vogel, 2007)

The Experiences in Close Relationships Scale-Short Form, including permission for use, is available from:

Meifen Wei  
Department of Psychology  
Iowa State University  
W112 Lagomarcino Hall  
Ames, IA 5011-3180  
[wei@iastate.edu](mailto:wei@iastate.edu)



## Appendix F

## Attitudes Toward Seeking Psychological Professional Help—Short Form

(ATSPPH-SF; Fischer & Farina, 1995)

Attitudes Towards Seeking Professional Psychological Help—Short Form  
(ATSPPH-SF; Fischer & Farina, 1995)

Attitudes Towards Seeking Professional Psychological Help—Short Form, including permission for use, is available from:

Edward H. Fischer  
Department of Clinical Research  
The Institute of Living  
400 Washington Street, Hartford, CT 06106

## Appendix G

## Demographics

What is your age? \_\_\_\_

What is your gender? \_\_\_\_

What is your highest level of education?

Less than high school

High school or equivalent

Some college

Associate's degree

Bachelor's degree

Master's degree

Doctorate

What is your ethnic background? \*

Arab

Asian/Pacific Islander

Black/African-American

Caucasian

Latino/a

Native American/Alaska Native Multi-Racial

Decline to Respond

Other

If you are currently enrolled or have been in college what is/was your major. \_\_\_\_\_

Have you ever been in psychotherapy before? (Optional)

Yes No

Have you ever studied psychology before?

No, A little, some, A lot