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ABSTRACT

While past research has found conflicting results on the place for client role preferences in psychotherapy, none of this research has examined the client role preferences in an actual client population seeking outpatient therapy. This study involved the development of a measure of client role preferences which attempted to survey a wider range of therapist traits and behaviors than has been typical in previous work and which was specifically designed for use in outpatient treatment settings. The Role Preference Inventory, a 74-item checklist of client role preferences in the areas of therapist characteristics, therapist activities, and client activities, was administered to clients seeking treatment at a university psychology clinic, a community mental health center in a small community, and a community mental health center in a larger urban area. Data were collected for one year at the mental health centers and for over 2 years at the psychology clinic. Results from 170 subjects suggest that it is possible to identify and measure distinct dimensions of client role preferences. Concern, support, expertise, problem resolution, and separateness or distance between the client and therapist all appeared to be general dimensions central to the clients' perceptions of therapists. A five cluster solution from the K-Means analysis data was selected as offering the best combination of statistical discrimination among groups and potential clinical meaningfulness of the groups. (NB)

Measurement of Client Preferences for Therapist Behavior

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Measurement of Client Preferences for Therapist Behavior

Goldstein and Stein (1979, pp. 9-10) state "The most celebrated nonspecific active ingredient discussed in the psychotherapy literature involves the interpersonal relationship between therapist and patient. . . . In each method of therapy, the sincerity, honesty, concern, utilitarian purposefulness, and confidentiality of the therapist-patient relationship provide the catalyst for new social and personal learning to occur." More recently Strupp and Binder (1984) as quoted in Henry, Schacht and Strupp, (1986, p. 31) concluded that "Techniques cannot be separated from the context of the interpersonal relationship, and indeed, future research is likely to reveal that management of the therapeutuc relationship is itself a technical cornerstone."

Strong (1968) argued that the therapeutic relationship could be understood in terms of the social psychology of interpersonal influence. He suggested that the therapist must first establish him/herself as expert, attractive, and trustworthy and must actively involve the client. If the therapist then introduces dissonance into the client's cognitive framework, and if the client cannot gather social support for his/her position, then change in the client's attitudes are likely.

One important element in therapy, then, may be the attractiveness of the therapist. Ross (1977) has argued that interpersonal attraction is increased by similarity on dimensions which are positively valued by the participants in the

relationship. Therefore, therapist behavior which matches what the client values in the potential therapist as reflected in what he/she wants the therapist to be like or to do, might facilitate the therapeutic relationship. Indeed, Duckro, Beal and George, (1979) suggest that it may be the failure to account for client preferences which has led to the inconclusive findings regarding the impact of meeting client role expectations in therapy.

Expectations and values are distinct and interact in shaping a person's behavior. Mischel (1973) defines expectations as subjective probabilities about events. Calanter (1962) measured subjective probability and utility (a type of value) and found that people choose those alternatives which offer the highest subjective probability of obtaining the most valued outcome. Price and Barrell (1984) found that feeling intensity is a complex function of desire (again a type of value) and expectancy.

Client role expectations (cf. Goldstein, 1962) have typically been understood as the subjective probabilities the client holds about the characteristics and behaviors of the therapist. Tinsley and Benton (1978) showed that client role expectations and preferences are clearly different. Preferences exceeded expectations of the same therapist qualities on five of their scales. Role preferences are defined here as the client's pre-therapy beliefs about what therapist characteristics and behaviors will be helpful. In other words, role expectations refer to subjective probabilities about therapist traits and behaviors, but role preferences refer to what therapist traits

and behaviors the client positively values regardless of whether such behaviors are anticipated from a particular therapist or not.

Research examining the effect of meeting or not meeting client role preferences has, however, produced inconclusive results. In two studies involving manipulation of degree of choice of treatment (Gordon, 1976; Kanfer & Grimm, 1978) greater choice was found to be associated with greater improvement. To the extent that choice reflects preference, these studies suggest that receiving a preferred treatment may be associated with greater benefit from treatment. Examining role preferences more directly, Grater (1964) found that differences in role preferences as measured by an adjective checklist were associated with differences in client behavior in the initial interview. In two studies role preferences were measured and used to assign clients to treatments. Clients receiving preferred treatments showed better process in the initial interview (Ziemelis, 1974) and better outcome (Devine & Fernald, 1973) than clients receiving non-preferred treatments.

Some studies, however, have failed to find a significant effect for meeting of role preferences. Pohlman (1964) used ratings of specific behaviors to assess the preferences of 38 students enrolled in a study skills course. These students then worked with 11 student counselors to improve study skills. The match between preferences and helper behavior was assessed by the difference between the pre-treatment preference ratings and the post-treatment frequency of occurrence of each behavior as rated by the subject. No significant relationships were found between

this index of matching and client, therapist, and practicum supervisor ratings of success of treatment. Duckro and George (1979) examined the effect of matching client role preferences in a therapy analogue study using 48 college students. Their data showed no effect of meeting of preferences upon three speech variables measured in the first ten minutes of a 30 minute interview nor upon subject ratings of satisfaction.

The conflicting findings in these studies indicate no clear and major role for client role preferences in psychotherapy. However, it is important to note that none of these studies has examined the relationship in an actual client population seeking outpatient therapy. Moreover, the procedures used to assess preferences have varied widely across studies, and only a limited range of helper traits and behaviors has been examined. It is possible that a measure which systematically examines preferences for a wider range of therapist traits and behaviors could provide a clearer understanding of the relationship between meeting of client role preferences and the process and outcome of therapy. The present study describes the development of a measure of client role preferences which attempts to survey a wider range of therapist traits and behaviors than has been typical in previous work and which is specifically designed for use in outpatient treatment settings.

Method

Materials

An initial pool of items for the Role Preference Inventory (RPI) was written to be consistent with my theoretical

classification of role preferences (Richert, 1983). This classification was based on the dimensions of therapist power/distance relative to the client (Authoritative--Cooperative) and therapist focus (Personal experience--External problem). Items were written to represent each pole of the two dimensions with the authoritative, cooperative and experience poles being represented by 19 items each, and the problem focus pole by 17 items. Twenty-six of the items were adjectives reflecting qualities the therapist might display for example, Active, Objective. Of these 74 items, 26 were adjectives describing qualities the therapist might display: for example Active, Objective. These 26 items represented primarily the authoritative--cooperative dimension. Another 33 items were short phrases describing things the therapist might do in a session (e.g., Ask about my ideas, Point out personal conflicts) and reflected both power/distance and focus of the therapist. Fifteen items were phrased as client activites (e.g., Report dreams, Answer questions) and again represented both power/distance and focus. Wording of some items was revised according to the suggestions of several therapists working in community settings to improve comprehensibility for the typical client.

For presentation to the subject, items were grouped into three sets: therapist characteristics, therapist activities and client activities. Items representing particular poles of the dimensions were randomized within these groupings. The final checklist, then, contained 74 items relevant to client role preferences, an open ended item simply listed as "Other" under

the heading "Things I would like to do in counseling" and blanks at the end of the form for the client's age, sex and level of education to be written.

The following instructions, which attempted to focus the client on his/her preferences rather than expectancies, were printed at the top of the form.

> We are trying to understand better what people look for in counseling before they begin receiving services. Many people, of course, have heard different things about what occurs in counseling before they decide to start. However, we would like you to answer these questions according to how you would like your counseling to be, not what you may have heard happens in counseling.
>
> Below are three lists. One describes qualities that a counselor might show; one lists things that a counselor might do; and one lists things that you might do in counseling. Place a check by those items that describe the way you would like your counseling or counselor to be.

Procedure and Subjects

Data were gathered from clients seeking treatment at three agencies. One was a university psychology clinic in a small community where 75% of the clientele come from the community at large and 25% are university students. Data were collected at this clinic for a period of two and one-half years. All clients requesting treatment and appearing for their first interview

during this period responded to the RPI.

The second agency was a community mental health center in a small community, and the third was a community mental health center in a larger (200,000 population) urban area. Data were collected in each of these settings for a period of one year. In the rural mental health center all clients applying for outpatient services during that period were given the RPI. For administrative reasons, all the clients who responded to the instrument in the urban center were seeking family therapy. In such cases each member of the family who arrived for the initial interview completed the RPI. In all the settings clients were given the RPI by clerical personnel either at the time of requesting services or when they arrived for the first interview. The RPI was always completed before the client had any contact with the therapist.

Before the data were analyzed, protocols were inspected to see that the subject had checked at least 10 and not more than 65 of the 74 items on the RPI. Subjects whose rate of response was outside these limits were excluded from the final sample. This procedure was followed because such protocols do not provide any clinically useful, discriminative information about what the respondant wants in a therapist. The extreme scores from such protocols would, however, greatly affect the correlation coefficients.

Twenty-one subjects were dropped from the sample using this criterion. The 170 subjects (54 males, 116 females) included in the final analyses had a mean age of 24.5 years for males and 27.3 years for females. The modal level of education for both

sexes was some college but no undergraduate degree. For the 21 subjects (11 males, 10 females) excluded the mean age for males was 23.7 and for females 34.6 years. For the males there was no clear modal level of education among the subjects excluded, but for females the modal level of education was some high school without completion.

There were, of course, some differences between the samples from the various agencies in the characteristics of the subjects included in the final sample. Men from the university clinic (N - 35) had a mean age of 26.0 years and a modal educational level of some college experience. Women in this setting (N = 74) had a mean age of 24.3 years and a modal education level of completion of high school. In the rural mental health center, males (N = 8) had a mean age of 26.5 years and a modal educational level of some college experience. Females in this clinic (N = 16) were somewhat older (mean age 36.4 years) with a modal education level of completion of high school. In the urban mental health center males (N = 11) had an average age of 20.7 years (median age was 15 years) and a modal educational level of some high school experience. Females, (N = 26) by contrast, had an average age of 29.2 (median age 35) with a modal educational level of completion of high school. The discrepancies in age for the males in this sample reflects the fact that most of the males in this agency were adolescents brought in by their mothers for family treatment. It is also worth noting that five of the eleven males dropped from the sample were adolescents (mean age 15.4 years) from this agency. In all cases they were dropped because they

had checked less than 10 items.

Results

Analyses

Two types of analyses were performed upon the data from the RPI. First, item responses were factor analyzed to examine the dimensions of clients' role preferences. Second, a K-Means cluster analysis of subjects was performed using scores on the dimensions derived from the factor analysis to determine if clinically meaningful groupings of clients on role preferences could be defined.

The raw data on the 74 RPI items from the 170 subjects in the final sample was subjected to a principal components factor analysis which selected only factors with an eigenvalue greater than 1.0. A varimax rotation procedure was used. The center at which the subject received services was included as a variable in this analysis as a check on possible differences in client preferences at the various agencies.

A further factor analysis of scores on the dimensions derived from the first factor analysis was done to see if the two principal dimensions of perception of the therapist's role suggested by Richert (1983) could be identified. The score on each factorially defined dimension used in this second factor analysis was the number of items endorsed by the subject which had a loading of .35 or more on the factor. The cutoff point of a factor loading of .35 was selected because this level allowed inclusion of 67 of the original 74 items. This maximized the information obtained from the original questionnaire. Items which

had loadings above .34 on more than one factor were assigned only to the factor on which they showed the highest loading. This second factor analysis was also a principal components analysis using a varimax rotation. The effects of age, sex and education on scores on the factorially defined role preference scales was assessed by computing correlations between scores on the 13 preference scales and each of these variables.

A K-Means cluster analysis of subjects was used to identify groups of subjects with distinct role preference patterns. percentage scores based on all items with a loading above .34 on the 13 factorially defined preference dimensions were used as the basis for this analysis.

Findings

Thirteen factors accounting for 91.9% of the variance in the matrix were extracted in the initial factor analysis. Sixty-seven of the original 74 items showed loadings above .34 on at least one of these factors. The items loading on each factor are shown in Table 1.

The first factor, Active Therapist Inquiry, accounted for 16.6% of the variance. Therapist activity items (N = 8) loading on this factor centered upon the therapist seeking information about activities or feelings of the client. Client activity items (N = 5) loading on this factor concerned the client giving information or expressing feelings. No therapist characteristic items loaded on this factor.

The second factor, Solutions, was defined by 7 items and accounted for 8.7% of the variance. Therapist characteristic items loading on this scale concerned the therapist's interest in

the client's personal values and goals, and the therapist activity items centered upon development of alternatives and solutions. No client activity items loaded on this factor.

The third factor, Teaches, was defined by only four items. Three of these were therapist activity items which focused on didactive instruction by the therapist. This factor accounted for 7.59% of the variance. Teaches lacks the emphasis upon the client's personal goals and values seen in Solutions. The items loading on Teaches appear to define a more impersonal, external stance on the part of the therapist than is true of the items loading on Solutions.

Client Advocate was the fourth factor. Therapist characteristic items (N = 2) loading here reflected concern for the client, and therapist activity items (N = 3) centered on learning the client's perspective The only client activity item loading on the factor suggested a focus on how other people create problems for the client. This factor accounted for 7.29% of the variance.

The fifth factor, Warmth/Support, was defined primarily by therapist characertistic items (N = 4) which depicted the therapist as a person with whom the client can become close. It accounted for 7.17% of the variance. Only one therapist activity item loaded on this factor: therapist focus on the client's current problems. This item had a negative loading on the factor. In Warmth/Support what the client wants from the therapist is someone who will provide comfort without pushing for problem resolution.

Client activity items were the primary definers of factor six, Tasks. These items (N = 4) suggested a client preference for developing and carrying out specific plans for dealing with his/her problems. The only therapist activity item which loaded on this factor was "Help set concrete goals that I can tell if I reach" which is consistent with the client activities. Tasks accounted for 6.64% of the variance in the matrix.

Three therapist characteristics defined factor seven, Expertise, which accounted for 6.01% of the variance. All the items loading on the factor focused on the skill of the therapist.

Three therapist characteristics, all centering on disclosure and commonality, loaded on the eighth factor, Closeness. The one therapist activity item which loaded here was "Work with me as a partner". This factor accounted for 5.79% of the variance.

The ninth factor was Personal Focus and accounted for 5.67% of the variance. Three items loaded on this factor, one therapist characteristic, Supportive, and two therapist activities which focused upon getting to know the client.

Six items loaded on the tenth factor, Formal/Distance. Three were therapist characteristic items which suggested an air of polite acceptance (Formal, Accommodating and Familiar). The other three were therapist activities which suggested a focus on external information rather than the personal reactions of the client. This factor accounted for 5.50% of the variance.

Factor eleven, Client Control, was defined by four items and accounted for 5.08% of the variance. Two therapist characteristics (Agreeable and Superior) and two therapist

activities which suggested that the therapist is less active or dominant than the client loaded on this factor.

Factor twelve, Active Collaboration, was also defined by two therapist characteristics (Active and Friendly) and two therapist activities. The activity items suggested that the therapist will involve the client in problem solving. This factor differs from factor eight, Closeness, in not having the implication of personal disclosure on the part of the therapist. The emphasis in Active Collaboration is upon shared, task directed effort rather than interpersonal sharing. Active Collaboration accounted for 4.94% of the variance in the matrix.

The final interpretable factor derived from the analysis was titled Answers and accounted for 4.91% of the variance. It was defined three items, one of each type of question. The items presented a picture of therapy as focusing upon factual information.

The purpose of this first factor analysis was to empirically identify dimensions that the clients were using to describe their preferences regarding psychotherapy. Because the intention was to use these factors as measurement scales, it was important to examine the reliability of scores on each of these factorially defined scales. For this purpose the average intercorrelation among all items loading on each scale was computed. This figure was then corrected for length of the scale using the Spearman-Brown formula (McNemar, 1969). The internal consistencies of these scales ranged from .86 to .41 (See Table 2) with the scales containing more items naturally showing higher reliabilities.

Five of the scales had reliabilities under .60. These were Warmth/Support, Closeness, Client Control, Active Collaboration, and Answers. Although the reliability of these scales makes them questionable even for research use, they were included in further analyses because of the preliminary nature of the study.

Correlations were computed between scores on the 13 factorially defined scales and subject age, sex and education. The correlations of client age and sex with scores on these scales were uniformly small. The two largest were -.19 between sex and Client Advocate indicating that men tend to have lower scores on that scale than women, and -.16 between age and Closeness. Three correlations between level of education and scale scores did achieve statistical significance. Education correlated .22 ($p < .001$) with Warmth/Support, -.35 ($p < .001$) with Closeness, and -.31 ($p < .001$) with Client Control. The absolute value of all the remaining correlations between level of education and scale scores was less than .15.

Scores on the thirteen scales were also factor analyzed. This second order factor analysis of the RPI data yielded four factors as shown in Table 3. The first factor, which accounted for 35% of the variance was a somewhat diverse cluster of scales. The scales loading on this factor suggested a view of psychotherapy which seemed quite close to the general cultural understanding of what psychotherapy is like. The therapist was seen as working for the client's benefit, focusing on the client's material and issues, actively conducting sessions and providing exercises and answers for the client. This factor was titled Professional Orientation.

Four scales each emphasizing the knowledge, expertise and higher interpersonal status of the therapist relative to the client in therapy loaded on the second factor. This factor was titled Reserved/External Focus and accounted for 30% of the variance. The third factor was titled Concerned Caring. It was defined by three scales all of which emphasized various aspects of closeness between the client and therapist. Concerned Caring accounted for 19% of the variance. The final factor in this second order analysis was defined by a single scale, Client Control and is so named. It accounted for 16% of the variance.

A five cluster solution from the K-Means analysis data was selected as offering the best combination of statistical discrimination among groups and potential clinical meaningfulness of the groups so defined. Table 4 shows that the five clusters defined by the K-Means analysis are clearly statistically differentiated on the thirteen scales. To examine whether these clusters showed differing profiles of scores on the thirteen scales that might be clinically meaningful, scales in each cluster were rank ordered on the basis of mean percentage of scale items endorsed by subjects in that cluster. The rankings for each cluster are shown in Table 5.

Because the rankings of scales were not identical across clusters but clearly were similar, the ranked lists were divided into three sets of scores: top four, middle five and bottom four. The lists were then inspected to see if a particular scale was placed in the same section of the ranking across groups. If this were uniformly the case, then the statistical distinction between

groups would rest primarily upon differences in mean scores which might be largely a function of overall rate of responding in each cluster, rather than upon differences in profile which might be clinically meaningful. Examining the data in this way made it clear that several scales did not effectively discriminate among groups because they were either uniformly ranked high or uniformly ranked low across groups. Those scales which ranked in the upper four in almost every cluster were Solutions, Warmth/Support, Personal Focus and Answers. Those scales which ranked in the lowest four in almost every cluster were Client Control, Formal/Distance and Closeness.

The relative ranking of the six scales not uniformly ranked high or low, along with the occasional deviation from the general ranking of the seven consensually ranked scales was then used as a basis for differentiating among the five clusters. When approached in this way, the five clusters developed by the K-Means analysis do appear to have distinct patterns of role preferences. The rankings of the discriminating scales for each cluster are shown in Table 6.

Clients in Cluster 1 appear to prefer that the therapist be a source of support and comfort, and that the client be somewhat active in treatment. Specific problem solutions and the therapist as an expert are relatively not preferred by clients in this cluster.

Clients in Cluster 2 also prefer that the therapist be a source of support and comfort, but appear to want the terapist to be active and expert in addressing the problems they bring. Unlike clients in Cluster 1 they appear to prefer not to be

actively involved in treatment.

Cluster 3 appears to represent a kind of problem solving preference. Clients in this cluster want to actively collaborate with an active, expert therapist. They rank therapist warmth and support relatively lower in terms of their preferences.

Clients in Cluster 4 seem to want the therapist to be a kind of friendly advisor. They rank "Teaches" and "Warmth/Support" highest among their preferences. Therapist activity and expertise rank low among the preferences in this group of clients, as does the therapist as a personal advocate.

Cluster 5 can be seen as representing a set of preferences somewhat similar to the role of the traditional insight therapist. Clients in this cluster want to collaborate with a therapist who keeps at a distance, teaches and focuses on the client's personal experience. They prefer, however, for the therapist not to be actively inquiring or to be a personal advocate or defender.

The distinctions among the five clusters can also be tentatively conceptualized in terms of the position of the clusters with regard to the second order factors derived in this study. For purposes of this description the factor "Client Control" was not used because all clusters ranked low on this factor. If the other three factors, "Professional Problem Orientation," "Reserved/External," and "Warmth/Support", are dichotomized and crossed, a cube with eight cells results. The five empirically derived clusters appear to fit in different cells in this cube (See Figure 1). Cluster 1 is high on Professional Problem Orientation and on Warmth/Support, but low

on Reserved/External. Cluster 2, by contrast, is high on all three dimensions. Cluster 3 is high on Professional Problem Orientation but low on Reserved/External and Warmth/Support. Cluster 4 is high on Warmth/Support but low on Reserved/External and on Professional Problem Orientation. Cluster 5 is high on Warmth/Support and on Reserved/External but low on Professional Problem Orientation.

Discussion

The results of this preliminary study suggest that it is possible to identify and measure distinct dimensions of client role preferences. Examination of clusters of clients on the preferences so defined reveals that all clients appear to want certain qualities and behaviors in their therapists and not to want others. Further, and most relevant to the issue of prescriptive psychotherapy, these dimensions of role preference may allow for the identification of groups of clients who have different profiles of desired characteristics and behaviors in their preferred therapist. Clinically these findings allow for the tailoring of initial therapeutic approaches to the preferences of people from the various clusters which should, following Ross (1977) and Strong (1968) facilitate the therapeutic relationship and change in the client.

The dimensions of client perception of the therapist's role which were identified in the present data appear to be quite similar to those defined in earlier studies of client perceptions of the therapist. Apfelbaum (1958) identified three clusters in client's role expectations which he termed Nuturant, Model and Critic. Dimensions such as Solutions, Warmth/Support, Teaches,

Client Advocate, and Personal Focus would seem to cover perceptions of the therapist subsumed under Apfelbaum's Nuturant cluster. Expertise and Closeness appear to get at the same client perceptions as Apfelbaum's Model cluster, and Tasks, Expertise and Active Collaboration to parallel his Critic cluster.

Loor (1965) identified five factors in client perceptions of therapist behaviors: Understanding, Accepting, Authoritarian, Independence-Encouraging and Critical-Hostile. In the present data, Client Advocate and Personal Focus are similar to Loor's Understanding; Warmth/Support, Closeness and Active Collaboration are similar to Accepting; Active Therapist Inquiry, Teaches, Answers, and Expertise appear to parallel Loor's Authoritarian factor; and Solutions and Tasks seem similar to his Independence-Encouraging factor. No factors that appear closely similar to Loor's Critical-Hostile factor appeared in the present data, although Formal Distance may capture some elements of this and Client Control may reflect the client's attempt to avoid a critical hostile therapist.

Tinsley, Workman and Kass (1980) factor analyzed scores on 17 scales from the Expectancies about Counseling questionnaire. The first factor they extracted, Personal Commitment, reflected the client's own investment in the therapeutic process. The other three appear quite similar to factors derived in the present and other studies. Facilitative Conditions was defined by items reflecting the genuineness, acceptance, trustworthiness and tolerance of the therapist. Counselor Nuturance was defined

by items concerning the attractiveness, caring and self-disclosure of the therapist. Counselor Expertise centered upon the directiveness and use of techniques of the therapist.

The commonality which emerges from these analyses is encouraging especially in view of the fact that common perceptions emerge regardless of whether the client is asked about role expectations, role preferences or simply about perceptions of therapists. It appears that there are some general dimensions that are central to the clients' perceptions of therapists. These dimensions seem to concern support, expertise, problem resolution and separateness or distance between the client and therapist.

More factors were identified in the initial analysis of the 74 items from the RPI than have typically been found in other studies. Some of these factors were defined by only a few items, and were extracted late in the analysis. For these reasons it may be quite likely that these factors will not cross-validate. Moreover, some of the factors identified in the first analysis appear to fit together logically with other factors. It was decided to interpret and discuss these factors recognizing that they may be artifacts of the analysis because of the preliminary nature of the present study. Although it is quite possible that some of these factors may not cross validate and that the number of stable factors may be smaller than the 13 found in the first analysis, it is also possible that the distinctions among the factors represent important discriminations which clients make about therapists.

Examination of the pattern of rankings of the thirteen

factors across the five clusters in the present data suggested that some dimensions of therapist behavior and functioning may be rather universally liked by clients. Solutions, Warmth/Support, Personal Focus and Answers were fairly consistently ranked among the four scales with the highest preference scores across the five clusters. That these dimensions may actually constitute rather general preferences concerning therapists is supported by some previous research. Tinsely, Brown, deSt.Aubin and Lucek (1984) in reviewing the results of earlier work on role expectancies conclude that all clients expect therapists to be warmly interested, expert, confident, problem centered on a personal level and trustworthy. Data from Pohlman's (1961) study of client preferences suggest that clients generally want answers and a friendly equal rather than a superior as a therapist. The fact that Formal/Distance and Client Control were among the four scales with the lowest endorsement percentages consistently across the five clusters is consistent with the relative dislike for superiority in the therapist suggested by Pohlman's data. Given the list of therapist characteristics and behaviors wanted by clients, it may be that the dislike for superiority refers not to status based on expertise, but rather to a desire not to be condescended to by the therapist.

If preferences for warmth, support, problem solution and a personal focus coupled with a distaste for aloofness and guardedness are general across clients, it may be because these qualities are central to the cultural definition of a psychological helper in our society. It is possible, then, that

to be successful all therapists need to demonstrate at least minimal levels of behaviors reflecting these qualities. Behaving in these ways would enhance the therapist's credibility as a culturally defined helper which Frank (1961) has argued is essential for the success of psychotherapy. A further implication is that if these preferences are universal, and therefore necessary to be accepted as a helper, they cannot serve as the basis for differentially tailoring the therapist's role to make him/her more attractive to particular clients.

However, the fact that five clusters of clients each with slightly different preferences for certain types of therapist qualities and behaviors could be identified provides a concrete direction for attempting to improve therapy by tailoring the behavior of the therapist to the preferences of the client. As seen in the present data these differential patterns of role preferences are defined by relative degrees of preference for therapist behaviors and characteristics rather than by liking versus disliking of them. The nature of the clusters seen here suggests that therapists might increase their attractiveness by appropriate choices among the following alternatives: (1) actively involving the client as opposed to allowing him/her to remain more passive, (2) focusing upon the client's responsibility versus providing direction and suggestions, and (3) being an ally or defender of the client or being more impartial.

Because factor analytic approaches inevitably capitalize upon the unique variance in a sample, cross-validation of the factors seen here is essential before the RPI can be examined for

real, clinical usefulness. Moreover, there is always an element of arbitrariness in deciding how many clusters to extract in a K-Means analysis, and the mere ability to discriminate clusters does not indicate that even replicated groupings are, in fact, clinically important. This point, too, must await further research. Finally, there is the consideration of method factors in the use of any self-report instrument in a clinical situation. What the client says he/she prefers when confronted with a list of traits and activites may be quite different from what he/she actually likes or finds helpful when confronted with actual therapist behavior. The potential importance of this distinction is highlighted by the work of Venzor, Gillis and Beal (1976) who found that clients indicated different preferences when presented with an adjective checklist and when presented with scripts representative of various helping styles.

Research is currently in progress on cross-validation of the first and second order factors and the clusters. Further research will examine improving the discriminativeness of those scales which best differentiate client clusters in terms of role preferences. The question of central interest remains whether tailoring treatment to client role preferences improves therapeutic process and outcome. The measure presented here may provide a useful tool for examining that important question.

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Table 1. Items loading on 13 factorially derived scales

	Loadings
Scale 1: Active Therapist Inquiry	
Ask about how I behave in certain situations	.69
Describe ways I have acted	.68
Ask about when I behave in certain ways	.66
Ask about how I feel in certain situations	.63
Explore memories	.59
Review childhood experiences	.58
Examine my reasons for behaving in certain ways	.57
Ask many questions	.55
Report dreams	.54
Explore the connection between my feelings and my behaviors	.51
Examine my fears	.50
Express my feelings freely	.37
Share my feelings about the counselor with him/her	37
Scale 2: Solutions	
Suggest things for me to do	.62
Interested in my personal goals	.60
Clarify alternatives	.55
Sugggest logical solutions	.50
Knowledgeable	.46
Interested in personal values	.43
Be someone I can use to get information and ideas	.45
Scale 3: Teaches	
Instruct me	.70
Gives instructions	.66
Give advice	.61
Talk about sexual experiences	.37
Scale 4: Client Advocate	
Responsive	.54
Talk about the behavior of others that is difficult for me	.50
Ask about what others do that concerns me	.45
Invested	.48
Help me express emotions	.39
Ask about my ideas	.38
Scale 5: Warmth/Support	

Approachable	.67
Personal	.64
Warm	.51
Distant	-.37
Focus on my current problems	-.37

Scale 6: Tasks

Discuss new plans for action	.64
Help set concrete goals that I can tell if I reach	.57
Do homework assignments	.56
Discuss personal conflicts	.46
Examine my values	.39

Scale 7: Expertise

Expert	.70
Efficient	.62
Skillful	.56

Scale 8: Closeness

Equal	.60
Work with me as a partner	.36
Cool	.38
Talks about himself/herself	.35

Scale 9: Personal Focus

Supportive	.67
Focus on my personal feelings	.52
Take the time to know my background	.37

Scale 10: Formal/Distance

Formal	.69
Familiar	.46
Discuss events	.42
Explore difficult situations	.40
Accommodating	.37
Focus on facts	.36

Scale 11: Client Control

Follow my lead	
Superior	.69
Listen more than he/she talks	.47
Agreeable	.43
	.40

Scale 12: Active Collaboration

Active	
Friendly	.59
Involve me actively	.57
Point out personal conflicts	.42
	-.35

Scale 13: Answers

Objective	
Offer explanations	.60
Answer questions	.54
	.40

Table 2. Reliabilities of Thirteen Factorially Dervied Scales

Scale	r_{tt}
Active Therapist Inquiry	.86
Solutions	.73
Teaches	.65
Client Advocate	.64
Warmth/Support	.58
Tasks	.65
Expertise	.66
Closeness	.41
Personal Focus	.63
Formal/Distance	.65
Client Control	.51
Active Collaboration	.48
Answers	.49

Table 3. Scales loading on second order factors

	Loadings
Factor 1: Professional Orientation	
Active Therapist Inquiry (1)	.79
Client Advocate (4)	.78
Personal Focus (9)	.71
Tasks (6)	.57
Answers (13)	.42
Factor 2: Reserved/External Focus	
Expertise (7)	.78
Solutions (2)	.69
Formal Distance (10)	.63
Teaches (3)	.62
Factor 3: Concerned Caring	
Active Collaboration (12)	.76
Closeness (8)	.58
Warmth/Support (5)	.52
Factor 4: Client Control	
Client Control (11)	.74

Table 4. Summary of K-Means analysis and scale profiles for 5 subject clusters

Summary Statistics for Five Clusters

Variable	Between SS	DF	Within SS	DF	F-Ratio	Prob
Scale 1	58823.41	4	75157.44	165	32.28	.000
Scale 2	81047.12	4	65977.02	165	50.67	.000
Scale 3	109107.44	4	275054.91	165	16.36	.000
Scale 4	61317.87	4	67900.23	165	37.25	.000
Scale 5	26047.06	4	81906.02	165	13.12	.000
Scale 6	51557.87	4	104479.86	165	20.36	.000
Scale 7	73477.66	4	138894.44	165	21.82	.000
Scale 8	32226.56	4	103508.76	165	12.84	.000
Scale 9	88499.19	4	137827.25	165	26.49	.000
Scale 10	49992.04	4	59324.09	165	34.76	.000
Scale 11	3718.78	4	57784.90	165	2.65	.035
Scale 12	13625.91	4	110739.41	165	5.08	.001
Scale 13	112042.12	4	86306.39	165	53.55	.000

Table 5. Rank Order of 13 Scales for 5 Subject Clusters Based on Mean Scale Scores

	Cluster 1	Cluster 2	Cluster 3	Cluster 4	Cluster 5
Scale Numbers	12	9	13	3	2
	5	2	5	9	12
	9	13	2	2	5
	4	5	9	13	8
	6	4	12	5	3
	13	1	7	6	9
	1	6	1	12	6
	2	7	6	1	7
	3	12	4	4	4
	8	3	3	8	1
	10	10	8	10	13
	11	8	10	11	10
	7	11	11	7	11

Table 6. Rank Order Listing of Discriminating Scales by Cluster

Rank	Scale
	Cluster 1
1	Active collaboration
2	Client advocate
3	Tasks
4	Answers
5	Active therapist inquiry
6	Solutions
7	Teaches
8	Expertise
	Cluster 2
1	Client advocate
2	Active therapist inquiry
3	Tasks
4	Expertise
5	Active collaboration
	Cluster 3
1	Active collaboration
2	Expertise
3	Active therapist inquiry
4	Tasks
5	Client advocate
	Cluster 4
1	Teaches
2	Warmth/Support
3	Tasks
4	Active collaboration
5	Client advocate
6	Expertise
	Cluster 5
1	Active collaboration
2	Closeness
3	Teaches
4	Personal Focus
5	Tasks
6	Expertise
7	Client advocate
8	Answers
9	Active therapist inquiry

Figure 1. Placement of five clusters on three factorially defined dimensions of role preference.