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USING THE Q-SORT METHOD

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ABSTRACT

This study used the Q-sort method and qualitative interview to gather exploratory data on what potential psychotherapy clients think that therapists should be doing to best help their clients. While current literature suggests that clinical psychologists generally align themselves with either "psychodynamic/humanistic" or "CBT/scientific" views of psychotherapy, little is known regarding whether individuals seeking psychotherapy have similar views of the therapy process. Fifty-eight Q-sort statements addressing what psychotherapy should be like were created in consultation with clinical psychologists. Forty participants, twenty from the general population and twenty seeking therapy at a college counseling center, took part in the study. The procedure involved ranking Q-sort statements according to level of agreement and answering follow-up questions during an interview. Results indicated that participants did have worldviews, or "lay theories" of psychotherapy that corresponded to different approaches to conducting therapy. Factor analysis yielded two distinct groups of participants, with one group endorsing a more "unstructured" type of therapy in which open-ended reflection and exploration were considered important for therapy but having a formal diagnosis was not considered as crucial, and the other characterized by a more "structured" type of therapy in which formal diagnosis, goal setting and problem solving were considered more important. Other significant findings included an overall preference by all participants for therapy to be uniquely tailored to the individual client, for therapists to help the client talk about the past, and for therapists to focus on interpretation of clients' communications.

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Chapter I

Introduction

The field of psychology encompasses myriad beliefs about the practice of psychotherapy, with disparate views on what approaches therapists might use to best help their clients. Although many distinct psychotherapy models are available, the terms "psychodynamic" and "cognitive-behavioral" are currently used to describe the dominant opposing paradigms in the field, expected to correspond to different assumptions about how therapy works best. However, little is known about how individuals seeking therapy view concepts endorsed by professional psychologists of various theoretical orientations. The current study investigates what individuals seeking therapy believe that therapists should be doing to help clients. More specifically, the study will explore whether individuals have lay theories that are associated with typically "psychodynamic" or "cognitive-behavioral" worldviews, and, if so, which particular beliefs might differentiate the two approaches. For example, should therapy be more structured, or more open-ended? Does focus on the therapeutic relationship improve outcome or does it detract from other work that can be done in therapy?

Since the goal of the current study is to explore potential clients' beliefs, perceptions, and opinions, a mixed quantitative-qualitative method, Q-Sort Method (Brown, 1993; Watts & Stenner, 2005), will be employed. A mixed method is ideal for this kind of exploratory study because information is obtained using both

statistical methods, which are ideal for discovering aggregate trends, and narrative interviews, which elucidate the more nuanced aspects of participants' responses. The Q-Sort method asks participants to rank a set of statements according to level of agreement, then quantitatively groups participants who respond in similar ways. The procedure also allows participants to share the reasoning behind their choices, which captures subjective interpretations that can be analyzed qualitatively.

The objective of this study is to discover whether potential clients have worldviews that resemble those of therapists, who generally align themselves with one particular theoretical orientation, often to the exclusion of other modes of therapy (Goldfried, 1980; Messer & Winokur, 1980; Norcross, Karpiak & Santoro, 2005). If clients do, indeed, hold pre-existing beliefs about how therapy should proceed, then these beliefs may be a significant variable when examining client expectations and preferences, client aptitudes for engaging in particular types of therapy, client-therapist matching, role induction or socialization, and therapist responsiveness. The information gathered in this study adds to the body of literature on client characteristics, an essential component of evidence-based practice as defined by the APA's Presidential Task Force (APA, 2006).

Chapter II

Literature Review

The "Two Cultures" of Psychology

In 1959, the writer C.P. Snow gave a lecture in which he identified the problem of "two cultures" that existed in academic circles:

> literary intellectuals at one pole—at the other scientists… Between the two a gulf of mutual incomprehension—sometimes (particularly among the young) hostility and dislike, but most of all lack of understanding. …Their attitudes are so different that, even on the level of emotion, they can't find much common ground (Snow, 1998, p. 4).

This sentiment has been echoed strongly in the field of psychology, where the "two cultures" have persisted, defined by those who view psychology primarily as a science, emphasizing rationality, objectivity, and empiricism, and those who view psychology primarily as a humanistic discipline, with emphasis on the ambiguities of the human condition, subjectivity, and intuitive ways of knowing (Messer & Winokur, 1980).

Despite the myriad approaches to psychotherapy available, the terms "psychodynamic" and "CBT (cognitive-behavioral therapy)" have become the predominant heuristic terms used to describe this philosophical dichotomy. Graduate school faculties often divide themselves into psychodynamic or cognitive-behavioral "camps," and graduate students, "sort themselves out as behaviorally or psychodynamically oriented, perhaps because they soon find one approach or the other more compatible with their own views of reality" (Messer & Winokur, 1980, p. 825). Choosing an orientation also has professional implications, as "an

identification with a school of therapy is likely to result in some very powerful economic, political, and social supports. After all, without a specific therapeutic orientation, how would we know what journals to subscribe to or which conferences to attend?" (Goldfried, 1980, p. 996).

The distinction between the "two cultures," or between "psychodynamic" and "cognitive –behavioral" ways of approaching psychotherapy has been defined and investigated in many ways, from discussions of philosophical underpinnings to differences in language and technique. At the philosophical level, Messer and Winokur (1980,1984) describe the two types of therapy in terms of "visions of reality," with the psychodynamic approach encompassing tragic, ironic, and romantic visions, and the behavioral approach aligning with the comic vision, referring to the structure of dramatic comedy. Within the psychodynamic visions, the therapist holds beliefs about the inevitability of suffering and the limits of change (tragic vision), seeks out conflicts, ambiguities, and contradictions (ironic vision), and sees therapy as an individualistic journey with unexpected developments (romantic vision). The behavioral therapist, in contrast, emphasizes optimistic outcomes available through learning new skills, as problems are confronted through direct inquiry and specific action (comic vision).

A study by Kimble (1984) examined philosophical differences between the "two cultures" by asking a group of undergraduates without psychological knowledge and a group of psychologists to answer questions about epistemological style and social values. Although the results were inconclusive, the data did suggest that individuals vary widely in their endorsement of dichotomous philosophical views.

Psychologists were slightly more polarized in their views than undergraduates, but each sample displayed a range of responses from more "humanistic" to more "scientific" worldviews. Thus it is plausible that there are significant differences, among both psychologists and lay people, in tendencies to endorse particular philosophies or epistemologies.

At the practical level, differences in technique between therapies are often described using the concept of adherence, or the extent to which a therapist behaves in ways that are unique to that particular type of therapy (Waltz, Addis, Koerner & Jacobson, 1993; Wampold, 2001). Some practice elements that differentiate psychodynamic therapies from CBT therapies are the extent to which the practitioner focuses on the past, use of homework, attention to the relationship between therapist and client as a repetition of earlier interpersonal patterns, direct or indirect targeting of symptoms, and the amount of direction provided by the therapist during the session (Larsson, Kaldo & Broberg, 2009; Leichsenring, Hiller, Weissberg & Leibing, 2006).

Despite evidence that two distinct cultures do, in fact, exist within the psychological community, little research to date has investigated whether these cultures are recognized by individuals seeking therapy. Even less is known about whether clients may be "inclined" towards one particular culture or another, and, if so, how these inclinations come to be.

Choice of Theoretical Orientation

If clients do, indeed, prefer certain approaches to psychotherapy over others, one might ask what factors contribute to the development of distinct worldviews.

Although a complete examination of factors influencing client's preferences is outside the scope of this study, it is worth noting that some attention has been paid to how therapists choose their theoretical orientations. A 1978 issue of *Psychotherapy: Theory, Research and Practice* was devoted to this topic, with focus on personality influences (Herron, 1978; Walton, 1978), psychological needs, (Lindner, 1978) and idiosyncratic training experiences (Cummings & Lucchese, 1978). A 2003 study of Australian psychologists found that cognitive-behavioral therapists were more likely to report stable early family environments, whereas psychodynamic therapists reported more often that their families of origin were "stressful, chaotic, or disengaged" (Poznanski & Mclennan, 2003, p. 225). A more recent study of clinical psychology trainees in the UK found that personality factors, such as openness to experience and neuroticism, were more highly correlated with a psychodynamic orientation, whereas trainees who identified with a CBT orientation were found to espouse more "mechanistic" or "rational/objective" worldviews (Buckman & Barker, 2010).

Given the research on the development of therapists' worldviews, one might similarly assume that personality variables, family-of-origin issues, life experiences, and socio-cultural contexts would play a role in how potential clients view therapy as well. As such, a heterogeneous sample of participants was recruited for this study in order to maximize the number of points of view represented.

Lay Theories: Definition and Research

The concept of "lay theories" in psychology comes from the area of social cognition, or the study of the ways in which individuals structure, interpret, and make meaning of the social world. A "lay theory" is defined as a fundamental assumption about some aspect of the environment that varies among individuals, even within a common culture (Molden & Dweck, 2006). Although the concept of a lay theory is closely related to concepts such as beliefs, opinions, and judgments, it differs in that a lay theory is thought of as "implicit," or outside of awareness. Thus, asking study participants to describe their views in an open-ended way generally produces responses such as "I don't know" or "I can't think of anything," whereas providing some initial information in the form of structured questions usually leads to thoughtful discussion about the topic.

A number of studies have investigated lay theories of psychotherapy, with similar results. In a U.K. study, Furnham and Wardley (1990) found that individuals varied in their levels of experience with therapy and knowledge about what psychotherapists do. Most subjects agreed with statements like, "psychotherapists aim to teach their clients to achieve better self-understanding about their real motives," "psychotherapists encourage the expression of emotions and feelings that have long been suppressed / depressed," and "the establishment of rapport is of major importance during the early phase of therapy." Subjects disagreed with statements like, "very often psychotherapists prescribe drugs," "younger, more flexible clients are the only ones to benefit from psychotherapy," and "most psychotherapy clients lie on a couch." The study also found some differences with respect to age, in that older

people and people with more experience with psychotherapy were more likely to be skeptical of therapy's potential benefits.

When this study was replicated in the United States., Wong (1994) found similar results, but emphasized the relative ignorance about psychotherapy evident in her sample. Only 20% of the student participants were able to name five psychologists, and only 50% thought they knew the difference between a psychologist, a psychiatrist, and a psychoanalyst (Wong, 1994, p. 630). This finding highlights the fact that the general population is relatively naïve about the kinds of mental health services that are available and the methods that mental health practitioners use to help their clients. Other studies suggest, however, that individuals appear to have lay theories about which therapies are differentially helpful for various disorders (Furnham, Pereira & Rawles, 2001).

The current study seeks to extend previous work on lay theories of psychotherapy by investigating what individuals think therapists *should* be doing to help clients, irrespective of what individuals think therapists actually do. With the proliferation of types of therapeutic approaches and media attention given to the heterogeneity of therapist activities, individuals may have strong implicit theories about how therapists should be operating in order to achieve the most effective results. The question of interest is whether individuals' lay theories correspond to dichotomous ways of approaching the therapeutic process that correspond generally to "psychodynamic" or "cognitive-behavioral" ways of thinking.

Client Expectations, Role Induction, and Socialization

If individuals and potential clients do have implicit, lay theories about what therapists should be doing to be helpful, then these views may also contribute to expectations about whether or not the therapy will be successful. A large body of research (e.g., Greenberg, Constantino & Bruce, 2006) shows that client expectations are one of the widely accepted "common factors" that contribute to positive outcome in therapy (Grencavage & Norcross, 1990), with clients who have greater expectations that therapy will be helpful showing more improvement. Other expectations are in regard to the roles of therapist and client (Joyce, McCallum, Piper & Ogrodniczuk, 2000), comfort level during sessions (Joyce & Piper, 1998), and duration of treatment (Clarkin & Levy, 2004). The overall conclusion of expectancy research is that client expectations are correlated with therapy outcomes, accounting by some estimates for 15% of the variance in therapy improvement (Lambert, 1992). Perhaps because clients are thought to be somewhat ignorant about the various theoretical orientations adopted by clinicians, little is known about whether clients expect therapists to engage in activities that might differentiate approaches. Rather, expectations regarding therapist roles tend to focus on general therapist/client behaviors such as who will talk or ask questions and what kinds of topics will be discussed (Joyce et al., 2000).

If expectations contribute significantly to therapy outcome, then a major task for the therapist in the initial stages of therapy should be to "socialize" the client to what therapy will be like, a process termed "role induction" (Beutler & Clarkin, 1990; Strassle, Borckhardt, Handler, & Nash, 2011). Most therapists likely engage in this

process automatically, as therapists are trained to provide a rationale for treatment and to reinforce behaviors that are commensurate with the treatment being provided while discouraging those that may be contraindicated. Some studies have investigated explicit role-induction procedures and have found that direct attention to client expectations produces improvements in outcome and treatment engagement (Childress & Gillis, 1977; Katz, Brown, Schwartz, King, Weintraub & Barksdale, 2007).

One of the assumptions of the proposed study is that potential clients enter therapy with existing lay theories about how therapy should proceed, such that the process of socialization may be more or less important depending on the strength of the lay theory and the degree of agreement with the therapist's theoretical orientation. For instance, a client who believes strongly that the therapist should lead the session and give practical suggestions will require little socialization into a cognitive-behavioral therapy, but will require greater justification of the rationale for a psychodynamic therapy that stresses the importance of client-guided sessions. If some clients have relatively weak lay theories, then socialization efforts of the clinician will play an even greater role in shaping how the client thinks about what is most helpful in therapy.

Client Preferences, Aptitudes, and Matching

"Rather than argue over whether or not 'therapy works,' we could address ourselves to the question of whether or not 'the client works'!" (Bergin & Garfield, 1994, p. 825).

Whereas client expectations are defined as what clients think *will* happen in therapy, a body of literature on client preferences explores what clients *want* to have

happen in therapy. Although client preferences have been less-well studied than client expectations (Glass, Arnkoff & Shapiro, 2001), a recent meta-analysis of 26 studies found that, "clients who were matched to their preferred treatment had a 58% chance of showing greater outcome improvement and were about half as likely to drop-out of treatment as non-matched clients" (Swift & Callahan, 2009, p. 379). However, only about half of the studies in the meta-analysis compared preferences for theoretical orientations/models of psychotherapy, with the other studies comparing psychotherapy to psychopharmacology, individual to group therapy, inpatient to outpatient therapy, and therapy to exercise (Swift & Callahan, 2009). Thus it is unclear whether a "match" to a preferred theoretical approach would similarly influence retention rates.

Glass et al. (2001) noted that while some clients may arrive in therapy without specific ideas about what they would like to have happen in therapy, others may have strong preferences along theoretical lines. The authors recommended that therapists assess preferences and attempt to accommodate those preferences, with the assumption that clients who receive their preferred treatment will be more engaged in therapy and more likely to comply with treatment methods. These authors also noted that in cases where the therapist's orientation differs from the client's preferences, the therapist may choose to refer the client elsewhere or postpone interventions that may be "difficult for the client to accept" until a strong therapeutic alliance has been established (p. 460). Similarly, Van Audenhove & Vertommen (2000) suggest a process of negotiation at the start of therapy, in which the therapist informs the client of the treatment options available, listens openly to the client's preferences, and helps

the client make a decision about the type of treatment and the type of therapist that the client believes will be most beneficial.

A related line of research investigates client *aptitudes*, or ability to participate in various types of treatments, given aspects of the client's personality and other psychological constructs. Such constructs include quality of object relations (Goldman & Anderson, 2007), psychological-mindedness (Joyce & McCallum, 2004), coping style (Beutler et al., 2003), and resistance (Beutler et al., 2003). The effects of client aptitudes on treatment outcome are usually studied with the ATI, or the "Aptitude X Treatment Interaction" method, which measures client variables as moderators between treatment type and outcome (e.g. Arnow et al., 2003; Beutler et al., 2003). A construct of particular interest when considering theoretical orientation is that of reactance (Dowd, Milne & Wise, 1991), defined as a client's "[perception] of loss of personal control" and "potential to resist the influence of the psychotherapist (Arnow et al., 2003). Individuals high on the Therapeutic Reactance Scale (Dowd et al., 1991) tend to endorse statements such as "If I am told what to do, I often do the opposite" and "I have a strong desire to maintain my personal freedom." As one might expect, individuals high in therapeutic reactance have been shown to respond better to non-directive treatments than to directive ones (Beutler et al., 1991).

Given the data on client preferences and aptitudes, it is clear that more information is needed regarding how individuals conceptualize therapy before the process begins. The present study seeks to accumulate rich qualitative data regarding what individuals believe should happen in therapy, as one would expect lay theories

of psychotherapy to be strongly related to how a client experiences the initial sessions of therapy. If one major difference of a "cognitive-behavioral" and "psychodynamic" worldview is the level of directiveness and authority present in the therapy, then one would also expect individuals with particular aptitudes, e.g., reactance, to have lay theories of psychotherapy that correspond with their particular aptitudes or personality traits.

Therapist Responsiveness

Clients' differing lay theories of psychotherapy may be a significant variable in therapist *responsiveness*, or the extent to which therapists adjust their actions in response to input from clients (Stiles, Honos-Webb & Surko, 1998). For example, a therapist may rephrase an interpretation to which the client responded negatively, or alter his or her emotional tone in response to a client's facial expression (Stiles, 2009). The concept of therapeutic responsiveness takes into account the activity of both therapist and client, as clients are seen as equally active participants in the therapy process (Bohart & Tallman, 1999). One of the reasons that so many practicing therapists report eclecticism or integrative practices (Norcross et al., 2005) is that a combination of approaches may be necessary to respond to idiographic variations in client presentations. If therapists are responsive to client feedback, they are better able to monitor therapeutic alliance, repair alliance ruptures, and make treatment decisions that will improve outcomes (Stiles et al., 1998).

The hypothesis of the current study is that clients have differing beliefs about what therapists should be doing to help clients, with the implication that therapists could be responsive to clients' lay theories about psychotherapy if more were known

about these theories and how to assess them. Currently, the emphasis within a theoretical orientation is to socialize the client into the therapy provided, rather than be responsive to the client's pre-existing thoughts about what therapy should be like. For instance, clients who arrive in psychodynamic therapy wanting structure, skills, and education are usually encouraged to "tolerate ambiguity," while those who arrive in cognitive-behavioral therapy wanting to "just talk" about their problems are seen as needing increased motivation and persistent redirection toward goals. With more attention to clients' lay theories of psychotherapy at the outset, therapists could be more responsive to clients' understanding of the therapy process, potentially improving client retention and early alliance. A major objective of this study is to gather data about the aspects of therapy about which potential clients feel strongly, and to determine whether these aspects might categorize clients along generally "psychodynamic" or "cognitive-behavioral" dimensions.

Chapter III

Method

Q-Sort Method Overview

The Q-sort method (or Q-Method) is a "qualiquantological" procedure that combines qualitative and quantitative approaches in order to analyze patterns in individuals' attitudes, beliefs, opinions, values, or preferences (Watts & Stenner, 2005). Q-method was first developed by William Stephenson (Brown, 1993), whose work on factor analysis led him to invert the procedure in order to group individual participants rather than individual variables. Stephenson recognized that the science of psychology was different from that of the natural sciences in that psychology involved a greater degree of individual subjectivity, requiring research procedures that could be used to study subjectivity systematically (Stenner, Watts & Worrell, 2008; Watts & Stenner, 2005). As strictly empirical and quantitative methods gained dominance in psychology, however, the Q-sort procedure became associated mainly with qualitative procedures. Important contemporary uses of the Q-sort Method in psychology include assessment of personality (California Q-sort, Block, 2008), psychopathy (Fowler & Lilienfeld, 2007), and behavior in social situations (Riverside Behavioral Q-sort, Funder, Furr & Colvin, 2000).

The Q-sort procedure follows six general steps: formulating a research question, generating a Q-set, or items to be evaluated, selecting a P-set, or group of participants, collecting data, analyzing Q-sort data, and interpreting Q factors (Stenner et al., 2008). The method is ideal for assessing potential clients' lay theories

about psychotherapy because, unlike a questionnaire, it allows participants to consider items comparatively and to make *relative* judgments about them. Another advantage is that the Q-sort analyzes group participants rather than items, which provides information about whether individuals respond in identifiable patterns. Once patterns are detected, qualitative data about participants' sorting choices enables the researcher to interpret these patterns in a meaningful way.

Development of the Q-set

Beginning with the research question of how individuals and potential clients think that therapy should proceed in order to best help the client, the next step in the Q-sort method is to generate a group of items, or Q-set, to be evaluated by participants. Different from traditional factor analysis, in which participants are "sampled" to be representative of a larger population, Q-sort method inverts the procedure such that it is the statements that are meant to be representative of a large, perhaps infinite number of opinions and beliefs about a particular topic of interest. Stephenson called this full set of beliefs a "concourse," and stressed that the Q-set be reflective of as many aspects of the concourse as possible (Stenner et al., 2008). Since the Q-set is intended to be broadly inclusive rather than theoretically driven, proponents of the Q-sort method recommend that the Q-set be created from a variety of different sources, including academic literature, popular media, consultation with experts, informal discussions, pilot studies, or other sources relevant to the subject matter. The final number of items in the Q-set can vary, but typical Q-sets contain about 40 to 80 statements (Watts & Stenner, 2005).

For the current study, an extensive review of the literature yielded approximately 80 initial statements, which covered themes including, but not limited to, the role of diagnosis in psychotherapy, the level of structure in the sessions, the directiveness of the therapist, how resistance to treatment is conceptualized, the nature of change in therapy, and the importance of the relationship between the therapist and client. (See Appendix A for a complete list of the final 58 Q-set items). Literature used to generate the Q-set included theoretical writings on differences between "cultures of therapy" (e.g., Messer & Winokur, 1984), papers discussing therapist choice of theoretical orientation (e.g., Poznanski & Mclennan, 2003), and scales of therapist adherence to particular modes of therapy (e.g., Waltz et al., 1993).

Since the aim of the current study was to determine whether individuals have beliefs that correspond to theoretical dichotomies between generally "humanistic" or "scientific" approaches to therapy, items were paired in order to emphasize differences between the two viewpoints. Although a few of the paired items were mutually exclusive (e.g. "The ideal length of therapy is less than 20 weekly sessions"/ "The ideal length of therapy is more than 20 weekly sessions"), the overwhelming majority of the paired items were written to be dialectic, or seemingly opposite beliefs which may actually be held simultaneously (e.g. "Therapists help clients to be realistic about changes that can be made." / "Therapists help clients to be optimistic about changes that can be made.") The dialectical nature of the paired items was intended to encourage participants to think critically and carefully about the items and to rank-order based on implicit preferences for one or another theoretical viewpoint.

In order to assess the accuracy and comprehensibility of the items, an edited list of 48 paired items was reviewed by 12 experts, including clinical faculty at several academic institutions, graduate students in clinical psychology, and practicing psychotherapists. The experts represented a variety of theoretical orientations, including cognitive-behavioral, psychodynamic (classical analytic, object relations, interpersonal/relational), person-centered, narrative, dialectical-behavioral, neuropsychological, and family systems. Experts commented on both the language and the content of the items, indicating whether they thought items were representative of orientation-specific beliefs in the field of psychology and whether the language of the items would be understandable to a general population. Experts also had the opportunity to suggest additional items or to highlight items they thought should be omitted. Items were then revised based upon experts' comments, with the final Q-set consisting of 29 pairs of items, or a total of 58 items.

Participant Recruitment

The selection and recruitment of participants differs in Q-method from other statistical methods. In traditional factor analysis, for example, participants are selected to be a representative sample of a general population of interest. The ultimate goal of traditional factor analysis is to group items that "hang together" to define an underlying theoretical concept that can be interpreted to hold true throughout the sample, and by extrapolation, the population. For this reason, traditional factor analysis emphasizes obtaining a large number of participants who will be representative of the greater population of interest.

Q-method inverts the factor analytic procedure, such that the selection of participants stresses *variation* in the choice of participants over *number* of participants (Stenner et al., 2008). The subjective viewpoint of each individual participant is considered a "gestalt" that can be compared with other viewpoints in order to determine which viewpoints, in their entirety, "hang together" (Watts & Stenner, 2005). It is therefore most important in Q-method to choose heterogeneous participants who will likely produce a variety of different viewpoints that can be analyzed and compared. Of secondary importance is the extent to which the participants are members of a particular population of interest, and of least importance is the number of participants, which is considered adequate when it can be expected to produce a "circumscribed range" of potential viewpoints (Stenner et al., 2008). In other words, the number of participants is satisfactory when the viewpoints expressed by these participants can be expected to represent the majority of possible viewpoints. Typical Q studies use approximately 40-60 participants (Stenner et al., 2008).

When selecting participants for the current study, therefore, it was important to consider both the relevance of the participant group to the research question and the heterogeneity of the participants and their viewpoints. For this reason, two groups of participants were selected for inclusion in the study. The first was a group of students presenting for initial psychotherapy appointments at a university college counseling center in a metropolitan area. As clients coming to therapy, these participants were clear stakeholders in the discussion of how therapy might best proceed in order to be helpful to the client. However, the student group was mostly

homogeneous in both age and geographic location, which had the potential to limit the types of viewpoints that would be obtained. A second group of participants was thus recruited through respondent-driven sampling (Wejnert & Heckathorn, 2008), in which colleagues of the principal investigator were asked to recruit their friends and family, who were in turn asked to refer participants, and so on. Participants recruited through this method were, as expected, more diverse in age and geographic location, though still somewhat homogeneous in level of education and socioeconomic status.

Although these homogeneous aspects of the participant pool did have the potential to skew the data towards a less diverse range of viewpoints, the degree of heterogeneity in the sample and the ultimate diversity of viewpoints expressed was determined to be sufficient to obtain meaningful data. To preserve relevance to the research question, participants were asked if they would be willing to seek therapy if they had a problem with which a therapist might help, and those who said they would not consult a therapist were excluded from the study. Also excluded were individuals who worked or studied in the psychological professions (psychology, psychiatry, social work, etc.), due to the concern that these individuals would have "professional" theories rather than "lay" theories of psychotherapy.

Participant Demographics

A total of 40 participants were recruited for the study, 20 students from the college counseling center and 20 through respondent-driven sampling. A list of participant demographics can be found in Table 1. The majority of participants were female, representing 60% of the college group and 75% of the general group. This

high ratio of female to male participants is consistent with the most recently available data on the demographics of adults seeking psychotherapy, which indicates that approximately 66% of adults seeking mental health services nationally are female (Vessey & Howard, 1993). As expected, the college group was more homogeneous in age, with 100% of the group being between the ages of 18 and 25 years old. The general group included participants of a variety of ages (25% 18-25 years old, 50% 26-35 years old, 5% 36-45 years old, 5% 46-55 years old, 10% 56-65 years old, and 5% 66-75 years old). However, the college group was more ethnically diverse (45% White, 20% Asian, 15% Hispanic, 10% African American, 10% Multiethnic) than the general group (85% White, 10% Asian, 10% Hispanic, 0% African American, 5% Multiethnic). As expected, the college group had similar levels of education (85% "some college," 15% "bachelor's degree"), whereas the general population had a variety of educational levels (30% "some college," 30% "master's degree," 15% "doctoral degree," 10% "some graduate school," 10% "bachelor's degree," 5% "high school diploma"). Also as expected, the general group was more geographically diverse, representing cities from all regions of the United States plus Alaska, whereas the majority of the college group identified as being from the East Coast. Thus use of two groups to obtain an overall more diverse group of participants was justified, as the two groups combined represented individuals of a variety of ages, ethnic backgrounds, and geographic area. The skew in both groups towards participants of a higher socioeconomic status and education level was not thought to significantly affect the data, since the recruiting methods allowed for enough heterogeneity to obtain an adequate range of potential viewpoints.

Table 1

Participant Demographics as a Percentage of the Sample

Characteristic	General Group (n=20)	College Group (n=20)	Combined (n=40)
Gender			
Male	25.0	40.0	32.5
Female	75.0	60.0	67.5
Age			
18-25	25.0	100.0	62.5
26-35	50.0	0	25.0
36-45	5.0	0	2.5
46-55	5.0	0	2.5
56-65	10.0	0	5.0
66-75	5.0	0	2.5
Ethnicity			
African American	0	10.0	5.0
Hispanic	10.0	15.0	12.5
Asian	0	20.0	10.0
White	85.0	45.0	65.0
Multi-Ethnic	5.0	10.0	7.5
Education			
High School	5.0	0	2.5
Some College	30.0	85.0	57.5
Bachelors Degree	10.0	15.0	12.5
Some Graduate	10.0	0	5.0
Masters Degree	30.0	0	15.0
Doctoral Degree	15.0	0	7.5
Therapy Experience			
Previous therapy	35.0	35.0	35.0
No previous therapy	50.0	60.0	55.0
No response	15.0	5.0	10.0

In terms of previous therapy experience, the groups were equivalent, with 35% of each group endorsing that they had had previous therapy experiences. Of these, 71% could name possible theoretical orientations to which their previous therapists subscribed, but when asked how confident they were that they knew the theoretical orientation of the therapist, they averaged a score of 2.2 on a 7-point

Likert scale, with 1 being "unsure" and 7 being "very sure." Individuals with previous therapy experience were included in the study in order to preserve similarities to the kinds of individuals who might present for initial therapy sessions, which include some people who are not naïve to the therapeutic process.

Q-Sort Construction

In a typical Q-sort procedure, participants are shown a row of columns, ranging from positive numbers on the right ("most agree") to negative numbers on the left ("least agree" or "most disagree.") These columns also contain numbers that indicate how many items should be placed in each column, which follows the shape of a normal or quasi-normal distribution. The forced distribution is used for statistical simplicity, but a "free" distribution could also be used (Watts & Stenner, 2005). Proponents of the Q-sort method argue that the shape of the distribution does not affect the ultimate factoring of the data, and so choices about the number of columns and rows in each column can be made somewhat arbitrarily (McKeown & Thomas, 1988). For the current study, a scale was created from +4 to -4, as follows:

-4	-3	-2	-1	0	+1	+2	+3	+4	Column headings
(4)	(5)	(7)	(8)	(10)	(8)	(7)	(5)	(4)	Number of cards in each column

In Q-sort method, the preferred method of labeling columns is at opposite ends of a spectrum, such as "most agree" to "most disagree." The reasoning for this is twofold. First, "most to least" agreement implies a level of agreement with all statements, which is limiting in that it does not allow participants to endorse "disagreement" (McKeown & Thomas, 1988). Secondly, there is a concern that

subjects will place "neutral" or "non-salient" items at the endpoint rather than in the center categories (Hughes, 2012). During pilot-testing of the Q-sort procedure for the current study, however, the endpoints of "most agree" to "most disagree" proved to be problematic. Participants assumed that they had to agree with all cards to the right of zero and disagree with all cards to the left of zero. Since participants tended to agree at least somewhat with the majority of the statements, they became concerned that they were "disagreeing" with statements that they actually endorsed to some level of agreement. Thus the decision was made to retain the sorting headings of "most agree" and "least agree." In order to address the possibility that subjects would place non-salient items in the leftmost columns, participants were told specifically to place "neutral" or non-salient items in the center columns. Follow-up questions asked of the participants verified that that they all placed salient items at the endpoints and more neutral items closer to the center.

A standard Q-sort procedure occurs in two steps. First, the subject is asked to read through the cards once and sort the cards into three stacks: agree, neutral, and disagree (Stenner et al., 2008). They are then asked to go through each pile individually and sort cards from right to left into the given distribution, as shown above. When this procedure was pilot-tested for the current study, the sorting procedure was unreasonably time-consuming, with participants taking 90 minutes or longer to complete the sorting. When the initial sorting was omitted, pilot-testers did not report having increased difficulty making ranking decisions about the statements. In order to facilitate evaluation of the statements, however, participants were instructed to "put statements wherever you think they go first, then at the end you can

go back over the statements and put the right numbers of cards in each column." This instruction functioned to preserve the standard Q-sort procedure of having more than one evaluation of each statement, but also reduced the sorting time to under 60 minutes.

Data Collection Procedure

Participants in the general population group were recruited through respondent-driven sampling and, once they agreed to participate, were mailed packets that included a consent form, demographic questionnaire, heading cards, statement cards, and a grid sheet on which to record their responses. The packet instructed them to call the principal investigator for instructions. Participants were told that they needed no prior experience with psychotherapy but that the current study was intended to investigate their opinions about what therapists should be doing to best help their clients. They were paid $10 for participation.

Participants in the college group were recruited at a college counseling center at a large public university in the Northeast. Working closely with the counseling center staff, the principal investigator identified students who were attending their first psychotherapy appointments. Students who were in crisis, suicidal, or visibly distressed were excluded from the study. The students were approached by the principal investigator and asked if they would like to participate in the study, which they could either complete in-person at the counseling center or take home and complete by phone. They were informed that the study was not affiliated with the counseling center and would not affect their therapy, but that the study was intended

to learn more about what people like themselves think that therapists should be doing to best help clients. They also received $10 for participating in the study. Approximately 20% of students approached to participant in the study agreed to participate and ultimately completed the study. Of the 20 college students recruited, 12 (60%) completed the study in-person and 8 (40%) completed the study over the telephone. There were no significant differences in response time or quality between those who completed the study in-person versus those who participated by phone. All participants were given verbal instructions on how to sort the 58 item cards. They were instructed to read paired items together (i.e. "Therapists help clients to be realistic about changes that can be made" / "Therapists help clients to be optimistic about changes that can be made"), but to make independent decisions about how to sort each item. Participants were told, "you might agree with both statements, disagree with both statements, or agree with one and disagree with the other." When they were finished sorting, the principal investigator asked a series of open-ended follow-up questions about their impressions of the procedure and their sorting choices. The time it took participants to complete the procedure ranged from 30-70 minutes with the average being around 45 minutes, including time for follow-up questions.

Overall, participants responded positively to the research procedures. Many commented that they thought the topic was "interesting" and that they had "never thought about" some of the topics before. Several participants stated that they were "confused at first" by the sorting procedure, but ended up feeling that it was "easy" to understand and "more enjoyable" than a regular questionnaire. Participants appeared

to appreciate the ability to rank-order statements in comparison to other items, as they had more control over their responses. When asked if they were confused by the language of the statements, all participants stated that they had understood the statements clearly. When a few participants complained about the "forced" nature of the distribution, stating that they would have rather been able to choose where to place all the statements, the principal investigator explained that the forced distribution was for statistical purposes. Confirming that the statements tapped individuals' lay theories about what is helpful in therapy, all participants said that they thought the statements covered the important aspects of how therapy works best. Participants had few ideas for additional statements that should be included, which is commensurate with the concept of lay theories in that individuals are able to respond to given stimuli but have difficulty generating concepts without prompting.

Chapter IV

Results

Descriptive Statistics

Before using factor analysis to determine which Q-sorts comprised identifiable factors, the data were analyzed using descriptive statistics to identify 1) items that had a high level of either agreement or disagreement by the majority of participants; in other words, aspects of therapy that most participants agreed would be most/least helpful; and 2) any significant differences between the responses of the college student group and those of the general population group. First, means, medians, modes, and standard deviations of all the items were calculated based on the numerical values of the category assigned to each item by each participant (See Table 2). The five items with the highest level of agreement were:

1. Item #14. Since no two people are alike, the therapist should choose an approach that fits the individual client.
2. Item #41. The therapist should help the client to talk about the past, because the past is likely an important part of the client's current difficulties.
3. Item #30. Clients can make significant changes through learning and practicing new skills.
4. Item #22. The therapist should help the client understand how symptoms can have hidden meanings, or can be expressions of inner conflict.
5. Item #56. A major goal of therapy should be to focus on how the client's thoughts and behaviors may cause problems in daily life.

The five items with the most disagreement were:

1. Item #21. The goal of therapy is to cure symptoms, rather than understand the hidden meanings behind them.
2. Item #24. The therapist should take what the client says more or less at face value.

3. Item #57. A therapist should monitor the client's progress in therapy by having the client fill out questionnaires on a regular basis.
4. Item #9. Being diagnosed with a psychological disorder is undesirable because it means that there is "something wrong" with the client.
5. Item #51. A client who is not making an effort to change should be encouraged to leave therapy and return when he or she is more willing to make changes.

Table 2

Level of Agreement for Total Sample, Listed by Mean

Q-sort item	Mean	Median	Mode	Standard Deviation
14. Since no two people are alike, the therapist should choose an approach that fits the individual client.	2.83	3	4	1.47
41. The therapist should help the client to talk about the past, because the past is likely an important part of the client's current difficulties.	1.95	2	1	1.60
30. Clients can make significant changes through learning and practicing new skills.	1.83	2	1	1.50
22. The therapist should help the client understand how symptoms can have hidden meanings, or can be expressions of inner conflict.	1.78	2	2	1.54
56. A major goal of therapy should be to focus on how the client's thoughts and behaviors may cause problems in daily life.	1.75	2	4	1.75
31. Therapists help clients to be realistic about changes that can be made.	1.55	2	2	1.57
23. The therapist should notice when the client says one thing but really means something different.	1.45	2	2	1.75
12. Clients are helped in therapy when the therapist encourages open-ended reflection and exploration.	1.43	2	2	2.00
2. Therapy should be a structured activity, with the therapist helping the client to set goals, solve problems, and monitor progress.	1.40	2	3	2.00
1. Therapy should be like a journey, with the therapist encouraging the client to find his or her own answers.	1.38	2	2	2.06
8. Clients can be helped in therapy without a formal diagnosis (i.e. "depression").	1.18	1	1	1.93
32. Therapists help clients to be optimistic about changes that can be made.	1.15	1	2	1.67
29. Clients can't change everything about themselves, but they can accept much about the way they are.	1.05	1	-1	2.17
36. It is better when therapy does not have a definite ending because clients need time to work through problems.	1.03	1	2	1.86
49. Therapists should be empathic, understanding, and supportive at all times.	1.00	1	1	2.01

Table 2 – Continued

28. A good outcome in therapy would be for the client to be able to experience and accept painful feelings.	0.88	1	1	1.99
58. A therapist should monitor a client's progress in therapy by asking periodically how the therapy is going.	0.68	1	-1	1.93
11. Clients are helped in therapy when the therapist encourages specific changes in thinking and behavior.	0.65	1	3	2.28
6. The therapist should address whatever topic the client brings to the session.	0.53	1	-1	2.11
3. Clients are helped in therapy when the therapist waits for the client to share information over time before deciding what the problem is.	0.45	0	0	2.10
26. Clients are frequently unclear about what is bothering them, and it is the therapist's job to identify what the problem really is.	0.35	0	0	1.96
16. It is important for techniques used in therapy to have been supported by scientific evidence.	0.33	0	-2	2.16
40. It is helpful for therapists to point out things that happen in the relationship between client and therapist, as this may lead to important realizations about what is happening in the client's other relationships.	0.23	1	1	1.97
17. Clients should be cautious about therapy that does not allow the client to come to her or her own conclusions.	0.20	0	0	2.11
33. Change in therapy involves experiencing and sometimes increasing negative feelings in order to help the client work through them.	0.20	1	1	1.81
18. Clients should be cautious about therapy in which the client is allowed to talk for a long time without making any progress.	0.15	0	0	2.38
27. A good outcome in therapy would be for the client to experience fewer painful feelings.	0.10	0	2	2.43
20. Uncertainty about what is happening is welcomed in therapy, as it can lead to new realizations or understanding.	0.05	0	-1	1.68
7. Having a formal diagnosis (i.e. "depression") is important, as this should guide the type of treatment the client receives.	-0.05	0	0	2.46

Table 2 - Continued

52. A client who is not making an effort to change should be encouraged to stay in therapy and address why progress is not being made.	-0.05	0	0	2.24
45. Psychotherapy is more like a science than an art.	-0.15	0	0	1.72
47. If the client resists making changes, it is the therapist's job to be patient and let the client make changes in his or her own time.	-0.18	0	1	2.06
34. Change in therapy involves decreasing negative feelings and increasing positive feelings in order to help the client feel better.	-0.20	0	-1	2.05
55. A major goal of therapy should be to focus on how aspects of the client's personality may cause problems in daily life.	-0.25	0	0	2.11
13. Since psychological problems have been scientifically studied, the therapist should choose a technique that has been shown to be effective with others.	-0.28	-1	-1	1.87
48. If the client resists making changes, it is the therapist's job to find new ways to help the client change.	-0.28	-1	-2	1.78
10. Being diagnosed with a psychological disorder is a relief, because it means that other people struggle with the same problems.	-0.33	0	0	2.02
50. Therapists sometimes need to use "tough love" in order to help a client.	-0.33	0	0	1.97
19. Uncertainty about what is happening is an obstacle in therapy, as clear understanding and specific goals are most helpful.	-0.60	-1	-2	1.97
44. The therapy session should be led mostly by the client.	-0.63	-1	-1	2.19
5. The therapist should address a topic directly related to the client's problem, even if this is not the topic on the client's mind that day.	-0.65	-1	-1	1.96
46. Psychotherapy is more like an art than a science.	-0.65	0	0	1.73
38. The ideal length of therapy is less than 20 weekly sessions.	-0.80	-1	0	1.98
4. Clients are helped in therapy when the therapist initially identifies the client's problem and sets goals for treatment.	-0.83	-1	-1	2.24
25. Clients know best what is bothering them, and it is the therapist's job to address the client's stated concerns.	-0.90	-1	-1	1.86

Table 2 – Continued

54. If a client is not making progress in therapy, this is most likely because the therapist is not using the right approach.	-0.95	-1	-1	1.84
43. The therapy session should be led mostly by the therapist.	-0.98	-1	0	1.80
53. If a client is not making progress in therapy, this is most likely because something about the client is getting in the way.	-1.00	-1	-1	1.65
37. The ideal length of therapy is more than 20 weekly sessions.	-1.10	-1	0	1.77
42. The therapist should help the client focus on current problems, as a client's difficulties can only be addressed in the present time.	-1.18	-2	-2	2.06
15. It is important for techniques used in therapy to have been used by experts for many years.	-1.20	-1	0	2.02
35. It is better when therapy has an agreed-upon ending at the start of therapy because the time will be used more effectively.	-1.25	-2	-3	2.11
39. Focusing on what is happening in the relationship between the therapist and client is not useful for helping the client and detracts from other work that can be done.	-1.58	-2	-2	1.66
51. A client who is not making an effort to change should be encouraged to leave therapy and return when he or she is more willing to make changes.	-1.95	-2	-4	1.66
9. Being diagnosed with a psychological disorder is undesirable because it means that there is "something wrong" with the client.	-2.05	-2	-4	1.72
57. A therapist should monitor the client's progress in therapy by having the client fill out questionnaires on a regular basis.	-2.08	-3	-3	1.62
24. The therapist should take what the client says more or less at face value.	-2.18	-2	-3	1.41
21. The goal of therapy is to cure symptoms, rather than understand the hidden meanings behind them.	-2.90	-3	-4	1.28

The standard deviation was also measured for each item in order to obtain a rough estimate of which items had the highest amount of variation among participants. These items would be expected to be the ones that were endorsed differently by participants and therefore might distinguish participants with opposing lay theories. The items with the highest standard deviations were:

1. Item #7. Having a formal diagnosis (i.e., "depression") is important, as this should guide the type of treatment the client receives.
2. Item #27. A good outcome in therapy would be for the client to experience fewer painful feelings.
3. Item #18. Clients should be cautious about therapy in which the client is allowed to talk for a long time without making any progress.
4. Item #11. Clients are helped in therapy when the therapist encourages specific changes in thinking and behavior.
5. Item #52. A client who is not making an effort to change should be encouraged to stay in therapy and address why progress is not being made.
6. Item #4. Clients are helped in therapy when the therapist initially identifies the client's problem and sets goals for treatment.

As these results indicate, participants had a range of beliefs about psychotherapy, spanning topics such as the importance of diagnosis, the role of the therapist, the nature of therapeutic change, and therapist reaction to resistance by the client.

In order to determine whether there were significant differences between the college student group and the general population group, t-tests were used to compare means. Significant differences ($p < .05$) were found for the following three out of 58 items:

1. Item #13. Since psychological problems have been scientifically studied, the therapist should choose a technique that has been shown to be effective with others. (College students slightly disagreed, general population slightly agreed.)
2. Item #28. A good outcome in therapy would be for the client to be able to experience and accept painful feelings. (College students slightly agreed, general population agreed more strongly.)

3. Item #50. Therapists sometimes need to use "tough love" in order to help a client. (College students disagreed, general population slightly agreed.)

Since there were few significant differences between the groups and these were not large, and since these three items likely emerged by chance, the groups were combined for further statistical analysis.

Differences Between Paired Items

Since items in the Q-set were presented as pairs of "psychodynamic" or "humanistic" items ("X Items") and "CBT" or "scientific" items ("Y Items"), noting how participants handled the paired nature of the items reveals important information about how participants constructed their lay theories of psychotherapy. For instance, participants could choose to agree with both items, disagree with both items, or agree with one item and disagree with the other. They could separate the items spatially in the grid, indicating they believed items to be mutually exclusive, or keep items together, indicating that they believed items to be dialectic, or equally true despite being opposite conceptually. The patterns of separation of paired items indicates which concepts participants thought would differentiate separate approaches to therapy, and which concepts could more easily co-exist within a particular therapeutic treatment. Figures for the average distance between items and how participants sorted paired items can be found in Table 3. The items with the greatest overall average distance, or more mutually exclusive items, were:

1. Item #22 (X). The therapist should help the client understand how symptoms can have hidden meanings, or can be expressions of inner conflict vs. Item #21 (Y). The goal of therapy is to cure symptoms, rather

than understand the hidden meanings behind them. [Total mean distance = 4.73; 95% of participants agreed with X more than Y.

2. Item #23 (X). The therapist should notice when the client says one thing but really means something different vs. Item #24 (Y). The therapist should take what the client says more or less at face value. [Total mean distance = 3.78; 83% of participants agreed with X more than Y.]

3. Item #36 (X). It is better when therapy does not have a definite ending because clients need time to work through problems vs. Item #35 (Y). It is better when therapy has an agreed-upon ending at the start of therapy because the time will be used more effectively. [Total mean distance = 3.53; 73% of participants agreed with X more than Y, 20% of participants agreed with Y more than X.]

4. Item #14 (X). Since no two people are alike, the therapist should choose an approach that fits the individual client vs. Item #13 (Y). Since psychological problems have been scientifically studied, the therapist should choose a technique that has been shown to be effective with others. [Total mean distance = 3.5; 90% of participants agreed with X more than Y.

5. Item #41. (X) The therapist should help the client to talk about the past, because the past is likely an important part of the client's current difficulties vs. Item #42 (Y). The therapist should help the client focus on current problems, as a client's difficulties can only be addressed in the present time. [Total mean distance = 3.48; 80% of participants agreed with X more thanY.]

The significant mean distances between the item pairs above indicate that overall, participants agreed strongly with some concepts and disagreed with their opposing counterparts. For instance, participants endorsed the view that the therapist's job is to interpret symptoms rather than focus solely on symptom reduction and to reveal meaning in what the client brings to session rather than take what the client says at face value. The majority of participants also agreed that the therapist should choose an approach that fits the individual rather than using an approach that has been scientifically shown to be effective with others, and that the therapist should

help the client talk about the past and not just present concerns. Interestingly, whereas a significant number of participants thought that therapy should not be constrained by an agreed-upon ending, there was a subset of participants who believed the opposite – namely, that having an agreed-upon ending at the start of therapy would help the therapy to be most effective.

Table 3

Differences Between Paired Items

Note. X = Psychodynamic/Humanistic items and Y=CBT/Scientific items. Percentage of participants with significant difference at ≥ 3 Q-sort columns in parentheses.

Item Pairs	Mean Distance Between Items	Subgroup Means		Numbers of Participants		
		X>Y	Y>X	X>Y	Y>X	X=Y
1. Therapy should be like a journey, with the therapist encouraging the client to find his or her own answers. (X) 2. Therapy should be a structured activity, with the therapist helping the client to set goals, solve problems, and monitor progress. (Y)	2.68	2.65	3.00	20 (50)	18 (50)	2
3. Clients are helped in therapy when the therapist waits for the client to share information over time before deciding what the problem is. (X) 4. Clients are helped in therapy when the therapist initially identifies the client's problem and sets goals for treatment. (Y)	2.88	3.46	3.20	24 (54)	10 (50)	6
5. The therapist should address a topic directly related to the client's problem, even if this is not the topic on the client's mind that day. (Y) 6. The therapist should address whatever topic the client brings to the session. (X)	2.58	2.79	3.50	25 (48)	8 (75)	7
7. Having a formal diagnosis (i.e. "depression") is important, as this should guide the type of treatment the client receives. (Y) 8. Clients can be helped in therapy without a formal diagnosis (i.e. "depression"). (X)	3.18	3.67	3.90	24 (54)	10 (70)	6
9. Being diagnosed with a psychological disorder is undesirable because it means that there is "something wrong" with the client. (X) 10. Being diagnosed with a psychological disorder is a relief, because it means that other people struggle with the same problems. (Y)	2.38	1.86	3.04	7 (14)	27 (48)	6
11. Clients are helped in therapy when the therapist encourages specific changes in thinking and behavior. (Y) 12. Clients are helped in therapy when the therapist encourages open-ended reflection and exploration. (X)	2.68	3.45	2.71	20 (65)	14 (43)	6

Table 3 – Continued

13. Since psychological problems have been scientifically studied, the therapist should choose a technique that has been shown to be effective with others. (Y) 14. Since no two people are alike, the therapist should choose an approach that fits the individual client. (X)	3.50	3.67	2.67	36 (67)	3 (67)	1
15. It is important for techniques used in therapy to have been used by experts for many years. (X) 16. It is important for techniques used in therapy to have been supported by scientific evidence. (Y)	1.98	1.80	3.33	5 (20)	21 (57)	14
17. Clients should be cautious about therapy that does not allow the client to come to her or her own conclusions. (X) 18. Clients should be cautious about therapy in which the client is allowed to talk for a long time without making any progress. (Y)	2.25	2.88	2.59	16 (44)	17 (47)	7
19. Uncertainty about what is happening is an obstacle in therapy, as clear understanding and specific goals are most helpful. (Y) 20. Uncertainty about what is happening is welcomed in therapy, as it can lead to new realizations or understanding. (X)	2.85	3.33	2.59	21 (62)	17 (59)	2
21. The goal of therapy is to cure symptoms, rather than understand the hidden meanings behind them. (Y) 22. The therapist should help the client understand how symptoms can have hidden meanings, or can be expressions of inner conflict. (X)	4.73	4.95	1.00	38 (87)	1 (0)	1
23. The therapist should notice when the client says one thing but really means something different. (X) 24. The therapist should take what the client says more or less at face value. (Y)	3.78	4.48	1.50	33 (82)	2 (0)	5
25. Clients know best what is bothering them, and it is the therapist's job to address the client's stated concerns. (Y) 26. Clients are frequently unclear about what is bothering them, and it is the therapist's job to identify what the problem really is. (X)	2.70	3.16	2.90	25 (52)	10 (40)	5

Table 3 – Continued

27. A good outcome in therapy would be for the client to experience fewer painful feelings. (Y) 28. A good outcome in therapy would be for the client to be able to experience and accept painful feelings. (X)	2.88	3.48	3.00	21 (57)	14 (43)	5
29. Clients can't change everything about themselves, but they can accept much about the way they are. (X) 30. Clients can make significant changes through learning and practicing new skills. (Y)	2.23	2.64	2.73	11 (45)	22 (41)	7
31. Therapists help clients to be realistic about changes that can be made. (X) 32. Therapists help clients to be optimistic about changes that can be made. (Y)	1.25	1.94	1.31	17 (18)	13 (08)	10
33. Change in therapy involves experiencing and sometimes increasing negative feelings in order to help the client work through them. (X) 34. Change in therapy involves decreasing negative feelings and increasing positive feelings in order to help the client feel better. (Y)	2.45	3.35	2.41	17 (71)	17 (47)	6
35. It is better when therapy has an agreed-upon ending at the start of therapy because the time will be used more effectively. (Y) 36. It is better when therapy does not have a definite ending because clients need time to work through problems. (X)	3.53	4.00	3.13	29 (72)	8 (75)	3
37. The ideal length of therapy is more than 20 weekly sessions. (X) 38. The ideal length of therapy is less than 20 weekly sessions. (Y)	1.50	2.18	3.27	11 (18)	11 (64)	18
39. Focusing on what is happening in the relationship between the therapist and client is not useful for helping the client and detracts from other work that can be done. (Y) 40. It is helpful for therapists to point out things that happen in the relationship between client and therapist, as this may lead to important realizations about what is happening in the client's other relationships. (X)	2.95	4.13	2.30	23 (91)	10 (30)	7
41. The therapist should help the client to talk about the past, because the past is likely an important part of the client's current difficulties. (X) 42. The therapist should help the client focus on current problems, as a client's difficulties can only be addressed in the present time. (Y)	3.48	4.13	2.33	32 (72)	3 (33)	5

Table 3 – Continued

43. The therapy session should be led mostly by the therapist. (Y) 44. The therapy session should be led mostly by the client. (X)	2.10	3.50	2.19	14 (57)	16 (25)	10
45. Psychotherapy is more like a science than an art. (Y) 46. Psychotherapy is more like an art than a science. (X)	1.95	2.64	4.08	11 (45)	12 (67)	17
47. If the client resists making changes, it is the therapist's job to be patient and let the client make changes in his or her own time. (X) 48. If the client resists making changes, it is the therapist's job to find new ways to help the client change. (Y)	2.15	2.50	2.73	18 (44)	15 (47)	7
49. Therapists should be empathic, understanding, and supportive at all times. (X) 50. Therapists sometimes need to use "tough love" in order to help a client. (Y)	2.88	3.23	3.44	26 (50)	9 (33)	5
51. A client who is not making an effort to change should be encouraged to leave therapy and return when he or she is more willing to make changes. (Y) 52. A client who is not making an effort to change should be encouraged to stay in therapy and address why progress is not being made. (X)	3.40	4.24	2.73	25 (92)	11 (45)	4
53. If a client is not making progress in therapy, this is most likely because something about the client is getting in the way. (Y) 54. If a client is not making progress in therapy, this is most likely because the therapist is not using the right approach. (X)	1.55	2.13	2.14	15 (27)	14 (36)	11
55. A major goal of therapy should be to focus on how aspects of the client's personality may cause problems in daily life. (X) 56. A major goal of therapy should be to focus on how the client's thoughts and behaviors may cause problems in daily life. (Y)	2.30	1.50	3.07	4 (25)	28 (57)	8
57. A therapist should monitor the client's progress in therapy by having the client fill out questionnaires on a regular basis. (Y) 58. A therapist should monitor a client's progress in therapy by asking periodically how the therapy is going. (X)	3.10	4.03	1.00	29 (79)	7 (0)	4

Looking specifically at the psychodynamic/humanistic items that were ranked more highly than their CBT/scientific counterparts, the items with the largest distance were:

1. Item #22 (X). The therapist should help the client understand how symptoms can have hidden meanings, or can be expressions of inner conflict vs. Item #21 (Y). The goal of therapy is to cure symptoms, rather than understand the hidden meanings behind them. [Mean distance = 4.95; 95% of participants]

2. Item #23 (X) . The therapist should notice when the client says one thing but really means something different vs. Item #24 (Y). The therapist should take what the client says more or less at face value. [Mean distance = 4.48; 83% of participants]

3. Item #52 (X). A client who is not making an effort to change should be encouraged to stay in therapy and address why progress is not being made vs. Item #51 (Y). A client who is not making an effort to change should be encouraged to leave therapy and return when he or she is more willing to make changes. [Mean distance = 4.24; 63% of participants]

4. Item #40 (X). It is helpful for therapists to point out things that happen in the relationship between client and therapist, as this may lead to important realizations about what is happening in the client's other relationships vs. Item #39 (Y). Focusing on what is happening in the relationship between the therapist and client is not useful for helping the client and detracts from other work that can be done.[Mean distance = 4.13; 58% of participants]

5. Item #41 (X). The therapist should help the client to talk about the past, because the past is likely an important part of the client's current difficulties vs. Item #42 (Y). The therapist should help the client focus on current problems, as a client's difficulties can only be addressed in the present time. [Mean distance = 4.13; 80% of participants]

The paired items above represent concepts where participants agreed strongly with the psychodynamic/humanistic ("X") item of the pair and disagreed with the CBT/scientific ("Y") item. As expected, the concept of therapist interpretation of symptoms is repeated here, but other concepts also stand out as significant.

Participants agreed that clients who are resistant to therapy should be encouraged to stay in therapy and address why change is not being made, as opposed to leaving therapy and returning when he/she is more willing to make changes. Participants also agreed that focusing on the therapeutic relationship is more helpful than not, and that talking about the past is more helpful than focusing only on the present. As these items were the most dichotomous for the items where participants agreed most with the psychodynamic/humanistic item, they represent items that participants thought distinguished distinct types of therapy.

Looking specifically at the CBT/scientific items that were ranked more highly than their psychodynamic/humanistic counterparts, the items with the largest distance were:

1. Item #45 (Y). Psychotherapy is more like a science than an art vs. Item #46 (X). Psychotherapy is more like an art than a science. [Mean distance = 4.08; 30% of participants]

2. Item #7 (Y). Having a formal diagnosis (i.e. "depression") is important, as this should guide the type of treatment the client receives vs. Item #8 (X). Clients can be helped in therapy without a formal diagnosis (i.e. "depression"). [Mean distance = 3.90; 25% of participants]

3. Item #5 (Y). The therapist should address a topic directly related to the client's problem, even if this is not the topic on the client's mind that day vs. Item #6 (X). The therapist should address whatever topic the client brings to the session. [Mean distance = 3.50; 20% of participants]

4. Item #50 (Y). Therapists sometimes need to use "tough love" in order to help a client vs. Item #49 (X). Therapists should be empathic, understanding, and supportive at all times. [Mean distance = 3.44; 23% of participants]

5. Item #16 (Y). It is important for techniques used in therapy to have been supported by scientific evidence vs. Item#15 (X) . It is important for techniques used in therapy to have been used by experts for many years. [Mean distance = 3.33; 53% of participants]

These item pairs represent the ones where the CBT/scientific item was agreed upon more strongly than the psychodynamic/humanistic item, and are quite different thematically from the item pairs previously discussed. These participants agreed strongly that psychotherapy is more like a science than an art, that having a formal diagnosis is important for guiding treatment, that therapists should address the client's problem directly instead of simply reacting to the client's statements, that therapists sometimes need to use "tough love" rather than being unconditionally supportive, and that techniques used in therapy should be supported by scientific evidence. Although a small percentage of participants ranked these CBT/scientific items more highly than their psychodynamic/humanistic counterparts, they nevertheless represent a significant subset of individuals who agreed most strongly with these CBT/scientific items and disagreed with the alternate view.

For some items, there were a large number of participants who placed paired items in the same column. This pattern of responding indicates that participants thought the items were highly dialectic, or likely to both be true simultaneously though seemingly opposite. Another reason why participants might have put paired items in the same column would be if they believed that both concepts might be true but would depend on the circumstances. During follow-up interviews, participants also said that they placed items in the same column if they "weren't sure" about which item they agreed with more or less, which is consistent with the nature of dialectic concepts in that seemingly opposite ideas can be held simultaneously, resulting in feelings of confusion. The following items had the most numbers of participants who placed the items in the same column:

1. Item #37 (X). The ideal length of therapy is more than 20 weekly sessions. and Item #38 (Y). The ideal length of therapy is less than 20 weekly sessions. [45% of participants]

2. Item #45 (Y). Psychotherapy is more like a science than an art. and Item #46 (X). Psychotherapy is more like an art than a science. [43% of participants]

3. Item # 15 (X). It is important for techniques used in therapy to have been used by experts for many years. and Item #16 (Y). It is important for techniques used in therapy to have been supported by scientific evidence. [35% of participants]

4. Item #53 (Y). If a client is not making progress in therapy, this is most likely because something about the client is getting in the way. and Item # 54 (X). If a client is not making progress in therapy, this is most likely because the therapist is not using the right approach. [28% of participants]

5. Item #43 (Y). The therapy session should be led mostly by the therapist. and Item #44 (X). The therapy session should be led mostly by the client. [25% of participants]

6. Item #31 (X). Therapists help clients to be realistic about changes that can be made. and Item #32 (Y). Therapists help clients to be optimistic about changes that can be made. [25% of participants]

A close examination of the above item pairs suggests that whereas some of these items were likely placed together because participants were unsure of how to respond, others were likely seen as "dialectic," or simultaneously true despite being apparent opposites. For instance, it is reasonable to hypothesize that participants might not have been sure about whether therapy should last more or less than 20 sessions, or who is more responsible, the client or the therapist, if the client is not making progress in therapy. In contrast, whether therapy is more like an art or a science, if techniques should be supported by therapist expertise or scientific evidence, if the therapy session should be led mostly by the client or therapist, or

whether therapists help clients be either realistic or optimistic about change, are all concepts that could be interpreted as "dialectic" or simultaneously true despite appearing contradictory. Information from follow-up interviews suggests that these items were placed by significant numbers of participants in the same columns because they were seen by participants as being compatible with each other instead of in conflict.

As shown in Table 3, there was a significant degree of variation in how participants chose to handle paired items when sorting the items into the Q-sort grid. As we shall see in the following factor analysis, this variation was ideal for determining distinct factors, or patterns of responding by participants.

Q-Method Factor Analysis Overview

The basic purpose of Q-Method factor analysis is to discover whether groups of participants sorted the Q-set items in similar ways. While the computations in Q-Method are similar to those in traditional, or "R" factor analysis, Q-method factor analysis is distinct in that it groups *participants* into factors rather than *items*. Thus, whereas the end result of an R factor-analysis is groups of sets of items that "hang together" to form an underlying concept, the end result of Q-Method factor analysis is groups of participants whose entire Q-sorts "hang together" to form a common viewpoint. This means that the ultimate goal of interpretation in a Q-sort analysis is to discover common themes that distinguish groups of participants from one another, regardless of whether the opinions endorsed by these participants have conceptual commonalities.

The statistics used in both types of factor analysis are similar until the interpretation stage, where Q-Method requires extra steps in order to arrive at a meaningful conceptual interpretation for each factor. Though it is fairly straightforward to derive underlying concepts from groups of items in R factor analysis, understanding the underlying similarities in groups of Q-sorts is not quite as straightforward. The process of creating factor scores and factor arrays, or "model" Q-sorts for each factor, is intended to facilitate interpretation of factors (McKeown & Thomas, 1988). However, since each participant's Q-sort represents a "site" of information about an individual's subjective viewpoint (Stenner et al., 2008), each Q-sort individually also contains valuable information about the nature of statistically derived factors and about the potential for variation in individual views. For this reason, Q-method analysis does not end with the creation of factor arrays but rather continues to analyze Q-sorts qualitatively. Q-method has therefore been called a "qualiquantological" procedure because it uses quantitative factor analysis to determine commonalities in subjective viewpoints but goes further to qualitatively interpret these viewpoints (Stenner et al., 2008).

The steps for Q-method factor analysis are: 1) Factor extraction and rotation 2) Factor scores 3) Factor Arrays and 4) Qualitative analysis and interpretation. These steps and the results will be described in the following sections.

Factor Extraction and Rotation

In the current study, all 40 Q-sorts were analyzed together using PQMethod 2.11, a free statistical software program specifically tailored to analyze Q-sort data

(Schmolck, 2002). A correlation matrix first identifies correlations between individual sorts, but this step is simply a means to extracting factors (Brown, 1993). The centroid method of factor extraction was used for this study, though other methods of extraction would be acceptable, as "it makes little difference whether the specific factoring routine is the principal components, centroid, or any other available method" (McKeown & Thomas, 1988). In Q-method analysis, however, "the centroid or simple summation method is generally preferred," because it, "offers a potential *infinite* number of rotated solutions," which preserves open interpretation of the data (Watts & Stenner, 2005). Using centroid extraction, seven factors were extracted, which is the default number of PQMethod 2.11 because Q-sort analyses very rarely exceed seven distinct factors.

To determine how many significant factors should be rotated, a scree plot was created using the eigenvalues of the unrotated factors. From the scree plot, two significant factors emerged before a drop in eigenvalue to below one, or an "elbow" curve in the plot. The factors were rotated using varimax rotation, which is preferred in Q-method analysis because it maximizes the amount of variance explained by the factors; "the varimax procedure is... consonant with one of our typical aims in using Q methodology; namely, to reveal the range of viewpoints that are favoured *(sic—British spelling)* by our participant *group*" (Watts & Stenner, 2005). Because varimax rotation is orthogonal, it also is the most effective rotation method for determining separate and independent factors (McKeown & Thomas, 1988). After varimax rotation, two distinct factors were confirmed, accounting for 33% of the total variance.

To determine which factor loadings were significant, the standard error was calculated with the formula: $SE = 1 / \sqrt{N}$, where N is the number of statements, or 58 (Brown, 1993). The standard error for the current study was 0.1313. Although Brown (1993) states that the significance level should be between 2 and 2.5 times the standard error, 2.58 is more frequently used as a more conservative value because loadings are then significant at the 0.01 level (McKeown & Thomas, 1988). The value for significant loadings in the current study was 0.339. Using this significance level, 75% of the participants loaded significantly on only one factor, with 22.5% of the participants loading significantly on both factors (i.e., "confounded") and 2.5% of the participants not loading on either factor. Of those participants who loaded significantly and exclusively, 66.7% loaded exclusively on Factor A and 33.3% loaded exclusively on Factor B.

Factor Scores

In order to interpret statistically derived factors, Q-method data analysis proceeds by calculating factor scores, or weighted averages, for each item in the Q-set. These factor scores will then be converted into factor arrays, whereby the weighted averages for each item are placed back into the shape of the Q-sort grid, so that the final, interpretable product is a "model" or "exemplar" Q-sort that defines each factor (Stenner et al., 2008). In other words, each of the distinct factors will ultimately be represented by a Q-sort grid in which the items are arranged such that they reflect the aggregate opinions of the participants who load independently on each factor. When calculating factor scores, only those sorts that load exclusively on one

factor are used and confounded sorts are excluded (Watts & Stenner, 2005) because the goal of calculating factor scores is to create prototype Q-sorts for only distinguishable factors.

The weights for each factor loading are calculated using the formula: weight = factor loading / 1 – (factor loading)^2 and multiplied by each participant's score for each item (Brown, 1993). The product scores are then summed across items, calculating a factor score for each item that is an average of all the participants' scores for each item, weighted by their factor loadings. To illustrate with an example, Participant #1 loads exclusively on Factor A with a factor loading of 0.4019. The weight for Participant #1 is therefore: weight = 0.4019 / (1-0.4019), = 0.4793. Participant # 8 also loads exclusively on Factor A with a factor loading of 0.4639, and a weight of 0.4639 / (1-0.4639) = 0.5911. Weights for all participants who load exclusively on Factor A are calculated similarly with this formula. To obtain a factor score for Factor A, Item #1, the scores given Item #1 by each participant are multiplied by their respective weights and summed:

Factor score = (weight1)(item rank1) + (weight2)(item rank2) …and so on

In this example, both Participant #1 and Participant #8 ranked Item #1 as "+2" on the Q-sort grid. Thus:

Factor Score (Factor A, Item #1) = (0.4793)(2) + (0.5911)(2) … and so on

These calculations are repeated for each factor and for each individual item, such that each item has one "factor score" for each independent factor – in this case, Factor A and Factor B. The factor scores are not particularly significant in themselves, but are an intermediate step towards creating factor arrays, described below.

Factor Arrays

As previously discussed, the factor arrays are the final product of Q-sort analysis, and are "model" Q-sort distributions created from the factor scores for each individual item. One factor array is created for each factor and is used as a prototype for interpreting each factor conceptually. The factor array is created by listing the factor scores for each item and, for each factor, ranking the factor scores in numerical order. Each item is then "returned to the original Q sort format" by assigning the same ranking values that defined the columns in the Q-sort grid (Brown, 1993). In this study, the Q-sort grid was constructed with endpoints of +/- 4, with 4 cards in each of these columns. Five cards were assigned to the +/- 3 columns, and so on. In order to create the factor arrays for Factor A and Factor B, the four highest factor scores were assigned values of +4, the next five scores a value of +3, etc. For each factor, the assigned ranking based upon factor score values are found in Table 4. The factor arrays, or "model" distributions for Factors A and B are shown in Figures 1 and 2, respectively.

Table 4

Factor Arrays with Ranking Values

Q-sort items	Factor A	Factor B
1. Therapy should be like a journey, with the therapist encouraging the client to find his or her own answers.	2	2
2. Therapy should be a structured activity, with the therapist helping the client to set goals, solve problems, and monitor progress.	2	3
3. Clients are helped in therapy when the therapist waits for the client to share information over time before deciding what the problem is.	0	1
4. Clients are helped in therapy when the therapist initially identifies the client's problem and sets goals for treatment.	-1	0
5. The therapist should address a topic directly related to the client's problem, even if this is not the topic on the client's mind that day.	-2	0
6. The therapist should address whatever topic the client brings to the session.	3*	-2*
7. Having a formal diagnosis (i.e. "depression") is important, as this should guide the type of treatment the client receives.	-2*	3*
8. Clients can be helped in therapy without a formal diagnosis (i.e. "depression").	3*	0*
9. Being diagnosed with a psychological disorder is undesirable because it means that there is "something wrong" with the client.	-3	-4
10. Being diagnosed with a psychological disorder is a relief, because it means that other people struggle with the same problems.	-2	0
11. Clients are helped in therapy when the therapist encourages specific changes in thinking and behavior.	1	1
12. Clients are helped in therapy when the therapist encourages open-ended reflection and exploration.	4*	-1*
13. Since psychological problems have been scientifically studied, the therapist should choose a technique that has been shown to be effective with others.	0	1
14. Since no two people are alike, the therapist should choose an approach that fits the individual client.	4	4
15. It is important for techniques used in therapy to have been used by experts for many years.	-4*	1*
16. It is important for techniques used in therapy to have been supported by scientific evidence.	-1*	3*
17. Clients should be cautious about therapy that does not allow the client to come to her or her own conclusions.	1	-1
18. Clients should be cautious about therapy in which the client is allowed to talk for a long time without making any progress.	0	2

Table 4 – Continued

19. Uncertainty about what is happening is an obstacle in therapy, as clear understanding and specific goals are most helpful.	-2*	1*
20. Uncertainty about what is happening is welcomed in therapy, as it can lead to new realizations or understanding.	1*	-3*
21. The goal of therapy is to cure symptoms, rather than understand the hidden meanings behind them.	-4	-4
22. The therapist should help the client understand how symptoms can have hidden meanings, or can be expressions of inner conflict.	4*	1*
23. The therapist should notice when the client says one thing but really means something different.	2	4
24. The therapist should take what the client says more or less at face value.	-3	-4
25. Clients know best what is bothering them, and it is the therapist's job to address the client's stated concerns.	-1	-3
26. Clients are frequently unclear about what is bothering them, and it is the therapist's job to identify what the problem really is.	-1*	4*
27. A good outcome in therapy would be for the client to experience fewer painful feelings.	2*	-3*
28. A good outcome in therapy would be for the client to be able to experience and accept painful feelings.	0*	3*
29. Clients can't change everything about themselves, but they can accept much about the way they are.	2	1
30. Clients can make significant changes through learning and practicing new skills.	4	2
31. Therapists help clients to be realistic about changes that can be made.	3	2
32. Therapists help clients to be optimistic about changes that can be made.	3*	0*
33. Change in therapy involves experiencing and sometimes increasing negative feelings in order to help the client work through them.	1	-1
34. Change in therapy involves decreasing negative feelings and increasing positive feelings in order to help the client feel better.	1	-1
35. It is better when therapy has an agreed-upon ending at the start of therapy because the time will be used more effectively.	-3	-2
36. It is better when therapy does not have a definite ending because clients need time to work through problems.	1	2
37. The ideal length of therapy is more than 20 weekly sessions.	-2	-2
38. The ideal length of therapy is less than 20 weekly sessions.	-1	-1
39. Focusing on what is happening in the relationship between the therapist and client is not useful for helping the client and detracts from other work that can be done.	-3	-2

Table 4 – Continued

40. It is helpful for therapists to point out things that happen in the relationship between client and therapist, as this may lead to important realizations about what is happening in the client's other relationships.	1	0
41. The therapist should help the client to talk about the past, because the past is likely an important part of the client's current difficulties.	3	3
42. The therapist should help the client focus on current problems, as a client's difficulties can only be addressed in the present time.	-1	3
43. The therapy session should be led mostly by the therapist.	0*	-3*
44. The therapy session should be led mostly by the client.	0	-1
45. Psychotherapy is more like a science than an art.	0	2
46. Psychotherapy is more like an art than a science.	0	-2
47. If the client resists making changes, it is the therapist's job to be patient and let the client make changes in his or her own time.	0	-1
48. If the client resists making changes, it is the therapist's job to find new ways to help the client change.	0	0
49. Therapists should be empathic, understanding, and supportive at all times.	2	0
50. Therapists sometimes need to use "tough love" in order to help a client.	-1	0
51. A client who is not making an effort to change should be encouraged to leave therapy and return when he or she is more willing to make changes.	-4	-2
52. A client who is not making an effort to change should be encouraged to stay in therapy and address why progress is not being made.	-1	-1
53. If a client is not making progress in therapy, this is most likely because something about the client is getting in the way.	-2	-2
54. If a client is not making progress in therapy, this is most likely because the therapist is not using the right approach.	-3*	1*
55. A major goal of therapy should be to focus on how aspects of the client's personality may cause problems in daily life.	-2*	2*
56. A major goal of therapy should be to focus on how the client's thoughts and behaviors may cause problems in daily life.	2	4
57. A therapist should monitor the client's progress in therapy by having the client fill out questionnaires on a regular basis.	-4	-4
58. A therapist should monitor a client's progress in therapy by asking periodically how the therapy is going.	1	0

Note. * = significant difference at ≥ 3 Q-sort columns

-4	-3	-2	-1	0	+1	+2	+3	+4
15. It is important for techniques used in therapy to have been used by experts for many years.	24. The therapist should take what the client says more or less at face value.	37. The ideal length of therapy is more than 20 weekly sessions.	38. The ideal length of therapy is less than 20 weekly sessions.	28. A good outcome in therapy would be for the client to be able to experience and accept painful feelings.	58. A therapist should monitor a client's progress in therapy by asking periodically how the therapy is going.	29. Clients can't change everything about themselves, but they can accept much about the way they are.	31. Therapists help clients to be realistic about changes that can be made.	14. Since no two people are alike, the therapist should choose an approach that fits the individual client.
21. The goal of therapy is to cure symptoms, rather than understand the hidden meanings behind them.	54. If a client is not making progress in therapy, this is most likely because the therapist is not using the right approach.	53. If a client is not making progress in therapy, this is most likely because something about the client is getting in the way.	50. Therapists sometimes need to use "tough love" in order to help a client.	48. If the client resists making changes, it is the therapist's job to find new ways to help the client change.	36. It is better when therapy does not have a definite ending because clients need time to work through problems.	27. A good outcome in therapy would be for the client to experience fewer painful feelings.	32. Therapists help clients to be optimistic about changes that can be made.	30. Clients can make significant changes through learning and practicing new skills.
57. A therapist should monitor the client's progress in therapy by having the client fill out questionnaires on a regular basis.	9. Being diagnosed with a psychological disorder is undesirable because it means that there is "something wrong" with the client.	5. The therapist should address a topic directly related to the client's problem, even if this is not the topic on the client's mind that day.	16. It is important for techniques used in therapy to have been supported by scientific evidence.	47. If the client resists making changes, it is the therapist's job to be patient and let the client make changes in his or her own time.	20. Uncertainty about what is happening is welcomed in therapy, as it can lead to new realizations or understanding.	49. Therapists should be empathic, understanding, and supportive at all times.	8. Clients can be helped in therapy without a formal diagnosis (i.e. "depression").	12. Clients are helped in therapy when the therapist encourages open-ended reflection and exploration.
51. A client who is not making an effort to change should be encouraged to leave therapy and return when he or she is more willing to make changes.	35. It is better when therapy has an agreed-upon ending at the start of therapy because the time will be used more effectively.	55. A major goal of therapy should be to focus on how aspects of the client's personality may cause problems in daily life.	26. Clients are frequently unclear about what is bothering them, and it is the therapist's job to identify what the problem really is.	3. Clients are helped in therapy when the therapist waits for the client to share information over time before deciding what the problem is	11. Clients are helped in therapy when the therapist encourages specific changes in thinking and behavior.	1. Therapy should be like a journey, with the therapist encouraging the client to find his or her own answers.	6. The therapist should address whatever topic the client brings to the session.	22. The therapist should help the client understand how symptoms can have hidden meanings, or can be expressions of inner conflict.
	39. Focusing on what is happening in the relationship between the therapist and client is not useful for helping the client and detracts from other work that can be done.	19. Uncertainty about what is happening is an obstacle in therapy, as clear understanding and specific goals are most helpful.	25. Clients know best what is bothering them, and it is the therapist's job to address the client's stated concerns.	18. Clients should be cautious about therapy in which the client is allowed to talk for a long time without making any progress.	17. Clients should be cautious about therapy that does not allow the client to come to her or her own conclusions.	2. Therapy should be a structured activity, with the therapist helping the client to set goals, solve problems, and monitor progress.	41. The therapist should help the client to talk about the past, because the past is likely an important part of the client's current difficulties.	
		7. Having a formal diagnosis (i.e. "depression") is important, as this should guide the type of treatment the client receives.	52. A client who is not making an effort to change should be encouraged to stay in therapy and address why progress is not being made.	13. Since psychological problems have been scientifically studied, the therapist should choose a technique that has been shown to be effective with others.	34. Change in therapy involves decreasing negative feelings and increasing positive feelings in order to help the client feel better.	23. The therapist should notice when the client says one thing but really means something different.		
		10. Being diagnosed with a psychological disorder is a relief, because it means that other people struggle with the same problems.	42. The therapist should help the client focus on current problems, as a client's difficulties can only be addressed in the present time.	45. Psychotherapy is more like a science than an art.	33. Change in therapy involves experiencing and sometimes increasing negative feelings in order to help the client work through them.	56. A major goal of therapy should be to focus on how the client's thoughts and behaviors may cause problems in daily life.		
				46. Psychotherapy is more like an art than a science.				
			4. Clients are helped in therapy when the therapist initially identifies the client's problem and sets goals for treatment.	43. The therapy session should be led mostly by the therapist.	40. It is helpful for therapists to point out things that happen in the relationship between client and therapist, as this may lead to important realizations about what is happening in the client's other relationships.			
				44. The therapy session should be led mostly by the client.				

Figure 1. Factor Array for Factor A

-4	-3	-2	-1	0	+1	+2	+3	+4
24. The therapist should take what the client says more or less at face value.	43. The therapy session should be led mostly by the therapist.	46. Psychotherapy is more like an art than a science.	17. Clients should be cautious about therapy that does not allow the client to come to her or her own conclusions.	58. A therapist should monitor a client's progress in therapy by asking periodically how the therapy is going.	15. It is important for techniques used in therapy to have been used by experts for many years.	45. Psychotherapy is more like a science than an art.	16. It is important for techniques used in therapy to have been supported by scientific evidence.	23. The therapist should notice when the client says one thing but really means something different.
21. The goal of therapy is to cure symptoms, rather than understand the hidden meanings behind them.	27. A good outcome in therapy would be for the client to experience fewer painful feelings.	37. The ideal length of therapy is more than 20 weekly sessions.	12. Clients are helped in therapy when the therapist encourages open-ended reflection and exploration.	10. Being diagnosed with a psychological disorder is a relief, because it means that other people struggle with the same problems.	11. Clients are helped in therapy when the therapist encourages specific changes in thinking and behavior.	31. Therapists help clients to be realistic about changes that can be made.	28. A good outcome in therapy would be for the client to be able to experience and accept painful feelings.	14. Since no two people are alike, the therapist should choose an approach that fits the individual client.
57. A therapist should monitor the client's progress in therapy by having the client fill out questionnaires on a regular basis.	20. Uncertainty about what is happening is welcomed in therapy, as it can lead to new realizations or understanding.	35. It is better when therapy has an agreed-upon ending at the start of therapy because the time will be used more effectively.	38. The ideal length of therapy is less than 20 weekly sessions. 44. The therapy session should be led mostly by the client.	5. The therapist should address a topic directly related to the client's problem, even if this is not the topic on the client's mind that day.	54. If a client is not making progress in therapy, this is most likely because the therapist is not using the right approach.	30. Clients can make significant changes through learning and practicing new skills.	7. Having a formal diagnosis (i.e. "depression") is important, as this should guide the type of treatment the client receives.	56. A major goal of therapy should be to focus on how the client's thoughts and behaviors may cause problems in daily life.
9. Being diagnosed with a psychological disorder is undesirable because it means that there is "something wrong" with the client.	25. Clients know best what is bothering them, and it is the therapist's job to address the client's stated concerns.	6. The therapist should address whatever topic the client brings to the session.	34. Change in therapy involves decreasing negative feelings and increasing positive feelings in order to help the client feel better.	4. Clients are helped in therapy when the therapist initially identifies the client's problem and sets goals for treatment.	13. Since psychological problems have been scientifically studied, the therapist should choose a technique that has been shown to be effective with others.	1. Therapy should be like a journey, with the therapist encouraging the client to find his or her own answers.	2. Therapy should be a structured activity, with the therapist helping the client to set goals, solve problems, and monitor progress.	26. Clients are frequently unclear about what is bothering them, and it is the therapist's job to identify what the problem really is.
	42. The therapist should help the client focus on current problems, as a client's difficulties can only be addressed in the present time.	53. If a client is not making progress in therapy, this is most likely because something about the client is getting in the way.	33. Change in therapy involves experiencing and sometimes increasing negative feelings in order to help the client work through them.	32. Therapists help clients to be optimistic about changes that can be made. 50. Therapists sometimes need to use "tough love" in order to help a client.	22. The therapist should help the client understand how symptoms can have hidden meanings, or can be expressions of inner conflict.	36. It is better when therapy does not have a definite ending because clients need time to work through problems.	41. The therapist should help the client to talk about the past, because the past is likely an important part of the client's current difficulties.	
		51. A client who is not making an effort to change should be encouraged to leave therapy and return when he or she is more willing to make changes.	52. A client who is not making an effort to change should be encouraged to stay in therapy and address why progress is not being made	8. Clients can be helped in therapy without a formal diagnosis (i.e. "depression"). 49. Therapists should be empathic, understanding, and supportive at all times.	3. Clients are helped in therapy when the therapist waits for the client to share information over time before deciding what the problem is.	18. Clients should be cautious about therapy in which the client is allowed to talk for a long time without making any progress.		
		39. Focusing on what is happening in the relationship between the therapist and client is not useful for helping the client and detracts from other work that can be done.	47. If the client resists making changes, it is the therapist's job to be patient and let the client make changes in his or her own time.	48. If the client resists making changes, it is the therapist's job to find new ways to help the client change.	29. Clients can't change everything about themselves, but they can accept much about the way they are.	55. A major goal of therapy should be to focus on how aspects of the client's personality may cause problems in daily life.		
				40. It is helpful for therapists to point out things that happen in the relationship between client and therapist, as this may lead to important realizations about what is happening in the client's other relationships.	19. Uncertainty about what is happening is an obstacle in therapy, as clear understanding and specific goals are most helpful.			

Figure 2. Factor Array for Factor B

Interpretation of Factors

Factor endpoints

In order to make sense of the meaning of each factor from the factor array, Q-sort interpretation usually begins by investigating which views are held strongly by participants in each factor, or the "poles" of each factor array (Watts & Stenner, 2005). These "poles" are the endpoints of the Q-sort grid, which represent items with which participants "most agree" or "least agree." The endpoints elucidate common themes which can be interpreted to gain understanding of the meaning of each factor.

For Factor A, for instance, participants agree with a relatively open and unstructured approach to therapy. They see the client as autonomous, and believe that therapy works best when the client is given the freedom to explore topics in a therapeutic context. They also disagreed that clients should be a given a time-limit in therapy in order to facilitate motivation for change. For example,

12. Clients are helped in therapy when the therapist encourages open-ended reflection and exploration.	+4
6. The therapist should address whatever topic the client brings to the session.	+3
35. It is better when therapy has an agreed-upon ending at the start of treatment because the time will be used more effectively.	-3

Participants in Factor A additionally believe that the role of the therapist is to interpret things said by the client, rather than taking what the client says at face value. The therapist might hypothesize about hidden meanings, or listen for expressions of inner conflict. Factor A participants believe that a therapist's job is not just to treat symptoms, but to help communicate to the client the emotional and psychological underpinnings of psychological disorders. For example,

22. The therapist should help the client understand how symptoms can have hidden meanings, or can be expressions of inner conflict. +4
24. The therapist should take what the client says more or less at face value. -3
21. The goal of therapy is to cure symptoms, rather than understand the hidden meanings behind them. -4

Participants represented by Factor A also had strong feelings about the role of diagnosis in psychological treatment. Although they do not believe that a diagnosis is necessary for effective treatment, they also do not believe that giving a diagnosis unfairly stigmatizes clients. For example,

8. Clients can be helped in therapy without a formal diagnosis (i.e., "depression"). +3
9. Being diagnosed with a psychological disorder is undesirable because it means that there is "something wrong" with the client. -3

Interestingly, participants in Factor A endorsed a strong belief that the therapist should play a role in managing the client's expectations and attitudes toward change. However, they endorsed these concepts dialectically, meaning that they endorsed seemingly contradictory views equally. For example,

31. Therapists help clients to be realistic about changes that can be made. +3
32. Therapists help clients to be optimistic about changes that can be made. +3

Finally, participants in Factor A strongly disagreed with items that assigned some responsibility to either the therapist or the client in situations where the client was not making changes. Factor A participants might have viewed resistance in therapy as part of the therapeutic process rather than an indication that something about their therapist or themselves is ineffective, e.g.,

51. A client who is not making an effort to change should be encouraged to leave therapy and return when he or she is more willing to make changes. -4
54. If a client is not making progress in therapy, this is most likely because the therapist is not using the right approach. -3

In contrast to Factor A participants, Factor B participants endorsed a more structured view of therapy, with the therapist helping the client to set goals and solve problems. Rather than view the client as someone who uses the space of therapy and the therapist's guidance to find his or her own answers, Factor B participants believed more strongly that the therapist should help clients directly address dysfunctional patterns of thought and behavior. Since open-ended exploration is not seen as helpful in therapy, uncertainty is not seen as being likely to lead to new realizations or understandings. Commensurate with the preference of participants in Factor B for therapy to be more structured and defined, participants in Factor B were more likely to agree that techniques used in therapy should be supported by scientific evidence. However, participants in Factor B did not equate increased structure with the idea that the therapist should lead the sessions. For example,

56. A major goal of therapy should be to focus on how the client's thoughts and behaviors may cause problems in daily life. +4
2. Therapy should be a structured activity, with the therapist helping the client to set goals, solve problems, and monitor progress. +3
16. It is important for techniques used in therapy to have been supported by scientific evidence. +3
20. Uncertainty about what is happening is welcomed in therapy, as it can lead to new realizations or understanding. -3
43. The therapy session should be led mostly by the therapist. -4

Similar to participants in Factor A, those in Factor B believed that an important role of the therapist would be to help clients see things that they do not see themselves.

Rather than focus on "hidden meanings" or "inner expressions of conflict," however, participants in Factor B focused on the idea that clients do not always know what the problem is and that it is important for therapists to be able to interpret and clarify the client's problem. Participants in Factor B also disagreed that the client's words should be taken at "face value," and that therapists should agree with the client's evaluation of the problem. For example,

23. The therapist should notice when the client says one thing but really means something different.	+4
26. Clients are frequently unclear about what is bothering them, and it is the therapist's job to identify what the problem really is.	+4
25. Clients know best what is bothering them, and it is the therapist's job to address the client's stated concerns.	-3
24. The therapist should take what the client says more or less at face value.	-4

Another major distinction between participants in Factor A and those in Factor B was the importance of diagnosis in treatment. In contrast to Factor A participants, who thought that clients could be helped without a formal diagnosis, Factor B participants thought therapists should use formal diagnoses to guide treatment. Like Factor A participants, those in Factor B disagreed that diagnoses were unfairly stigmatizing or meant anything negative about the client.

7. Having a formal diagnosis (i.e. "depression") is important, as this should guide the type of treatment the client receives.	+3
9. Being diagnosed with a psychological disorder is undesirable because it means that there is "something wrong" with the client.	-4

Whereas Factor A participants had strong feelings about how therapists help clients manage expectations about change in therapy, Factor B participants had strong

feelings about what defines good outcomes in therapy. They thought that a good outcome in therapy would be for the client to be able to experience and accept painful feelings rather than experience fewer painful feelings. Surprisingly, these juxtaposing items were placed at opposite endpoints of the grid, denoting mutually exclusive items, despite the seemingly dialectic nature of these two items:

28. A good outcome in therapy would be for the client to be able to experience and accept painful feelings.	+3
27. A good outcome in therapy would be for the client to experience fewer painful feelings.	-3

As evidenced by consistencies in the items endorsed most strongly by participants in each factor, it is clear that the two factors do, in fact, represent distinct viewpoints about the nature of therapy and what therapists should do to best help their clients. At the same time, there were some outlooks on the part of both Factor A and Factor B participants that were surprising in that they would not necessarily be expected to cohere with the rest of the factor array. Although an examination of the endpoints of the Q-sort factor arrays gives a good initial indication of how the two factors should be defined, it is only a first step in the interpretation of the factors.

Factor array differences

The next step in factor interpretation is to examine significant differences between the two factors, or individual items that are ranked very differently by participants included in each factor array. Although a difference of two Q-sort grid columns is generally considered to be significant enough to be unlikely to be caused by chance (Brown, 1993), a more conservative value of three columns was used for

this study in order to ensure that differences between factors were truly meaningful. Values for factor array differences are shown in Table 5.

Table 5

Factor Array Differences

Column Difference	Factor A Value	Factor B Value	Item
5	3 Agree	-2 Disagree	The therapist should address whatever topic the client brings to the session. (X)
5	4 Agree	-1 Neutral	Clients are helped in therapy when the therapist encourages open-ended reflection and exploration. (X)
5	2 Agree	-3 Disagree	A good outcome in therapy would be for the client to experience fewer painful feelings. (Y)
5	-2 Disagree	3 Agree	Having a formal diagnosis (i.e. "depression") is important, as this should guide the type of treatment the client receives. (Y)
5	-4 Disagree	1 Neutral	It is important for techniques used in therapy to have been used by experts for many years. (X)
5	-1 Neutral	4 Agree	Clients are frequently unclear about what is bothering them, and it is the therapist's job to identify what the problem really is. (X)
4	1 Neutral	-3 Disagree	Uncertainty about what is happening is welcomed in therapy, as it can lead to new realizations or understanding. (X)
4	-1 Neutral	3 Agree	It is important for techniques used in therapy to have been supported by scientific evidence. (Y)
4	-3 Disagree	1 Neutral	If a client is not making progress in therapy, this is most likely because the therapist is not using the right approach. (X)
4	-2 Disagree	2 Agree	A major goal of therapy should be to focus on how aspects of the client's personality may cause problems in daily life. (X)
3	3 Agree	0 Neutral	Clients can be helped in therapy without a formal diagnosis (i.e. "depression"). (X)
3	4 Agree	1 Neutral	The therapist should help the client understand how symptoms can have hidden meanings, or can be expressions of inner conflict. (X)

Table 5 – Continued

3	3 Agree	0 Neutral	Therapists help clients to be optimistic about changes that can be made. (Y)
3	0 Neutral	-3 Disagree	The therapy session should be led mostly by the therapist. (Y)
3	0 Neutral	3 Agree	A good outcome in therapy would be for the client to be able to experience and accept painful feelings. (X)
3	-2 Disagree	1 Neutral	Uncertainty about what is happening is an obstacle in therapy, as clear understanding and specific goals are most helpful. (Y)

Note. X=Psychodynamic/Humanistic items and Y=CBT/Scientific items

Upon examination, significant differences between Factor A and Factor B follow themes already identified through interpretation of the endpoints, which indicates that the items that distinguish the two factors are fairly consistent with items the participants in each factor feel strongly about. To summarize, these themes are: 1) The degree of structure in therapy 2) The importance of formal diagnosis 3) The role of the therapist in interpreting what the client says 4) The nature of expectations and positive outcomes in therapy.

One theme not specifically addressed in the interpretation of factor arrays is the importance of therapist credibility and the foundation of therapeutic techniques. Factor B participants were more likely than Factor A participants to agree that techniques used in therapy should be supported by scientific evidence, or that they should have been legitimized by being used by experts for many years. Factor B participants preferred the foundation of scientific evidence over therapist expertise,

but they agreed with both statements significantly more than did participants in Factor A.

Factor array similarities

Another important aspect of factor interpretation is the degree to which the factors are similar, or contain items that show few differences between the factors. Participants may feel strongly about such items, or they may have more neutral views towards them. High level of agreement, however, indicates that these are commonly held beliefs among most participants. In the current study, almost half of the items (46.6%) were separated by either zero or one column in the factor arrays, indicating that these items are not the ones that establish differences among participants' views.

The items common to both factor arrays that are most interpretable are those at the endpoints, or those with the most strongly held beliefs by both groups of participants. The following items were rated at the endpoints in both factor arrays:

	Factor A	Factor B
14. Since no two people are alike, the therapist should choose an approach that fits the individual client.	+4	+4
41. The therapist should help the client to talk about the past, because the past is likely an important part of the client's current difficulties.	+3	+3
57. A therapist should monitor the client's progress in therapy by having the client fill out questionnaires on a regular basis.	-4	-4
21. The goal of therapy is to cure symptoms, rather than understand the hidden meanings behind them.	-4	-4
24. The therapist should take what the client says more or less at face value.	-3	-4
9. Being diagnosed with a psychological disorder is undesirable because it means that there is "something wrong" with the client.	-3	-4

Of these items, the two with the most common themes are Item #21 and Item #24, both of which address the role of the therapist in interpreting both the client's verbal communication and the potential meaning of the client's symptoms. The theme of diagnosis is also represented as a belief held by both groups, as participants feel strongly that clients are not stigmatized by having a psychological diagnosis or that psychological diagnosis necessarily means something inherently negative about the client.

The other three items do not appear to address themes previously identified in the data. Item #14, which was highly endorsed by most participants, indicates a strongly held belief that therapy should be tailored to each client's needs, and that the role of the therapist is to choose an approach that will best help the client. Participants, as potential clients, want their therapists to address them as individuals and to maintain enough flexibility to use techniques that they think will be most suited to the individual's problem. The high level of agreement with Item #41 indicates that most participants agree that the past is an important part of a person's psychology and should be addressed directly in treatment. Participants appear to believe that a current psychological problem is likely influenced by the individual's history and thus only by talking about that history can a current problem be improved. Participants strongly disagree with Item #57, that therapists should monitor a client's progress by filling out questionnaires. This may be because participants, as potential clients, think that filling out questionnaires would be burdensome, or they may think that questionnaires are an ineffective method of monitoring progress. Another

possibility is that a formal questionnaire introduces pressure to make progress in therapy, whereas participants seem to believe that clients should not be penalized or pressured to leave therapy if they are not making progress. Interestingly, though a large number of participants disagreed strongly with this item, the issue of monitoring progress through questionnaires was not one that participants chose to discuss during follow-up interviews.

Participant Responses to Follow-Up Questions

The Q-sort method was not intended to be a purely quantitative analytic procedure (Brown, 1993). Although the factor analysis used shares some common elements with traditional factor analysis, Q-sort differs from traditional factor analysis in that the products of the analysis are factor arrays, which must be interpreted by the researcher in order to make meaning of the factors. According to Watts and Stenner (2005), this process is inherently subjective, as the decisions about where to place the items in the Q-sort grid may differ for each participant. For this reason, it is important to gather information from participants about the thought processes they used when sorting the items and whether they have additional thoughts about the overall topic, particular items, or the sorting process. The use of qualitative data in conjunction with quantitative analysis therefore adds to the interpretation of the results by clarifying the meanings of participants' responses.

In the current study, each participant was verbally asked five follow-up questions by the principal investigator when they had completed sorting the items into the Q-sort grid:

1. Did you have any questions about any of the items? Were any of the items confusing?
2. Which items did you most agree with, or place on the right side of the grid? Why?
3. Which items did you most disagree with, or place on the left side of the grid? Why?
4. Which items did you place in the middle columns of the grid? Why?
5. Were there any concepts or ideas that you thought should be added to the items? Was any topic about psychotherapy left out?

For questions two through four, participants were not asked to address each and every item they placed in every item of the grid. Rather, their spontaneous responses were recorded as these were most likely to capture the most accessible and therefore salient beliefs.

In order to assist in the interpretation of the factor arrays, the answers to questions two through four were investigated for common themes. The item pairs that were mentioned most frequently by independent participants were:

1. Item #1. Therapy should be like a journey, with the therapist encouraging the client to find his or her own answers, and Item #2. Therapy should be a structured activity, with the therapist helping the client to set goals, solve problems, and monitor progress.

2. Item #7. Having a formal diagnosis (i.e. "depression") is important, as this should guide the type of treatment the client receives, and Item #8. Clients can be helped in therapy without a formal diagnosis (i.e. "depression"), with Item #9. Being diagnosed with a psychological disorder is undesirable because it means that there is "something wrong" with the client, and Item #10. Being diagnosed with a psychological disorder is a relief, because it means that other people struggle with the same problems.

3. Item #35. It is better when therapy has an agreed-upon ending at the start of treatment because the time will be used more effectively, and Item #36. It is better when therapy does not have a definite ending because clients need time to work through problems, with Item #37. The ideal length of therapy is more than 20 weekly sessions, and Item #38. The ideal length of therapy is less than 20 weekly sessions.

4. Item #45. Psychotherapy is more like a science than an art, and Item #46. Psychotherapy is more like an art than a science.

Two of these item pairs – numbers one and two in the list above – cover themes that were indicated in the interpretation of the factor arrays. These are 1) the relative importance of structured vs. open-ended therapy process and 2) the role of diagnosis in the treatment of psychological disorders. The other two items – numbers three and four – address topics not discovered in the interpretation of the factor arrays. These include themes of 1) the length of therapy and 2) the theoretical nature of psychotherapy as art vs. science. Although the items in the list above were those most frequently mentioned spontaneously by participants, nearly all of the items were mentioned by at least one participant. In addition, there were several situations in which one individual participant had a great deal to say about a particular item, which is important because individuals may be able to articulate beliefs that are also held by others. In order to fully understand the subjective views of participants, significant items will be addressed individually, with quotations from participants used to fully capture the meanings of these items for individuals.

Regarding the topic of structured vs. open-ended processes in psychotherapy, many participants felt strongly that therapy should be more "like a journey, with the therapist encouraging the client to find his or her own answers." One participant stated, "the client is the most important part of the therapy. He needs to find answers by himself with the guidance of a therapist." Another said, "I disagree that therapy should be a structured activity or that the therapist should have something in mind, like a goal, where the therapist has a lot of control. …I think it should be more like an open-ended process." Other participants, however, were more in favor of a structured

process, such as the participant who stated, "I agreed with more items that clustered around the issue of how rigorous therapy should be. I think it should be structured, supported by scientific evidence, and… clients should be cautious about therapy in which no progress is being made." Another said, "I favor the kind of therapy with more structure, but I believe more in semi-structure."

These differing views are commensurate those identified as separating Factor A from Factor B. Whereas Factor A participants were more likely to endorse a view of therapy as working best when it is open-ended, Factor B participants were more in favor of therapy that incorporated structure and goals. The specific views endorsed by participants mirror those addressed in the literature. The benefits of open-ended therapy include greater autonomy given to the client and allowing the client to find a personal truth that may differ from the ideas of the therapist, but open-ended therapy may not lead to the kinds of progress some expect from the therapeutic process. Structured therapy may be more "rigorous" as goals are directed by the therapist, but this may present the client with fewer opportunities to explore feelings in a spontaneous way.

The topic of psychological diagnosis was another theme that was discussed frequently by participants during follow-up interviews. The Q-set items included two concepts relating to diagnosis, the first addressing whether diagnosis is important for effective treatment and the second addressing potential for stigmatization versus self-acceptance when a diagnosis is given. Regarding the first idea, one participant commented, "I agreed strongly with… maybe because if you've ever been diagnosed with psychiatric diagnoses or have family members who have… you can't do justice

to people's treatment if you don't understand what their diagnosis is." Another participant stated, "I agreed with anything that had to do with diagnosis or specific symptoms, because it's necessary for treatment to accomplish anything." Participants also had strong feelings about whether receiving a psychological diagnosis would be stigmatizing, such as the participant who said, "I disagreed… that diagnosis is a relief – nah, come on. I don't agree with that." Another participant had an alternative view:

> Being diagnosed with a problem means that there's something wrong. There *is* something wrong. People with depression or anxiety are expected to cope, but people with schizophrenia definitely have a problem. In therapy you should figure out what to do if you have a problem – take care of it just like other diseases. A psychological problem is the same thing as other diseases that need treatment. I had a strong reaction to the card.

Yet another participant struggled with the issue of diagnosis, and thought about it extensively before deciding to place opposite items in the same column. This participant stated, "I put them in the same column because… it kind of depends. I like to know it's a recognized phenomenon, but on the other hand I sometimes feel pigeonholed."

These disparate responses from participants in their own words confirm that there are a variety of viewpoints about the role of diagnosis in therapy, and that this is an issue about which individuals maintain strong opinions. The ideas expressed in the qualitative follow-up questions also mirror the distinction found quantitatively between the two factors. Factor A participants were more likely to believe that psychological diagnosis was not essential for effective resolution of psychological problems, whereas Factor B participants thought that having a diagnosis was an important step in guiding treatment. Although participants in both factors strongly

disagreed that having a psychological disorder meant that there is "something wrong" with the client, the qualitative responses do suggest that some people believe that having a diagnosis unfairly labels clients, or "pigeonholes" individuals into categories. These findings suggest that clients come to therapy with preexisting beliefs about whether the therapist has a responsibility to formulate and share diagnostic assessment or whether the client would feel unnecessarily labeled by a diagnosis. As one participant pointed out, this topic also relates to whether clients feel that psychological problems are similar to medical problems in that treatment follows from diagnosis, or whether the treatment approach is not necessarily founded on a specific diagnosis.

One aspect of therapy that was salient in the qualitative data but not in the Q-sort analysis was the length of psychotherapy treatment. Some participants had strong views about how long treatment should last, while a significant number of participants weren't sure or were conflicted about the length of therapy. One participant who had a strong view shared, "I disagreed with the items about the number of sessions. I think it's wrong to put an arbitrary number on the length of treatment. Treatment should take its own course, whether short or long." Others were more uncertain about the possible length of therapy, such as the participant who stated, "I wasn't sure about the length of therapy. But I don't think therapy should go on forever." Another thought the length of therapy might be geographically specific, stating, "The length of therapy questions were confusing. I think it's regional. In [some places] it's typical to see therapists weekly forever and ever. In other places that's not as common. Many will see you until they feel, or you feel, that it's

enough." Yet another participant said, "the number of sessions – it depends on the person," acknowledging that the length of treatment might be dependent on the client's presenting issue or the client's response to treatment. Regarding the specific item that asked whether therapy should be more or fewer than 20 sessions, many participants responded that they thought there might be a right or wrong answer but that they "weren't sure what's considered normal."

One potential reason that the length of therapy was mentioned in the follow-up interviews but did not show up in the factor analysis is that many participants were "confused" about the items and either placed them in the same category or in the center of the Q-sort grid. Thus it was not a concept that had strong differences in agreement or disagreement, but still one that participants thought carefully about and contemplated seriously before answering. This suggests that participants think the issue of the length of treatment is important, despite being unsure about the specific details of how the length of therapy is decided. The length of therapy might be dependent on the client's problem, regional norms, or might be an evolving discussion between therapist and client.

A second set of items that, similarly, did not emerge as significant in the factor analysis but was highly salient in the follow-up responses was the question about whether psychotherapy was "more like an art" or "more like a science." As with the topic of length of therapy, some participants felt strongly one way or another, but many were either confused or thought that both could be true. There were equal numbers of participants who felt strongly either that therapy should be more like an art than a science or that therapy should be more like a science than an art. For

instance, one participant responded, “I didn’t agree with things like therapy is an art. I think of it more like a science than anything.” Another said, “I found myself strongly agreeing with the idea that psychology is an act of science and that techniques that have been successful with other patients should be utilized.” Others, however, had opposite views, such as the participant who stated, “In the least agree column I put that therapy is more like a science than an art. It gave the sense that therapy has achieved scientific standing, but I don’t think we’re there yet.” Another participant agreed, “It shouldn’t be a science because people aren’t fixed in stone. People are different. …It’s not about science but about healing the client. It’s not a branch of medicine.” A third group of participants were confused by the item, or thought that both could be true. As one participant articulated, “I wasn’t sure where to put them. …I think the science art distinction is about credibility. Art is more intuitive, but science is more of a standard for credibility.” Another participant thought that “scientific” or “artistic” approaches to therapy were not mutually exclusive, stating, “both are right. I think techniques should be proved by science but then used by those who have experience and expertise.”

These responses are significant because they highlight distinct opinions held by individual participants, which may also reflect views that clients hold when coming to initial therapy sessions. Whereas some prefer that psychotherapy resemble more of a medical model, or for the therapist to communicate the scientific underpinnings of the approach being used, others do not believe that a scientific approach is best-suited to the individual and often subjective nature of psychotherapy. The rigor of science may confer a higher degree of credibility or standardization

among therapists, but it does not necessarily make use of the "intuitive" skills of the therapist to guide treatment. As some participants identified, the concepts of "science" and "art" might not be mutually exclusive in psychotherapeutic treatment, as the therapist can use treatments supported by scientific evidence but can also use his or her expertise and judgment to adapt these treatments to the individual client. Regardless, it is clear that opinions differ as to how much psychotherapy is or should be regarded as science, and that this is a topic that could be addressed by therapists with their clients in order to facilitate rapport and agreement about how therapy should proceed.

Within the qualitative data obtained from participants in follow-up interviews, there were some types of responses that were not expressed with great frequency, but were significant nonetheless because at least one participant articulated strong feelings about a particular issue. For example, one participant shared, "I really agreed that the issue of talking about the past is important. I definitely agreed right away because just talking about the present doesn't do the job. You can solve one problem that's been bothering you but then there's stuff you haven't dealt with." The issue of focusing on the past versus the present in therapy is one that did not differentiate Factor A from Factor B because in both groups, participants were just as likely to agree that addressing the past is an important part of treatment and disagree that the focus should be exclusively on present problems. The participant who shared strong feelings about this issue likely reflects a common belief among participants that exploring the past can reveal "stuff you haven't dealt with," or issues that are contributing to a presenting issue in therapy.

Another such response is one regarding the issue of "tough love" versus emotional support in therapy. One participant stated, "It made me think of things that would work or wouldn't work in my own experience. Like the way someone talks to you. Like tough love or support. You're probably getting tough love in your life so you probably need more support from your therapist. But then a therapist who is overly supportive wouldn't be good either." This comment highlights the way that potential clients might want a therapist who uses unconditional positive regard to make the client feel comfortable and valued. However, this participant also contemplates how a therapist who is "overly" supportive might not be ideal either, as this type of therapist might not be willing to share important information that may be difficult for the client to hear but is essential to making progress in treatment. In the quantitative analysis, there were no significant differences between Factor A and Factor B for these items, though there was a trend for Factor A participants to preference "support" over "tough love."

A final issue that was addressed in the qualitative data but was not significant in the quantitative analysis was how much the relationship between therapist and client should be addressed directly in sessions. Participants in both Factor A and Factor B thought that addressing the therapeutic relationship was more helpful than not, but neither group agreed strongly that things in the therapeutic relationship might lead to important realizations. One participant, however, expressed strong feelings about this issue in the follow-up interview, stating, "I disagree that it's helpful for therapists to point out things in the [therapeutic] relationship. I don't think therapists and clients should have relationships. The therapist and client shouldn't be too

involved or know too much about each other. I don't think that's appropriate." This view reflects the possibility that clients might feel uneasy about a therapist's choice to use the therapeutic relationship to address dysfunctional relational patterns in the client's life. As well, if the therapist becomes "too involved," there is a potential danger of dual relationships or harm to the client through inappropriate boundaries. The concern expressed by this participant indicates that therapists may want to give a rationale for exploring the therapeutic relationship before doing so, and reassure the client that appropriate boundaries will be maintained.

Chapter V

Discussion

Main Findings

This study used Q-sort methodology to gain information about what everyday people and potential psychotherapy clients think that therapists should be doing to be most helpful to their clients. The study was also designed to determine if individuals' lay theories about psychotherapy would follow the general trend of therapists to align more strongly with either "psychodynamic/humanistic" or "CBT/scientific" models. Since this was an exploratory study, the primary goal was to obtain a variety of subjective opinions about the nature of psychotherapy. A secondary goal was to determine whether these subjective opinions could be viewed as following an identifiable pattern.

The hypothesis in this study was that individuals – even those who are relatively naïve to the practice of psychotherapy – would have distinct and definable lay theories about what therapists should do to best help their clients, and that not only would individuals identify what aspects of psychotherapy are most important to them, but they could explain in their own words why they think that certain approaches to psychotherapy would be more beneficial than others. Moreover, the statistical results of the Q-sort analysis would show that there are distinct viewpoints about what is most effective in psychotherapy and that these viewpoints would generally follow the models of "psychodynamic/humanistic" and "CBT/scientific" approaches to psychotherapy.

Results of the study confirmed that two broad factors, A and B, did distinguish distinct viewpoints among lay people who were relatively naïve about the practice of psychotherapy. The aspects of psychotherapy that defined the two worldviews included:

1) *Open-ended versus structured therapy*. Factor A participants endorsed a preference for therapy that would encourage open-ended exploration and address whatever topic the client brought to sessions, whereas Factor B participants preferred a type of therapy that was more structured and focused on goal-setting and problem-solving.

2) *Importance of formal diagnosis*. Factor A participants believed that clients could be helped without a formal diagnosis. In contrast, Factor B participants believed that having a formal diagnosis should guide the kind of treatment the client receives.

3) *The role of therapist interpretation.* Both groups of participants agreed that the therapist should not take what the client says at face value, but should be able to offer some interpretation of the client's problems that the client does not see for him or herself. For Factor A participants, this meant that the therapist should have insight into the "hidden meanings" of the client's symptoms and help the client understand how symptoms can be "expressions of inner conflict." Factor B participants, however, did not think that the therapist's interpretative role was to discover "hidden meanings" or "expressions of inner conflict." Rather, they thought it was the therapist's job to look beyond the client's stated concerns because clients are not necessarily accurate about what is bothering them and require assistance to get to the root of the problem. In other words, Factor A participants were more interested in the therapist's ability to reveal symbolic aspects of the client's symptoms or difficulties, whereas Factor B participants focused more strongly on the therapist's ability to define and clarify problems.

4) *The nature of expectations and outcomes.* Whereas Factor A participants had strong feelings about the role of the therapist in managing client expectations, Factor B participants had strong feelings about what would define a good outcome in psychotherapy. Factor A participants thought that it was the therapist's job to help the client be both realistic and optimistic about the possibility of change. Factor B participants were less concerned with expectations about change, but thought that a good outcome of therapy would be for clients to be able to experience and accept painful feelings.

5) *The foundation of therapeutic techniques*. Factor B participants agreed more strongly than Factor A participants with the idea that therapeutic techniques should be supported by scientific evidence or by therapist expertise. Overall, however, Factor B participants agreed more strongly that techniques used in therapy should be supported by scientific evidence, and only secondarily that techniques used should be those that have been used by experts for many years.

In addition to these differences in the worldviews of individuals, participants as a whole overwhelmingly agreed with particular aspects of psychotherapy. The most expected of these findings was the idea that therapy should be tailored to the individual client. Participants endorsed the idea that psychotherapy should be a highly personal process that unfolds between a therapist and a client. They believed that the most effective therapy occurs when the therapist chooses an approach that fits the client's needs and can flexibly adapt the treatment as required by the nature of the client and the client's problems. The high level of agreement with this philosophy also reflects individuals' understanding that psychotherapy will be different depending on the client's problem, personality, preferences, abilities and nuanced aspects of each particular client's situation. This finding is commensurate with research indicating that even evidence-based treatments work best whey they are considered in the context of therapeutic relationships and adapted to client factors (Norcross & Lambert, 2011).

Unexpected Findings

Several important findings of this study were unexpected, and therefore worth considering in the context of commonly held beliefs about psychotherapy as described in the literature. First, all participants in the study overwhelmingly agreed

that, "the therapist should help the client talk about the past, because the past is likely an important part of the client's current difficulties." This finding is surprising because many approaches to therapy – for instance, some forms of CBT or modern relational models of psychodynamic therapy – do not focus on the past but rather help the client address current problems through careful monitoring of symptoms or via focus on the here-and-now of the therapy session. Since participants did not comment about this aspect of therapy during follow-up interviews, it is unclear why individuals assigned such importance to discussion of the past in psychological treatment. One hypothesis is that the influence of Freud is still quite pervasive in our society, such that lay theories of psychotherapy incorporate the notion that an individual's psychic difficulties are caused by early childhood experiences. This hypothesis is supported to some degree by the finding that in the current sample of participants, 62.5% named Freud as a "well-known" psychologist. Another potential reason for the belief that addressing the past is important could be that individuals acknowledge that psychological problems rarely occur spontaneously but rather develop over time. Thus a client presenting to treatment with certain symptoms or issues may have been struggling for a long time, or may be looking for help with a problem that has its origins in the past.

A second surprising finding of the current study is the ways in which lay theories of individuals differ significantly from those described in the literature. Given the striking dichotomies in both theory and practice between psychodynamic and CBT models of psychotherapy, one would expect more distinct discrepancies in lay theories as well. Although significant differences were found in the current study,

they were not necessarily those that would have been predicted from the most salient differences between psychodynamic and CBT practice often emphasized in the literature on psychotherapy. For example, the notion of whether psychotherapy should be practiced more like a "science" or more like an "art," is a distinction that tends to dichotomize and polarize professionals in the field of psychology (e.g., Kimble, 1984). In the sample population of lay people, however, most agreed that psychotherapy could be both a "science" and an "art" simultaneously, or did not seem to think that this question had any practical bearing on what activities would best help a client with his or her problems.

Implications of Study Findings

As an exploratory study, the current research reveals some interesting, if preliminary, findings about what everyday people think that therapists should be doing to best help their clients. The most significant of these findings is that potential clients, like therapists themselves, differ in how they view the process of therapy. Individuals are not completely naïve about what occurs in psychotherapy, but rather have lay theories about the process that derive from exposure to cultural representations of therapy, personal experience, and association to friends and family who have sought psychotherapy services. Although individuals may not be able to express their beliefs about psychotherapy when asked open-ended questions, they are able to express preferences when given specific topics to consider. These preferences are sometimes quite strong, with individuals emphatically stressing that some particular aspects of psychotherapy are important to them, and that they would be

dissatisfied with a therapy that did not conform to their expectations. For instance, an individual who believes that effective treatment can only follow from appropriate diagnosis likely would be disappointed in a therapist who did not offer diagnostic information.

As clinicians, and as evidenced by empirical research, we understand that the success of psychotherapeutic treatment is quite dependent on the therapeutic relationship (Norcross & Lambert, 2011). By identifying and discussing clients' lay theories of psychotherapy at the outset of treatment, we increase the likelihood that they will feel understood and, therefore, may be more willing to engage actively in the process. The current study highlights several key areas where potential clients have strong opinions, which might guide therapists towards certain kinds of communication during initial therapy sessions.

First, since most individuals agree that therapy should be tailored to the individual, therapists might consider emphasizing this aspect of treatment when initially presenting a treatment plan. Especially in treatments that are more structured or manualized, the therapist should consider communicating clearly that he or she will be attending carefully to the client's response to treatment and will be adjusting the process to fit the client's individual needs.

Secondly, since potential clients also believe strongly that it is therapists' job to help clients interpret their symptoms or identify problems in ways that clients do not see, therapists should communicate their ability to do so and inform clients that the therapy will involve understanding things in a different way or seeing things from alternative perspectives.

Thirdly, as previously discussed, individuals differ in their opinions about whether a formal diagnosis is important for guiding treatment, and thus it would be useful for clinicians to inquire about whether the client would like to discuss diagnosis at the outset of treatment or whether a discussion of diagnosis would feel overly stigmatizing. The results of this study also indicate that the individuals who believe that formal diagnosis is important for treatment are also more likely to value information about the rationale for providing a certain type of treatment, and will likely feel more comfortable if they are offered an explanation of the treatment approach and its use/effectiveness in scientific studies or by experts in practice.

Fourthly, some individuals are more likely to prefer an open-ended, reflective type of therapy, whereas others will prefer a more structured, problem-focused process. By asking the client at the outset of treatment if he or she expects therapy to proceed in a particular way, misattunements in the therapy process can be minimized. Some therapists might decide to adapt their preferred approach to conform to a client's preference, whereas others might decide to spend additional time presenting a rationale for their favored treatment approach and thereby socializing the client into the type of therapy being provided. In either case, an active dialogue about therapeutic process at the outset would likely lead to improved therapeutic alliance by communicating clients that their feelings about the treatment itself are not unimportant and will be taken seriously.

Fifthly, and finally, since the majority of individuals believe that talking about the past is an important part of psychotherapy, it would be beneficial for a clinician who chooses to focus on the present to thoroughly explain the rationale for this type

of treatment to the client and to give the client opportunities to explore the past as desired or indicated. By understanding which aspects of therapy are most likely to be important to new clients, clinicians can better communicate with them about what to expect in therapy and be attentive to clients' pre-existing notions about how therapy should proceed.

Limitations

Although the current study provided some interesting information about what potential clients believe therapy should be like, it has significant limitations. As an exploratory study in the sense that the primary goal was to gather information rather than confirm hypotheses, the findings should be considered preliminary and would require further study in order to confirm that the conclusions are valid and generalizable to larger populations. Generalization is also limited by the particular nature of Q-sort method and how results derived from this method differ from those in other kinds of studies. In conventional studies, the generalizability of findings increases when 1) the study sample is similar demographically to the population of interest and 2) the number of participants in the sample is large. As previously discussed, however, the selection of the sample, or P-set, in a Q-sort study does not follow these conventional rules. Q-sort method seeks to identify worldviews or viewpoints, but does not attempt to "make claims about the frequency of their occurrence amongst the general population" (Stenner et al., 2008). Participants are thus selected in order to maximize the number of viewpoints represented, because the ultimate goal of the Q-sort is to identify the range of viewpoints that exist and

determine if any of these viewpoints, or factors, are distinct from one another (Watts & Stenner, 2012).

In the current study, two groups of participants were recruited in order to maximize the likelihood that the viewpoints expressed would be 1) varied – that is, different enough from each other to result in separate factors, and 2) held by stakeholders – that is, people who have an interest in participating in psychotherapy. Recruitment was successful in that it did ultimately produce distinct factors by individuals who communicated that they had an interest in the topic of study. Since not much is known regarding the possible demographic or other factors that might influence a particular individual's lay theory of psychotherapy, every attempt was made to recruit a range of participants in demographic categories such as age, geographic location, ethnicity, etc. However, the participant group that was recruited did tend to be quite homogeneous in education level, which may have limited the kinds of viewpoints expressed. This limitation is especially important in a Q-sort study, because the goal is to discover as many distinct viewpoints as possible. It is thus unknown whether recruiting participants of a different education level, or from other kinds of populations or demographics, would have revealed different viewpoints or factors.

Another limitation of the current study is that despite the presence of two distinct factors, there were also a significant number of Q-sorts that were "confounded," or loaded significantly on both factors. Confounded sorts are usually ignored in Q-sort studies in favor of a focus on unique factors, but it remains important to acknowledge the presence of confounded sorts in the discussion of the

conclusions that can be drawn from the data. Although two separate factors, or viewpoints, regarding lay theories of psychotherapy emerged, it would be incorrect to assume that all individuals fall into one category or the other. Rather, some individuals have viewpoints that share some features with both factors. For this reason, the data regarding the means and mean differences of particular items, in combination with qualitative data, are also significant because they are based on data from the entire sample and add information beyond the concepts identified solely by factor analysis.

Future Research

The current research adds to the body of research on psychotherapy worldviews, expectations and preferences, and presents opportunities for future research. First, the study should be repeated with different samples in other types of settings, such as community mental health centers, hospitals, or private practices, in order to determine whether the factors are robust and consistent among various populations. The next step would be to plan more controlled studies in which hypotheses regarding the relationship between clients' lay theories and psychotherapy progress and outcome in different therapies could be tested. For example, one possibility would be to build a psychometrically reliable questionnaire for the assessment of psychotherapy lay theories, and then to use this questionnaire to identify clients with strong worldviews about how psychotherapy should proceed. These clients could then be assigned to a type of psychotherapy that was either a match or a mismatch to their worldview, and measures of alliance, process and

outcome could be collected to determine whether "matching" of this type benefits the therapy. Another direction would be to create a protocol for routinely assessing and directly addressing clients' lay theories in initial psychotherapy sessions, and then to test the effectiveness of this kind of standardized assessment. Although many opportunities for future research exist, the current study adds to the body of research on the intersection of psychotherapy processes and theoretical orientation by identifying significant "lay theories" of psychotherapy held by those who would potentially seek psychotherapy services.

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Appendix A
List of Q-set items

1. Therapy should be like a journey, with the therapist encouraging the client to find his or her own answers.
2. Therapy should be a structured activity, with the therapist helping the client to set goals, solve problems, and monitor progress.

3. Clients are helped in therapy when the therapist waits for the client to share information over time before deciding what the problem is.
4. Clients are helped in therapy when the therapist initially identifies the client's problem and sets goals for treatment.

5. The therapist should address a topic directly related to the client's problem, even if this is not the topic on the client's mind that day.
6. The therapist should address whatever topic the client brings to the session.

7. Having a formal diagnosis (i.e. "depression") is important, as this should guide the type of treatment the client receives.
8. Clients can be helped in therapy without a formal diagnosis (i.e. "depression").

9. Being diagnosed with a psychological disorder is undesirable because it means that there is "something wrong" with the client.
10. Being diagnosed with a psychological disorder is a relief, because it means that other people struggle with the same problems.

11. Clients are helped in therapy when the therapist encourages specific changes in thinking and behavior.
12. Clients are helped in therapy when the therapist encourages open-ended reflection and exploration.

13. Since psychological problems have been scientifically studied, the therapist should choose a technique that has been shown to be effective with others.
14. Since no two people are alike, the therapist should choose an approach that fits the individual client.

15. It is important for techniques used in therapy to have been used by experts for many years.
16. It is important for techniques used in therapy to have been supported by scientific evidence.

17. Clients should be cautious about therapy that does not allow the client to come to his or her own conclusions.
18. Clients should be cautious about therapy in which the client is allowed to talk for a long time without making any progress.

19. Uncertainty about what is happening is an obstacle in therapy, as clear understanding and specific goals are most helpful.
20. Uncertainty about what is happening is welcomed in therapy, as it can lead to new realizations or understanding.

21. The goal of therapy is to cure symptoms, rather than understand the hidden meanings behind them.
22. The therapist should help the client understand how symptoms can have hidden meanings, or can be expressions of inner conflict.

23. The therapist should notice when the client says one thing but really means something different.
24. The therapist should take what the client says more or less at face value.

25. Clients know best what is bothering them, and it is the therapist's job to address the client's stated concerns.
26. Clients are frequently unclear about what is bothering them, and it is the therapist's job to identify what the problem really is.

27. A good outcome in therapy would be for the client to experience fewer painful feelings.
28. A good outcome in therapy would be for the client to be able to experience and accept painful feelings.

29. Clients can't change everything about themselves, but they can accept much about the way they are.
30. Clients can make significant changes through learning and practicing new skills.

31. Therapists help clients to be realistic about changes that can be made.
32. Therapists help clients to be optimistic about changes that can be made.

33. Change in therapy involves experiencing and sometimes increasing negative feelings in order to help the client work through them.
34. Change in therapy involves decreasing negative feelings and increasing positive feelings in order to help the client feel better.

35. It is better when therapy has an agreed-upon ending at the start of treatment because the time will be used more effectively.
36. It is better when therapy does not have a definite ending because clients need time to work through problems.

37. The ideal length of therapy is more than 20 weekly sessions.
38. The ideal length of therapy is less than 20 weekly sessions.

39. Focusing on what is happening in the relationship between the therapist and client is not useful for helping the client and detracts from other work that can be done.

40. It is helpful for therapists to point out things that happen in the relationship between client and therapist, as this may lead to important realizations aobut what is happening in the client's other relationships.

41. The therapist should help the client to talk about the past, because the past is likely an important part of the client's current difficulties.
42. The therapist should help the client focus on current problems, as a client's difficulties can only be addressed in the present time.

43. The therapy session should be led mostly by the therapist.
44. The therapy session should be led mostly by the client.

45. Psychotherapy is more like a science than an art.
46. Psychotherapy is more like an art than a science.

47. If the client resists making changes, it is the therapist's job to be patient and let the client make changes in his or her own time.
48. If the client resists making changes, it is the therapist's job to find new ways to help the client change.

49. Therapists should be empathic, understanding, and supportive at all times.
50. Therapists sometimes need to use "tough love" in order to help a client.

51. A client who is not making an effort to change should be encouraged to leave therapy and return when he or she is more willing to make changes.
52. A client who is not making an effort to change should be encouraged to stay in therapy and address why progress is not being made.

53. If a client is not making progress in therapy, this is most likely because something about the client is getting in the way.
54. If a client is not making progress in therapy, this is most likely because the therapist is not using the right approach.

55. A major goal of therapy should be to focus on how aspects of the client's personality may cause problems in daily life.
56. A major goal of therapy should be to focus on how the client's thoughts and behaviors may cause problems in daily life.

57. A therapist should monitor the client's progress in therapy by having the client fill out questionnaires on a regular basis.
58. A therapist should monitor a client's progress in therapy by asking periodically how the therapy is going.