

COOPER-NORCROSS INVENTORY OF PREFERENCES (C-NIP): PSYCHOMETRIC CHARACTERISTICS OF THE CZECH VERSION

TOMÁŠ ŘIHÁČEK, MICHAELA MIKUTOVÁ

Department of Psychology, Faculty of Social Studies, Masaryk University, Brno

ABSTRACT

Objective. The Cooper-Norcross Inventory of Preferences (C-NIP) is a new and promising tool for measuring clients' preferences regarding psychotherapy. However, the psychometric evaluation of this measure is scarce in general and completely missing for the Czech adaptation of the measure. This study aimed to test the Czech version of the C-NIP factor structure, test its measurement invariance, and establish cut points.

Methods. $N = 772$ adults answered the C-NIP in an online survey. Confirmatory and exploratory factor analyses were used to test the factor structure and assess the C-NIP measurement invariance between men and women and across several levels of psychotherapy experience.

Results. The original four-factor model was not supported. Instead, a five-factor model was sug-

gested that fit the data adequately and was strictly invariant with respect to gender and levels of experience with psychotherapy.

Conclusions. The Czech C-NIP can be considered a valid and reliable measure of clients' preferences regarding psychotherapy. The replication of the new factor model is needed.

key words:

clients' preferences,
factor structure,
measurement invariance

klíčová slova:

preference klientů,
faktorová struktura,
invariance měření

Hundreds of psychotherapy schools have been developed to treat mental disorders and help people reach their psychological potential. However, none of these schools has shown its superiority over the others, which suggests that technique alone is not the decisive factor of psychotherapy effectiveness (Wampold & Imel, 2015). Therefore, attempts to prescribe specific treatments to specific disorders do not seem particularly effective (Norcross & Wampold, 2011), and variables other than a psychiatric diagnosis seem to be more critical in determining psychotherapy outcomes (Beutler & Harwood, 2000). To be effective with different types of clients, psychotherapists should develop flexibility within their personal styles in consideration of clients' preferences regarding the therapeutic process, as well as many other nondiagnostic variables (Norcross & Wampold, 2018).

In their systematic review, Chewing et al. (2012) found that clients currently prefer shared decision-making more often than they did in the past. Swift et al. (2018) conducted a meta-analysis of 53 studies on accommodating clients' treatment preferences and found that clients whose preferences are not explored tend to drop out of treatment

Submitted: 28. 5. 2021; T. Ř., Department of Psychology, Faculty of Social Studies, Masaryk University, Joštova 10, 602 00 Brno; e-mail: rihacek@fss.muni.cz.

This study was funded by the Specific University Research Grant (grant number MUNI/A/1216/2020) provided by the Czech Ministry of Education, Youth, and Sports.

We thank Lucie Uhrová for her help with data collection and Markéta Fialová and Madgalena Frouzová for their kind assistance with the translation.

1.79 times more often and have worse outcomes ($d = 0.28$) than those whose preferences are considered. While Lindheim et al.'s (2014) meta-analysis arrived at similar conclusions, Windle et al. (2020) did not find any significant relationship between the accommodation of client preferences and clinical outcomes, dropout, and treatment satisfaction. However, substantial methodological caveats may prevent researchers from obtaining unbiased findings in this area of research (Swift & Callahan, 2009).

There are multiple paths through which accommodating clients' preferences can positively impact their treatment. First, such accommodation allows therapists to correct their ideas about what clients want in therapy and tailor treatments accordingly. For instance, Cooper et al. (2019) found that clients tend to prefer more therapists' directivity and less emotional intensity than do therapists. Being aware of this fact may help therapists provide treatments that are more readily accepted by clients. Second, the acknowledgment of clients' preferences demonstrates therapists' genuine interest in the individual client and may therefore strengthen the working alliance (Iacoviell et al., 2007; Kwan et al., 2010). Third, such acknowledgment may increase clients' positive expectations from psychotherapy, which, in turn, may lead to higher treatment adherence and better outcomes (Stone et al., 1965). Finally, inviting clients to participate in decisions regarding the course of their treatment provides clients with a sense of empowerment, which may positively impact their treatment outcomes (Seligman, 1995).

Clients' preferences may concern various aspects of the treatment and its provider. Clients may prefer psychotherapy to pharmacotherapy (or vice versa), one psychotherapy approach over another (e.g., cognitive-behavioral therapy over psychodynamic psychotherapy), a particular therapeutic setting (e.g., individual vs. group therapy), or particular therapeutic activities (e.g., chairwork, Socratic dialog, or free association). Their preferences may also concern therapists' characteristics, such as gender, race, sexual orientation, faith, personality, and therapeutic style (Swift et al., 2019). While some of these characteristics are more or less static (such as gender) and clients can be matched to suitable therapists on their basis (Beutler et al., 1993), others can be accommodated within a treatment depending on the flexibility of the therapists' personal style (Řiháček & Roubal, 2017).

Several measures exist that allow for the systematic assessment of clients' preferences, including the Psychotherapy Preferences and Experiences Questionnaire (PEX, Sandell et al., 2011), the Preference for College Counseling Inventory (PCCI, Hatchett, 2015), the Counseling Preference Form (CPF, Goates-Jones & Hill, 2008), and the Therapy Personalization Form (TPF, Bowens & Cooper, 2012). These instruments have been criticized for their difficult interpretability (PEX), problematic applicability in clinical settings (PCCI), excessive length (PCCI), unknown validity (TPF, CPF), and low reliability level (TPF, CPF) (Cooper & Norcross, 2016). For these reasons, Cooper and Norcross developed the Cooper-Norcross Inventory of Preference (C-NIP).

The C-NIP (Cooper & Norcross, 2016) is a relatively short (18 bipolar items, plus 11 open-ended questions) self-report measure of clients' preferences that was developed to assess preferences either at the beginning or during psychotherapy. The authors selected the items by means of principal component analysis of a pool of 39 items based on the TPF, interviews with psychotherapists, literature on clients' preferences, and the authors' clinical practice. While a previous version of the measure contained reverse-scored items, all items are scored in the same direction in the current version. The measure consists of four dimensions, namely, preference for therapist vs. client directiveness ($\alpha = .84$), emotional intensity vs. emotional reserve

($\alpha = .67$), past vs. present orientation ($\alpha = .73$), and warm support vs. focused challenge ($\alpha = .60$). The authors have established empirical cut points that define the lower and upper quartiles of the clients' preference distribution to facilitate clinical use. These cut points help therapists determine whether their client's preferences in one or another direction are strong enough to require adjustments in the therapeutic process. In subsequent studies, a somewhat lower internal consistency has been reported for most subscales, except warm support vs. focused challenge, with values of .54, .51, .80, and .61 (Cooper et al., 2019) and .67, .54, .61, and .63 (Cooper et al., 2021).

Although the measure has been translated into seven languages thus far, only the Portuguese version has been assessed psychometrically (Malosso, 2020). Confirmatory factor analysis revealed an unsatisfactory fit, and the author recommended removing items 15 and 16. However, after this modification, the fit was still not optimal: $\chi^2(97) = 221.942$, CFI = 0.872, RMSEA = 0.069, and TLI = 0.841. The internal consistency values of the four subscales were $\alpha = .67, .51, .70$, and .42.

Cooper and Norcross (2019) found that women prefer more warm support than men. Sandell et al. (2011) and Cooper and Norcross (2019) also found that people may differ in their preferences depending on their previous psychotherapy experiences. However, making comparisons among such groups assumes measurement invariance of the C-NIP across these groups. People with different gender identities or levels of experience with psychotherapy (e.g., no experience vs. currently in therapy) may have different concepts of psychotherapy, which may manifest in various factor structures of the measure. This assumption has not yet been tested. Therefore, we must first determine whether the C-NIP measures the same latent variables across these groups before making any conclusions about differences among them.

Aim of the Study

This study aimed to test the factor structure of the Czech version of the C-NIP and its measurement invariance with regard to gender and different levels of psychotherapy experience. Furthermore, we sought to establish cut points for the assessment of client preferences in clinical practice.

METHOD

Study Design and Sample

An online survey was created using the Qualtrics platform. A link to the survey was disseminated via social networks (an invitation to participate with a link to the survey was posted to 36 Facebook groups focused on mental health). Adults who had current or previous experience with psychotherapy or who had an intention to start psychotherapy were eligible to participate in the study. A total of 1324 people responded to the invitation and opened the survey. However, 123 of them did not begin the survey. Another 82 reported that they had no intention to seek psychotherapy, and the survey was terminated for them at that point. Furthermore, 22 respondents who were in alternative or self-help treatments were also excluded. Of the remaining respondents, 271 did not fill in any of the C-NIP items, and 54 filled in only half of the items (the questionnaire was split into two pages). Thus, the final sample consisted of $N = 772$ adults (58.3% of the total number of respondents). See Table 1 for the sample characteristics.

Of the final sample, $n = 518$ (67%) reported participating (either at that time or previously) in psychotherapy. These respondents reported being in individual therapy (81.7% of the 518), group therapy (9.5%), couple therapy (1.0%), family therapy (0.6%), or a combination of these settings (7.3%). They reported attending up to five

sessions (18.0%), six to 20 sessions (32.8%), 21 to 50 sessions (22.4%), or more than 50 sessions (26.8%). They reported having seen one therapist (32.4%), two therapists (27.8%), three therapists (20.7%), four therapists (7.7%), 5, or five or more (11.2%).

Those who had been in therapy previously but were no longer in therapy at the time of the data collection ($n = 282$) reported having ended their treatment four (21.6%), five (14.1%), six (10.8%), seven (4.2%) or eight (3.7%) months ago.

Table 1 Sample characteristics (N = 772)

<i>Age (years)</i>	
Mean (SD)	30.76 (11.57)
Range	18-99
Missing	0 (0%)
<i>Gender</i>	
Female	429 (55.6%)
Male	149 (19.3%)
Other	4 (0.5%)
Missing	190 (24.6%)
<i>Education</i>	
Primary	53 (6.9%)
Secondary	376 (48.7%)
Tertiary	153 (19.8%)
Missing	190 (24.6%)
<i>Experience with psychotherapy</i>	
No experience thus far	254 (32.9%)
Is in therapy	236 (30.6%)
Was in therapy	282 (36.5%)

Measures

Cooper-Norcross Inventory of Preferences (C-NIP). The C-NIP (Cooper & Norcross, 2016) is a multidimensional self-report measure of client preferences regarding psychotherapy. It consists of 18 bipolar items scored on a seven-point scale ranging from 3 (strong preference in one direction) to -3 (strong preference in the opposite direction), with 0 indicating no or equal preferences in both directions. The scale consists of four dimensions measuring preference for therapist vs. client directiveness (items 1 to 5), emotional intensity vs. emotional reserve (items 6 to 10), past vs. present orientation (items 11 to 13), and warm support vs. focused challenge (items 14 to 18). The measure also contains several open-ended questions about client preferences (e.g., therapists' gender, theoretical orientation, and length of therapy). The answers to these questions were not analyzed in this study.

The process of adaptation of the scale into Czech included several steps. First, eight people independently translated the scale from English to Czech. The group of translators (all native Czech speakers) was composed of two psychotherapists, two psychology students, three laypeople who had experienced psychotherapy as clients, and a professional translator. Second, four of the translators then discussed the indi-

vidual translations and developed a consolidated version. Third, the result was back-translated to English by a native English speaker and was compared with the original. Fourth, the final version was administered to five respondents representing different age and education groups, and a cognitive interview was conducted with each of them to assess the comprehensibility of the items. The final Czech version of the scale is available at <https://www.c-nip.net/>.

Demographic questionnaire. The demographic questionnaire contained questions about the respondents' gender, age, and education. Furthermore, it included questions regarding the respondents' experience with psychotherapy (the options consisted of "no intention", "no therapy but intends to use it", "strives to find a therapist", "has sought a therapist and is waiting for the first session", "is currently in therapy", and "was in therapy previously", which were then recoded into three larger categories including "no experience thus far", "is in therapy", and "was in therapy"), type of therapy attended (individual, couple, family, self-help, alternative, other), number of sessions, and months after the last session.

Statistical Analysis

First, we conducted a confirmatory factor analysis (CFA) to test the original four-factor model (Cooper & Norcross, 2016). Since the values of some C-NIP items were nonnormally distributed, we used the robust maximum likelihood estimator (MLR). The model was defined as congeneric, thereby fixing the variance of latent variables to 1. The model fit was assessed using scaled chi-square statistics, the standardized root mean square residual (SRMR), the root mean square error of approximation (RMSEA), and the Tucker-Lewis index (TLI). Hu and Bentler (1999) recommended values close to 0.08 for the SRMR, 0.06 for the RMSEA, and .95 for the TLI as cutoffs for a fitting solution. Other authors, however, have suggested less stringent criteria for model rejection, i.e., $RMSEA > 0.10$ and $TLI < .90$ (Brown, 2015).

Second, because the proposed model did not fit our data, we continued with exploratory analysis. We randomly split the sample into halves, hereafter referred to as the exploration sample and the confirmation sample. We conducted an exploratory factor analysis (EFA) on the exploration sample using the principal axis factoring method for factor extraction and the oblimin method for factor rotation. The number of factors was determined using Horn's parallel analysis, scree plot, and Kaiser's rule, as well as the interpretability of the factor solution. Subsequently, we tested the resultant model using CFA on the confirmation sample. Finally, we refit the model on the whole sample to obtain more stable estimates of the model parameters. We reported the internal consistency of the individual factors of the final model in terms of Cronbach's alpha and Raykov's omega.

Third, we tested the measurement invariance between men and women and among three levels of experience with psychotherapy (i.e., "no experience thus far", "is in therapy", and "was in therapy"). We gradually fixed the factor loadings (metric invariance), item intercepts (scalar invariance), residual variances (strict invariance), and means. The invariance was assessed by a change in fit compared to a previous model; a change in $TLI \geq .010$ (for all levels of invariance), supplemented by a change in $RMSEA \geq .015$ (for all levels of invariance) or a change in $SRMR \geq .030$ (for metric invariance) and $\geq .010$ (for scalar and strict invariance) indicate noninvariance in samples with $N > 300$ (Chen, 2007). We also conducted a significant difference test. When the assumption of strict invariance was found to be tenable, we compared the latent means across the groups and reported the standardized effect sizes (Cohen's d). The measurement invariance analysis was conducted on the confirmatory sample only.

To derive cut points for strong preferences, we followed the procedure described by Cooper and Norcross (2016). First, we computed raw sum scores for each subscale. Second, we established the lower and upper quartiles of the raw score distribution. Third, we calculated the lower and upper quartiles of scores centered at 0 (preserving the original standard deviation). Fourth, the cut points were determined by calculating the average of the two values (i.e., the respective quartiles based on the raw and centered distributions) and rounding the values downwards (for the lower end scores) and upwards (for the upper end scores). As Cooper and Norcross argued, these values represent a compromise between partitioning the sample based on the empirical distribution of values and doing justice to the overall preference of the population towards one of the poles of a respective subscale.

The statistical analysis was conducted using R software version 4.0.4 (R Core Team, 2021) with the lavaan (Rosseel, 2012), semTools (semTools Contributors, 2016), psych (Revelle, 2018), nFactors (Raiche, 2010), and REdaS (Maier, 2015) packages.

RESULTS

Factor Analysis

The fit of the original model proposed by (Cooper & Norcross, 2016) was not satisfactory: $\chi^2(129) = 857.110$, $p < .001$, BIC = 50094.971, SRMR = 0.093, RMSEA = 0.094 [0.088, 0.100], TLI = 0.753. Therefore, we proceeded with EFA. The Kaiser-Meyer-Olkin measure verified the sampling adequacy for the analysis, with KMO = .82 (“meritorious” according to Kaiser, 1974), and the KMO values for individual items ranged from .63 to .92. Bartlett’s test of sphericity, $\chi^2(153) = 2361.849$, $p < .001$, indicated that the correlations between items were sufficiently large for EFA. Parallel analysis, Kaiser’s criterion, and the scree plot converged on a five-factor solution. The model differed from the original model in two aspects: (1) the emotional intensity/reserve factor was split into two factors, namely, processing of emotions (items 6 and 9) and focus on the therapeutic relationship (items 7 and 8), with only a modest correlation between them ($r = .34$), and (2) item 10 (focus on feelings vs. thoughts) loaded primarily on the present/past orientation factor and had only a weak loading on the emotional intensity/reserve factor to which it theoretically belonged. With the exception of item 10, the factor structure was clear; all the primary loadings were higher than .40, and there were no cross-loadings above .20.

Next, we conducted a CFA on the confirmatory sample to test this solution. Since the content of item 10 was inconsistent with the factor to which it was placed by the EFA, we removed it from the model. Furthermore, factor loadings were constrained to the same value in the case of factors composed of two items only. The model fit was satisfactory: $\chi^2(129) = 225.720$, $p < .001$, BIC = 23467.195, SRMR = 0.059, RMSEA = 0.057 [0.046, 0.068], TLI = 0.908. The baseline model’s RMSEA = 0.191. We also tried to fit a more conservative modification of the original model: a four-factor model without item 10 and with residual correlations allowed between items 6 and 9 and between items 7 and 8. However, this model yielded negative estimates of item 6 and 9 variances and, therefore, we abandoned it.

Finally, we refit the model on the total sample. See Table 2 for the model parameters and internal consistency of the factors. Raykov’s omega ranged between .67 and .88 (Cronbach’s alpha ranged between .68 and .88, see Table 2). The first factor had the lowest internal consistency, and it would not be increased by the deletion of any item. Furthermore, we determined the cut points for strong preferences towards one or another pole of each subscale. See Table 4 for the cut-point values.

Table 2 Factor loadings and correlations (completely standardized)

Items	λ_1	λ_2	λ_3	λ_4	λ_5	ε
i1	.623					.612
i2	.636					.596
i3	.573					.672
i4	.454					.793
i5	.453					.795
i6		.773				.403
i9		.789				.377
i7			.833			.306
i8			.783			.387
i11				.844		.288
i12				.832		.307
i13				.853		.273
i14					.706	.501
i15					.635	.597
i16					.544	.704
i17					.640	.591
i18					.581	.663
<i>Factor correlations</i>						
F1		.337	.248	.322	.295	
F2			.434	.204	.108	
F3				.070	.204	
F4					.432	
<i>Internal consistency</i>						
α	.67	.76	.79	.88	.76	
ω	.68	.76	.79	.88	.76	

Note. The final model refit on the total sample. F1 = therapist/client directiveness, F2 = processing of emotions, F3 = focus on the therapeutic relationship, F4 = past/present orientation, F5 = warm support / focused challenge. Item 10 was removed based on EFA (see the main text). Model fit: $\chi^2(111) = 328.760, p < .001, BIC = 46881.338, SRMR = .052, RMSEA = .056 [.049, .063], TLI = .916.$

Measurement Invariance

We tested the measurement invariance of the final model across levels of psychotherapy experience (see Table 3 for the fit indices). Overall, the fit indices suggested the strict invariance of the model. A chi-square test did not indicate any statistically significant deterioration of the fit in any step until latent means. In fact, there was an increase in fit in terms of the RMSEA and the TLI in more constraint models. However, the three levels differed in terms of latent means. If we refit the model on the total sample and consider the “is in therapy” condition as a reference group, those who have already ended their treatment preferred less focus on the therapeutic relation-

Table 3 Scale statistics of the C-NIP

Scale	Mean	SD	75 th percentile	25 th percentile	Strong pref. (L)	No strong pref.	Strong pref. (R)
Therapist vs. client directiveness	6.38	5.35	10.25	3	15 to 8	7 to 0	-1 to -15
Processing vs. not processing of emotions	4.42	2.10	6	4	6 to 4	3 to 2	1 to -6
Focus vs. not focus on the therapeutic relationship	1.87	3.02	4	0	6 to 4	3 to 0	-1 to -6
Past vs. present orientation	2.67	5.14	7	-1	9 to 6	5 to -2	-3 to -9
Warm support vs. focused challenge	2.78	6.37	8	-1	15 to 7	6 to -2	-3 to -15

Note. Strong pref. (L) = Strong preference for left-hand term in title, Strong pref. (R) = Strong preference for right-hand term in title.

ship ($d = -0.19$) and less encouragement of processing emotions ($d = -0.18$). Those who had no psychotherapy experience thus far preferred more therapist directiveness ($d = 0.34$) and orientation on the present ($d = -0.20$) compared to those currently in therapy.

Furthermore, we tested the measurement invariance between women and men. We removed the people who did not report their gender or chose the “other” option ($n = 101$). The decrease in fit was negligible up to the level of strict invariance. When refit on the total sample, women reported higher preference for therapist directiveness ($d = 0.49$), processing emotions ($d = 0.27$), past orientation ($d = 0.31$), and warm support ($d = 0.60$) than men.

DISCUSSION

Our study tested the factor structure of the Czech adaptation of the Cooper-Norcross Inventory of Preferences (C-NIP). The original model proposed by Cooper and Norcross (2016) did not yield a good fit. Therefore, we modified the model based on an exploratory analysis by (1) dividing the emotional intensity/reserve factor into two factors and (2) removing item 10. The modified model yielded a satisfactory fit and demonstrated measurement invariance between men and women and across three levels of psychotherapy experience (i.e., “no experience thus far,” “is in therapy,” and “was in therapy”).

The division of the emotional intensity/reserve factor into two factors makes sense from the clinical perspective; while the “processing of emotions” factor represents clients’ attitude towards emotions and their capacity to deal with high emotional intensity, the “focus on the therapeutic relationship” factor concerns the relationship between the client and the therapist. The fact that the correlation between the two factors was only modest further supports our conclusion that the two factors represent two distinct phenomena. However, measuring each of the factors with two items only is not optimal (Costello & Osborne, 2005), and at least one item should be added for each of the two factors in future versions of the measure.

Table 4 Fit indices for invariance testing

Invariance	χ^2	df	$\Delta\chi^2$	Δdf	BIC	ΔBIC	SRMR	$\Delta SRMR$	RMSEA	$\Delta RMSEA$	TLI	ΔTLI
<i>Experience with psychotherapy (N = 772)</i>												
Configural	536.958***	333			24067.472		20.075		0.072		0.861	
Metric	558.951***	351	22.910	18	23989.059	-78.413	0.082	0.007	0.071	-0.001	0.864	0.003
Scalar	595.093***	375	35.877	24	23880.610	-108.449	0.084	0.002	0.070	-0.001	0.867	0.002
Strict	634.637***	409	44.355	34	23753.743	-126.867	0.095	0.011	0.070	-0.001	0.869	0.002
Means	655.995***	419	21.592*	10	23717.745	-35.998	0.099	0.005	0.071	0.001	0.866	-0.003
<i>Gender (N = 578)</i>												
Configural	371.590***	222			17498.555		0.072		0.071		0.859	
Metric	382.122***	230	11.401	8	17471.063	-27.492	0.076	0.004	0.071	0.000	0.860	0.000
Scalar	404.552***	242	22.606*	12	17426.012	-45.051	0.078	0.002	0.071	0.000	0.858	-0.002
Strict	431.180***	259	27.070	17	17369.618	-56.394	0.081	0.003	0.072	0.000	0.856	-0.002
Means	451.675***	264	23.120***	5	17362.277	-7.341	0.089	0.008	0.074	0.002	0.847	-0.009

Note: SRMR = standardized root mean square residual, RMSEA = robust root mean square error of approximation, TLI = robust Tucker-Lewis index. *** p < .001.

Invariance	χ^2	df	$\Delta\chi^2$	Δdf	BIC	ΔBIC	SRMR	$\Delta SRMR$	RMSEA	$\Delta RMSEA$	TLI	ΔTLI
<i>Experience with psychotherapy (N = 386)</i>												
Configural	647.676***	333			47543.203		0.062		0.065		0.888	
Metric	657.157***	351	12.654	18	47440.386	-102.817	0.065	0.003	0.063	-0.002	0.896	0.008
Scalar	684.136***	375	24.410	24	47305.524	-134.862	0.066	0.001	0.061	-0.002	0.903	0.007
Strict	722.485***	409	46.165	34	47162.941	-142.583	0.071	0.005	0.060	-0.001	0.905	0.003
Means	751.488***	419	30.862***	10	47128.461	-34.481	0.074	0.004	0.061	0.001	0.902	-0.003
<i>Gender (N = 285)</i>												
Configural	442.999***	222			34958.720		0.059		0.063		0.891	
Metric	452.335***	230	10.249	8	34921.590	-37.137	0.061	0.002	0.062	-0.001	0.893	0.003
Scalar	489.198***	242	39.457***	12	34883.100	-38.491	0.063	0.002	0.064	0.001	0.888	-0.005
Strict	534.525***	259	43.414***	17	34836.160	-46.934	0.067	0.004	0.065	0.002	0.882	-0.006
Means	577.185***	264	49.867***	5	34851.640	15.478	0.078	0.011	0.069	0.004	0.869	-0.013

Item 10 (“I would like the therapist to focus mainly on my feelings vs. focus mainly on my thoughts”) was problematic probably because it was the only item in the emotional intensity/reserve factor that was genuinely bipolar, with both poles defined positively. The remaining four items were, in fact, unipolar in that they asked clients to express their preference (or lack thereof) for the given quality. Therefore, item 10 might have required clients to employ a different kind of mental processing than the remaining items, thereby making it less compatible with the remainder of the subscale. Furthermore, in the exploratory analysis, item 10 had a higher loading on the present/past orientation than on the emotional intensity/reserve factor where it was supposed to load primarily. For this reason, we suggested removing it from the scale.

Unlike the Portuguese study (Malosso, 2020), we concluded that the Czech version of the C-NIP is a viable instrument with an acceptable internal consistency of the subscales (except for the first factor, the internal consistency of which was slightly sub-threshold). However, the alternative factor structure suggested in our study remains to be examined in future studies.

We confirmed Cooper and Norcross’ (2019) finding that women generally have a higher preference for warm support from their therapist than do men. Furthermore, we found that women appreciate more directiveness from their therapist, more orientation on their past life and childhood, and more encouragement to process strong emotions than do men, with small to medium effect sizes.

We also found that people with different levels of experience with psychotherapy tend to differ in their preferences. People with no experience tended to prefer more therapist directiveness and more orientation on the present situation and adulthood issues instead of the past. Those who had already ended their therapy tended to prefer less focus on the therapeutic relationship (although this difference was rather small). We hypothesize that the psychotherapy experience changes clients’ expectations and preferences to a certain degree. However, it may also be the preferences themselves that predispose people to seek and complete their treatments. The correlational nature of this study does not allow us to address the causality direction of these relationships.

Following Cooper and Norcross’ (2016) guidelines, we have also established the cut points that allow therapists to easily differentiate between strong preferences (i.e., those that may require some accommodation on the therapists’ side) and weak or no preferences (i.e., those that usually do not require changing the therapists’ usual style of work). Overall, we found a higher preference for therapist directiveness, past orientation, and warm support in the Czech sample compared to the findings of Cooper and Norcross (2016). However, these differences may be a product of a different composition of the samples and may not be generalizable to other populations.

The study had several sample-related limitations. First, the response rate was relatively low and would probably be even lower if we knew the number of those who received our invitation but did not respond to it. Second, young adults with secondary education prevailed in our sample, which may limit the generalization of the findings to older people and, especially, to those with only a primary education. Third, the study was based on a general population sample, and the severity of psychopathology was not measured. It is thus not clear to what degree the sample represents various areas and degrees of psychopathology. The generalizability of our findings to various segments of the clinical population must be determined in future studies. Furthermore, gender was not evenly represented in the sample. However, this reflects the fact that psychotherapy is more often sought by women and, from this point of view, the sample represents the clinical population well. Unfortunately, a considerable portion of the sample did not answer the question about gender and had to be removed from

the gender-related part of the analysis (i.e., measurement invariance and gender-based differences).

CONCLUSION

Our study assessed the psychometric properties of the Czech adaptation of the Cooper-Norcross Inventory of Preferences. We discovered and confirmed a five-factor structure that demonstrates strict measurement invariance between women and men and across three levels of clients' psychotherapy experience. However, this factor structure remains to be examined in future studies and with different language versions of the measure. We also established cut points to differentiate between clients with and without strong preferences regarding the C-NIP subscales.

REFERENCES

- Beutler, L. E., & Harwood, T. M. (2000). *Prescriptive psychotherapy: A practical guide to systematic treatment selection*. Oxford University Press.
- Beutler, L. E., Patterson, K. M., Jacob, T., Shoham, V., Yost, E., & Rohrbaugh, M. (1993). Matching treatment to alcoholism subtypes. *Psychotherapy, 30*(3), 463-472. <https://doi.org/10.1037/0033-3204.30.3.463>
- Bowens, M., & Cooper, M. (2012). Development of a client feedback tool: A qualitative study of therapists' experiences of using the Therapy Personalisation Forms. *European Journal of Psychotherapy & Counselling, 14*(1), 47-62. <https://doi.org/10.1080/13642537.2012.652392>
- Brown, T. A. (2015). *Confirmatory factor analysis for applied research* (2nd ed.). The Guilford Press.
- Chen, F. F. (2007). Sensitivity of goodness of fit indexes to lack of measurement invariance. *Structural Equation Modeling, 14*(3), 464-504. <https://doi.org/10.1080/10705510701301834>
- Chewning, B., Bylund, C. L., Shah, B., Arora, N. K., Gueguen, J. A., & Makoul, G. (2012). Patient preferences for shared decisions: a systematic review. *Patient Education and Counseling, 86*(1), 9-18. <https://doi.org/10.1016/j.pec.2011.02.004>
- Cooper, M., & Norcross, J. C. (2016). A brief, multidimensional measure of clients' therapy preferences: The Cooper-Norcross Inventory of Preferences (C-NIP). *International Journal of Clinical and Health Psychology, 16*(1), 87-98. <https://doi.org/10.1016/j.ijchp.2015.08.003>
- Cooper, M., Norcross, J. C., Raymond-Barker, B., & Hogan, T. P. (2019). Psychotherapy preferences of laypersons and mental health professionals: Whose therapy is it? *Psychotherapy, 56*(2), 205-216. <https://doi.org/10.1037/pst0000226>
- Cooper, M., van Rijn, B., Chryssafidou, E., & Stiles, W. B. (2021). Activity preferences in psychotherapy: what do patients want and how does this relate to outcomes and alliance? *Counselling Psychology Quarterly*. Advance online publication. <https://doi.org/10.1080/09515070.2021.1877620>
- Costello, A. B., & Osborne, J. W. (2005). Best practices in exploratory factor analysis: Four recommendations for getting the most from your analysis. *Practical Assessment, Research & Evaluation, 10*(7), 1-9. <https://doi.org/10.11.1.110.9154>
- Goates-Jones, M., & Hill, C. E. (2008). Treatment preference, treatment-preference match, and psychotherapist credibility: Influence on session outcome and preference shift. *Psychotherapy: Theory, Research, Practice, Training, 45*(1), 61-74. <https://doi.org/10.1037/0033-3204.45.1.61>
- Hatchett, G. T. (2015). Development of the preferences for College Counseling Inventory. *Journal of College Counseling, 18*(1), 37-48. <https://doi.org/10.1002/j.2161-1882.2015.00067.x>
- Hu, L. T., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling, 6*(1), 1-55. <https://doi.org/10.1080/10705519909540118>
- Iacoviello, B. M., McCarthy, K. S., Barrett, M. S., Rynn, M., Gallop, R., & Barber, J. P. (2007). Treatment preferences affect the therapeutic alliance: Implications for randomized controlled trials. *Journal of Consulting and Clinical Psychology, 75*(1), 194-198. <https://doi.org/10.1037/0022-006x.75.1.194>
- Kaiser, H. F. (1974). An index of factorial simplicity. *Psychometrika, 39*(1), 31-36.
- Kwan, B. M., Dimidjian, S., & Rizvi, S. L. (2010). Treatment preference, engagement, and clinical improvement in pharmacotherapy versus psychotherapy for depression. *Behaviour Research and Therapy, 48*(8), 799-804. <https://doi.org/10.1016/j.brat.2010.04.003>
- Lindhiem, O., Bennett, C. B., Trentacosta, C. J., & McLearn, C. (2014). Client preferences

- affect treatment satisfaction, completion, and clinical outcome: A meta-analysis. *Clinical Psychology Review*, 34(6), 506-517. <https://doi.org/10.1016/j.cpr.2014.06.002>
- Maier MJ (2015). *Companion Package to the Book "R: Einführung durch angewandte Statistik"*. R package version 0.9.3. <http://CRAN.R-project.org/package=REdaS>
- Malosso, M. (2020). Adaptação transcultural para o português e validação de duas ferramentas de avaliação das preferências do cliente em psicoterapia: C-NIP E PEX. Doctoral dissertation. ISPA Instituto Universitário. <http://hdl.handle.net/10400.12/7294>
- Norcross, J. C., & Wampold, B. E. (2011). What works for whom: Tailoring psychotherapy to the person. *Journal of Clinical Psychology*, 67(2), 127-132. <https://doi.org/10.1002/jclp.20764>
- Norcross, J. C., & Wampold, B. E. (2018). A new therapy for each patient: Evidence-based relationships and responsiveness. *Journal of Clinical Psychology*, 74(11), 1889-1906. <https://doi.org/10.1002/jclp.22678>
- R Core Team (2021). *R: A language and environment for statistical computing*. R Foundation for Statistical Computing, Vienna, Austria. Retrieved from <https://www.R-project.org/>
- Raiche, G. (2010). *nFactors: An R package for parallel analysis and non graphical solutions to the Cattell scree test*. R package version 2.3.3.1.
- Revelle, W. (2018). *psych: Procedures for personality and psychological research*. Northwestern University. <https://CRAN.R-project.org/package=psych>
- Řiháček, T., & Roubal, J. (2017). Personal therapeutic approach: Concept and implications. *Journal of Psychotherapy Integration*, 27(4), 548-560.
- Rosseel, Y. (2012). lavaan: An R Package for Structural Equation Modeling. *Journal of Statistical Software*, 48(2), 1-36. <https://doi.org/10.18637/jss.v048.i02>
- Sandell, R., Clinton, D., Frövenholt, J., & Bragesjö, M. (2011). Credibility clusters, preferences, and helpfulness beliefs for specific forms of psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 84(4), 425-441. <https://doi.org/10.1111/j.2044-8341.2010.02010.x>
- Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The Consumer Reports study. *American Psychologist*, 50(12), 965-974. <https://doi.org/10.1037/0003-066X.50.12.965>
- semTools Contributors (2016). *semTools: Useful tools for structural equation modeling*. R package version 0.4-14. <https://CRAN.R-project.org/package=semTools>
- Swift, J. K., & Callahan, J. L. (2009). The impact of client treatment preferences on outcome: A meta-analysis. *Journal of Clinical Psychology*, 65(4), 368-381. <https://doi.org/10.1002/jclp.20553>
- Swift, J. K., Callahan, J. L., Cooper, M., & Parkin, S.R. (2019). Preferences. In J. C. Norcross, & B. E. Wampold (Eds.), *Psychotherapy relationships that work: Evidence-based responsiveness* (pp. 301-315). Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780199737208.003.0015>
- Swift, J. K., Callahan, J. L., Cooper, M., & Parkin, S. R. (2018). The impact of accommodating client preference in psychotherapy: A meta-analysis. *Journal of Clinical Psychology*, 74(11), 1924-1937. <https://doi.org/10.1002/jclp.22680>
- Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). Routledge.
- Windle, E., Tee, H., Sabitova, A., Jovanovic, N., Priebe, S., & Carr, C. (2020). Association of patient treatment preference with dropout and clinical outcomes in adult psychosocial mental health interventions. *JAMA Psychiatry*, 77(3), 294. <https://doi.org/10.1001/jamapsychiatry.2019.3750>

SOUHRN

Cooperův-Norcrossův inventář preferencí (C-NIP): Psychometrické vlastnosti české verze

Cíl. Cooper-Norcross Inventory of Preferences (C-NIP) představuje nejnovější a slibný nástroj určený k měření preferencí klientů ve vztahu k psychoterapii. Psychometrické zhodnocení tohoto nástroje je však zatím sporé a u české verze zcela chybí. Cílem této studie bylo ověřit faktorovou strukturu české verze C-NIP, ověřit invarianci měření a stanovit hraniční skóry.

Metody. $N = 772$ dospělých respondentů vyplnilo C-NIP v online průzkumu. K ověření faktorové struktury a invariance měření mezi pohlavími a napříč různými úrovněmi zkušenosti s psychoterapií byla použita konfirmační faktorový analýza.

Výsledky. Původní faktorová struktura nebyla podpořena. Namísto toho byl navržen pětifaktorový model, který vykazoval adekvátní shodu s daty a byl striktně invariantní ve vztahu k pohlaví i úrovni zkušenosti s psychoterapií.

Závěr. Českou verzi C-NIP lze považovat za validní a reliabilní nástroj na měření preferencí klientů ve vztahu k psychoterapii. Je zapotřebí replikovat navrženou faktorovou strukturu.