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The Role of Client Preference for Therapeutic Alliance in Retention in Therapy

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ABSTRACT. This study used a delay discounting model to examine the decisions around and preferences for different levels of therapeutic alliance and different lengths of therapy for therapeutically motivated participants. Overall, the level of bond was predicted to impact participants' decisions about therapy duration with an overall preference for a stronger bond even if it meant lengthening treatment. A total of 105 participants completed an online delayed discounting questionnaire designed to assess at what indifference point in the therapeutic bond clients were willing to switch to a longer therapy. All participants were either currently attending therapy or waiting to attend therapy, and were primarily White and female with an average age of 34.92 years. A series of nonparametric tests were statistically significant for each of the hypotheses (ps < .001) except for 2c. Specifically, findings indicated that participants switched to the longer treatment duration in order to pursue a stronger therapeutic bond when they were offered a short therapy program with an unbonded or neutral therapeutic bond (1a and 1b), and that people needed higher therapeutic alliances to justify switching to longer therapy programs as their durations increased (8–12 weeks; 2a and 2b). Also, contrary to our predictions, people preferred a longer therapy with a lower bonded therapist over a shorter therapy duration with the highest bonded therapist possible (1c), and people discounted the same amount of therapeutic alliance when switching to the 8- and 12-week programs (2c). These results suggest that therapeutic alliance influences retention, but participants' motivation to attend therapy may also be a contributing factor. These findings are important for clinicians to consider when forming relationships with their clients, as previous literature has been mixed on the relationship between alliance and retention.

Keywords: therapeutic alliance, client retention, client preferences, therapy length, client motivation

Research has previously indicated that clients value the therapist alliance in therapy (Dimic et al., 2023), specifically clients residing in western countries (Giallorenzo, 2024). However, less is known about how this preference is predictive of the length of time clients are willing to stay in therapy. Considering the research on client preferences for therapeutic alliance (Dimic et al., 2023; Giallorenzo, 2024), the goal of this study was to use a delayed discounting (DD) methodology to investigate the point at which a client chooses a longer therapy to satisfy their preferences for a therapeutic alliance as opposed to a shorter, equally effective therapy with a therapist that does not necessarily satisfy their alliance preferences. In other words, this study sought to assess at what point clients who are motivated to attend therapy discount (i.e., give up) a therapeutic alliance with their therapist for a shorter duration of therapy.

This study used the Prochaska and Diclemente's Stages of Change Model (Prochaska & DiClemente, 1983) to examine how people in the Action and Maintenance stages of the readiness model are influenced by different levels of therapeutic alliance when choosing between equally effective shorter and longer therapy programs. The Prochaska and DiClemente's Stages of Change Model highlights the

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stages that people go through when it comes to deciding on, taking action on, and maintaining changes in their lifestyle and cognition that promote improved mental health. These stages include *Precontemplation*, where the person is in denial that they need help, *Contemplation*, where the person has some awareness of their problem, *Preparation*, where the person is ready to change, *Action*, where the person engages in actions that will bring about change, *Maintenance*, where the person implements strategies to maintain their progress for a prolonged period of time, and potential *Relapse*, where the person returns to their unhealthy behavior (Prochaska & Norcross, 2002). This study focused on the Action and the Maintenance stages of therapy by ensuring that all participants were currently receiving or waiting for treatment for symptoms of a mental health condition, whether it be through therapy, medication, hospital and residential treatment programs, or other types of treatment. The Preparation stage was excluded because, although these people are ready to make change, our sample only included people who had already taken action to receive therapeutic treatment (currently receiving or waiting to receive mental health treatment), and hence truly began considering their engagement in therapy, preferences for therapeutic alliance, and therapy duration. Meanwhile, people in the Preparation stage might not have completely processed these preferences yet. It is important to focus on the Action and Maintenance populations when studying client preferences for therapeutic alliance because these stages suggest that the client is approaching therapy with a positive attitude and a willingness to change. In the case of retention, this ensures that it is more likely to be the therapeutic alliance that affects the time clients choose to stay in therapy, not the client's negative attitude about therapy. This is supported by Brocato (2004), who found that, in a prison population, clients' willingness to change was positively related to the number of days they spent in treatment, meaning that people who were not ready to make positive changes in their lives to improve their mental health were more likely to drop out of therapy. Client motivation, such as those who are currently in treatment, therefore, may play a role in making this population want to attend therapy for longer than clients who are unmotivated.

One factor that might influence dropout in clients who are already motivated to attend therapy is the therapeutic alliance, or the bond between the client and the therapist within therapy. Research has shown that clients' pretherapy motivation to attend therapy influences the client–therapist alliance within therapy, although findings have been mixed. For example, Calsyn et al. (2006), Meier et al. (2005), and Cheng et al. (2010) found that, when clients are motivated to attend therapy, their perception of the therapeutic alliance increases. It is important to keep these findings in mind when studying people in the Action and Maintenance stages because these therapeutically motivated clients may be uniquely influenced by the therapeutic alliance when they are making decisions about how long they are willing to attend therapy.

The client–therapist alliance is an important factor of therapy to study, as multiple meta-analyses have shown moderate but positive significant relationships between the therapeutic alliance and positive outcomes in therapy (Flückiger et al., 2018; Martin et al., 2000). One specific study that showed this relationship was Levin et al. (2024), who found that, when depressed clients in a therapy trial rated their therapeutic alliance over time, the level of alliance (i.e., bond) tended to predict their depression scores (with depression scores decreasing as their therapeutic alliance increased).

Additionally, findings have shown that a higher therapeutic alliance could increase client retention in therapy. A meta-analysis (Sharf et al., 2010) found a moderately strong negative relationship between the therapeutic relationship and client dropout rates, signifying that a stronger therapeutic alliance leads to lower dropout rates. Meier et al. (2024) also found this relationship, suggesting that higher alliance scores and lower client distress are associated with longer attendance in therapy. Furthermore, Sijercic et al. (2021) showed that the overall therapeutic alliance positively affects client retention in cognitive processing therapy for patients with PTSD symptoms, although ratings of the initial alliance, late alliance, and change in alliance over time did not predict retention. These findings reinforce the need for therapists to form a strong therapeutic relationship early in the therapy process.

However, the findings on the association between therapeutic alliance and client retention are mixed. Some studies have found that the therapeutic alliance predicts retention in some cases but not others, such as Barber et al. (2001), which found that the relationship between therapeutic alliance and retention for people struggling with cocaine addiction depended on the type of treatment given. In this study, people who were given supportive-expressive therapy and individual drug counseling treatments showed a positive relationship between bond and retention (higher bond, higher retention) or no relationship between therapeutic bond and retention, and cognitive therapy treatments showed a negative relationship between therapeutic alliance and retention (higher bond, less retention). Finally, research has also indicated that there is no relationship between therapeutic alliance and retention, such as Brocato

(2004), who found that therapeutic alliance was not a predictor of client retention in therapy in a prison substance abuse program. Because all of these studies consisted of different conditions, a better understanding of the conditions that impact direction or degree of the relationship between alliance and retention is needed.

Time, or length of treatment, is one of these variables that needs further investigation as it relates to alliance, given that creating a therapeutic alliance takes time. For example, Prusiński (2024) found that, for adults with adaptation disorders, the therapeutic alliance increased by a stable linear trend over time throughout the course of a year's worth of therapy for individuals whose therapy was successful, and that stronger alliance correlates with better treatment outcomes. Furthermore, Littauer et al. (2005) found that most clients needed two sessions, on average, before a good or very good alliance with their therapist was created. Overall, therapeutic alliance is a predictor of positive therapeutic outcomes and longer attendance in therapy; however, this can take time to build.

It is important to look at how time influences the therapeutic bond because client premature termination of therapy is a problem within psychotherapy (Sijercic et al., 2021), and clients often drop out early because they do not feel a strong bond with their therapist (Meier, 2023). Early formation of a therapeutic bond, however, can mediate these early dropout rates, as shown in Anderson et al. (2018). In this naturalistic study of clients participating in individual, couple and family, or high conflict coparenting therapy, 20% discontinued therapy within the first three sessions; however, formation of an early therapeutic alliance played a significant role in client retention after these three sessions. This demonstrates that the therapeutic alliance is something that clients value in therapy, and that clients will be willing to attend therapy longer if there are higher levels of therapeutic alliance early in therapy.

The current study used a DD model (Smith & Hantula, 2008; Tesch & Sanfey, 2008) to identify therapy clients' tendency to choose between shorter and longer therapy programs that offer differing levels of alliances with their therapist. Specifically, this study used DD to calculate the point in the therapeutic alliance at which clients are willing to go to therapy for longer, despite options for a shorter therapy program with a lower therapeutic bond. DD is the tendency of individuals to favor smaller, immediate rewards over larger rewards that come after a delay (Berns et al., 2007; Kirby et al., 1999; as cited in Lempert et al., 2012), suggesting that the subjective value of rewards decrease over time. For example, a person may subjectively favor $50 today over $75 one month from now, in which case the person subjectively deems the larger reward of $75 as less valuable because of the time they must wait to receive the reward (Swift & Callahan, 2009). Although several methods for calculating DD have been proposed (Smith & Hantula, 2008; Tesch & Sanfey, 2008), the overall method of assessing a participant's degree of discounting (i.e., indifference point) is by identifying the moment when the person considered the smaller, immediate reward equivalent to the larger, delayed reward (Chadwell et al., 2019; Swift & Callahan, 2009). DD assessments typically involve systematically manipulating the value of rewards (or the therapeutic bond in this study) until a participant no longer indicates a preference for one reward over another (Chadwell et al., 2019; Swift & Callahan, 2009). Extrapolating from the above example, an individual may choose a delayed reward over the $50 immediate reward if the delayed reward is raised from $75 to $100. In this case, because the person chose the immediate reward when the delayed reward was only $75 but switched to the delayed reward when it increased to $100, the person's indifference point would fall in between $75 and $100. In other words, at some point between $75 and $100, the subjective value of the delayed reward is equal to the value of the immediate reward. The rates that people discount future rewards have varied across individuals and contexts, so it is important to understand factors that may influence people's varied discounting rates.

DD has been widely used in psychological and economic research to study decision-making behaviors, specifically in studies related to self-control and impulsivity in decision making (da Matta et al., 2011). Although DD has been used in various ways, it has emerged as an important measure for psychotherapy researchers. For example, Swift and Callahan (2009, 2010a) used DD to assess certain client preferences (such as the client or therapist talking more within sessions), client expectancies, and client termination. Furthermore, Chadwell et al. (2019) uses DD to assess client's preferences around treatment effectiveness and therapist process characteristics. DD is beneficial when looking at client preferences because oftentimes subjective values can be assigned to these preferences. For example, Swift and Callahan (2010) tested client preferences by asking participants to choose between a treatment that has a 70% recovery rate that is conducted by a therapist with few years of experience, and a treatment that has a 10% recovery rate that is conducted by a therapist with many years of experience. They then increased the 10% efficacy rate by 10% until the participant switched over to treatment with a therapist with many years of experience. This study found that clients were willing to discount a significant amount of treatment efficacy to ensure that their therapist would have

a greater level of experience. In terms of other measures, participants also discounted treatment efficacy to ensure a satisfactory therapeutic relationship, an empathetic and accepting therapist, and therapy sessions dominated by the client talking.

This study used similar measures of DD, but used client preferences for therapeutic alliance and therapy length instead of treatment efficacy and therapist characteristics for two sets of study hypotheses below (1a, 1b, 1c, 2a, 2b, and 2c*)*.

Hypothesis 1a and 1b predicted that, when offered a short therapy duration of treatment with an unbonded or neutral therapeutic bond, respectively, participants would eventually switch to the longer therapy to pursue a stronger bond with their therapist. This makes sense, because in the DD paradigm, people tend to choose the lower, more immediate bond until the delayed, higher reward is just as favorable, at which point they switch to the delayed reward. Hypothesis 1c was also based on the delayed discounting framework, predicting that, when given the option of shorter therapy with the highest bonded therapist possible, people will always prefer this therapy over a longer therapy with a lower bonded therapist. This makes sense, because in the DD paradigm, when a person is offered an immediate reward that is higher than delayed reward, they tend to choose the large immediate reward because the delay only decreases the already low reward.

Hypotheses 2a, 2b, and 2c looked at differences between clients' preferences when they switched to an 8-week and to a 12-week program. Hypotheses 2a and 2b predicted that participants would require a significantly higher bond to switch to the 12-week therapy program than they required to switch to an 8-week therapy program from a 4-week program with unbonded therapeutic bonds and neutral therapeutic bonds, respectively. This aligns with the DD paradigm because switching from a 4-week program to a 12-week program involves more delay than switching from a 4-week program to an 8-week program, and therefore the therapeutic alliance value when switching to a 12-week program will be subjectively discounted at a higher rate than switching to an 8-week program. It follows that people will stay in the 4-week therapy program for longer when given the choice of the 12-week program than the 8-week program, as the delayed rewards mean less. Finally, Hypothesis 2c predicted that there would be no significant difference between participants' indifferent points when switching to the 8- and 12-week conditions because they would always choose the shorter therapy program with the highest level of therapeutic alliance available over the longer therapy with a less bonded therapist. This makes sense because, according to the DD paradigm, people tend to always want a larger immediate reward, and therefore would never choose the longer therapy in either case.

Data from this research can inform therapists of what levels of therapeutic relationships are important to clients who are ready to attend therapy and make changes in their lifestyles to improve their mental health, as well as how these relationships affect clients' willingness to continue therapy for longer periods of time. This study was guided by the Prochaska's Stages of Change Model (Prochaska & DiClemente, 1983), as participants were screened to be either currently attending therapy or waiting to attend therapy to ensure that they were in the Action and/or Maintenance stages of the model and ready to make psychological changes in their life. It is important to study this group of participants because this self-motivation could play a role in how much therapeutic alliance is needed for this group to remain in therapy for longer.

Methods

Participants

A total of 115 participants who resided in the United States expressed an interest in participating in the study. Participants were eliminated from the final analysis sample for several reasons including: technical time out issue for a participant resulting in two sets of data ($n = 1$), substantial missing data ($n = 3$), or participant random clicking during the survey (e.g., all scores were unrelated, which was observed because of the continuous nature of the DD questionnaires; $n = 6$). Of the final participant pool of 105 participants, a total of 79 identified as women, 26 identified as men, 8 identified as nonbinary, and 1 identified as other. For sexual orientation, 69 participants identified as heterosexual/straight, 12 identified as gay/lesbian, 32 identified as other, and 1 reported not knowing which group they identified with. The participants' average age was 34.92 years ($SD = 10.87$) with a range of 20 to 75 years ($N = 112$). In terms of race, 92 participants identified as White, 11 identified as Black or African American, 5 identified as American Indian or Alaska Native, 2 identified as Asian Indian, 1 identified as Chinese, 1 identified as Vietnamese, and 2 identified as other Asian. One hundred one participants did not identify with Hispanic, Latino/a, or Spanish origin, while 6 identified with Mexican, Mexican American, and/or Chicano/a, 2 identified as Puerto Rican, 1 identified as Cuban, and 3 identified with another Hispanic, Latino/a, or Spanish origin. Participant employment status included 63 participants working as paid employees, 15 working (self-employed), 2 not working due to a temporary layoff from a job, 15 not working but looking for work,

2 not working due to retirement, 9 not working due to a disability, and 7 not working for other reasons, with 1 participant stating that they were "working on their mental health until they were able to work." In terms of marital status, 67 participants were never married, 32 participants were married, 3 participants were widowed, 11 were divorced, and 1 was separated. Other participant demographic variables included education, with 1 participant having lower than a high school degree, 15 participants having only graduated high school, 26 participants having some college but no degree, 13 participants having an associate's college degree (2 years), 38 participants having a 4-year bachelor's degree, 17 participants having a master's degree, 1 participant having a doctoral degree, and 3 participants having a professional degree (JD, MD, etc). Participants' total household income for the last 12 months before taxes consisted of 19 participants earning less than $25,000, 30 participants earning in between $25,000 and $49,999, 19 participants earning in between $50,000 and $74,999, 16 participants earning between $75,000 and $99,999, 14 participants earning between $100,000 and $149,999, 8 participants earning between $150,000 and $199,999, 3 participants earning between $200,000 and $249,999, and 2 participants earning $250,000 or more. Finally, 12 participants noted that they did not have health insurance, while 102 did have health insurance. Of the participants who noted that they did have health insurance, 3 participants claimed that it did not offer mental health coverage, while 95 participants claimed that they did have mental health coverage through their health insurance.

Procedure

Following IRB approval from the University of San Diego, eligible participants were recruited via Prolific, a web-based data collection platform that allows researchers to recruit participants for online research studies. To be included in the study, participants had to be at least 18 years old, reside in the United States, and currently be receiving or waiting to receive treatment for symptoms of a mental health condition (i.e., indicative of being in the Action and Maintenance stages of readiness). Participants were offered $6.00 to complete the online survey using Qualtrics. Participants were told that the study would take approximately 30 minutes to complete, although the average amount of time participants took to complete the study was 15 minutes and 31 seconds. After completing a consent form, participants completed a series of questionnaires that assessed participants' validation (i.e., CAPTCHA), background information, current mental health functioning, general health-seeking behaviors, path to treatment, attitudes towards seeking professional mental health, and preferences for a therapist, as well as questions that assess how long clients are willing to stay in therapy in the face of differing therapist interpersonal traits and differing strengths of therapeutic alliance in therapy. Finally, participants completed questions that measured attention and comprehension. For purposes of this article, in addition to study validation, attention measures, and comprehension measures, only the study questionnaires described below were evaluated. Data from this study were part of a larger study that included additional questionnaires noted above proposed to be related to alliance and client retention.

Assessments

To assess participant background information, participants were asked various questions including age, gender, race, ethnicity, total household income, current student enrollment status, employment status, marital status, military background, and access to health insurance.

To study client preferences for therapeutic alliance and length of therapy, this study used vignettes created by the principal investigator and co principal investigator modeled after Swift and Callahan's (2009) DD framework. In Vignettes Series 1a (weeks 4 and 8), participants read vignettes and then responded to indicate their preference for length of therapy and therapeutic alliance, as shown in Appendix A below. Descriptions utilized terminology from The Working Alliance Inventory-Short Revised (Paap & Dijkstra, 2017) that were provided for each of the anchors for bonding.

Then, participants responded to 10 questions that asked them to rate preferences for a 4-week treatment with a 1/10 therapeutic bond or 8-week treatment with varying levels of therapeutic bond (1–10/10) using the scale noted above. The second vignette followed the same pattern, with 10 questions asking participants to choose between a 4-week treatment with a neutral bond (5/10) with their therapist or an 8-week treatment with varying levels of therapeutic bond (1–10/10). The third vignette also follows this pattern, with 10 questions that offer a strong therapeutic bond (10/10) for the 4-week program and asks participants if they would rather this or an 8-week treatment with varying levels of therapeutic bond (1–10/10).

The same pattern was used for the fourth, fifth, and sixth vignettes for Vignettes Series 1b (weeks 4 and 12), except the vignettes were now comparing weeks 4 and 12 (week 8 above was replaced with 12 here). Weeks 4, 8, and 12 were chosen as anchors because research has indicated that, compared to week 4 of treatment, people tend to show increases in well-being (and related anxiety) following cognitive behavioral therapy at week 8 and again at week 12 (Gallagher et al., 2020).

In Vignettes Series 1a (weeks 4 and 8) and Vignettes Series 1b (weeks 4 and 12), the DD measure was used to calculate the indifference point, or the point at which participants switched from the 4-week therapy to a longer therapy with different levels of therapeutic alliance. For the sake of this study, the indifference point was calculated by averaging the points that the participant switched preferences between a pair of comparison points (Odum et al., 2011), mirroring Swift and Callahan's (2009) manner of DD calculation in psychotherapy research. For example, say a participant in this study chose to remain in the 4-week therapy with a neutral bond (5/10) with their therapist until the longer, 8-week therapy offered a 7/10 bond with their therapist. In this case, the person made the switch to the longer therapy when it could offer in between a 6/10 and a 7/10 level bond. Their indifference point would therefore be 6.5 (the average of 6 and 7), indicating that the person would rather stay in a shorter, 4-week therapy with a neutral therapist (5/10) until the longer, 8-week therapy offered a therapeutic bond of 6.5/10 (see Appendix B). A higher indifference point indicates that the person is more willing to discount the therapeutic relationship in therapy, and they require a higher therapeutic bond to justify switching to a longer therapy program. A lower indifference point indicates that people discount less of the therapeutic bond for therapy length, and they do not require as much of a therapeutic bond to switch to a longer therapy program. Indifference points for each participant were created for each of the 6 conditions (1/10 for 4 weeks, __/10 for 8 weeks; 5/10 for 4 weeks, __/10 for 8 weeks; 10/10 for 4 weeks, __/10 for 8 weeks; 1/10 for 4 weeks, __/10 for 12 weeks; 5/10 for 4 weeks, __/10 for 12 weeks; 10/10 for 4 weeks, __/10 for 12 weeks) in order to run analysis for Hypotheses 1 and 2.

Results

Hypothesis 1: Client Preferences for Therapeutic Alliance and Therapy Length at the Unbonded, Neutral, and Bonded Bond Levels

Three sub-hypotheses for Hypothesis 1 were formed to examine client's preferences for therapeutic bond and length of therapy through a measure of DD. Before testing these hypotheses, data assumptions were evaluated. The data were not normally distributed for DD values for weeks 4 to 12 by bond, despite attempts to normalize the data using log transformations. Therefore, Wilcoxon signed-rank tests were conducted for all three levels of therapeutic bond. See Figure 1.

Hypothesis 1a: Unbonded

A single sample Wilcoxon signed-rank test determined that the median change in indifference point when subjects reported on willingness to continue from 4- to 8-week treatment (Mdn = 4.50) was significantly different than the hypothetical value for the unbonded bond (Mdn = 1.00), Z = 8.81, p < .001, N = 102. Similarly, a second single sample Wilcoxon signed-rank test determined that the median change in indifference point when subjects reported on willingness to continue from 4- to 12-week treatment (Mdn = 5.50) was significantly different than the hypothetical value for the unbonded therapeutic relationship (Mdn = 1.00), Z = 8.85, p < .001, N = 104.

Hypothesis 1b: Neutral Bond

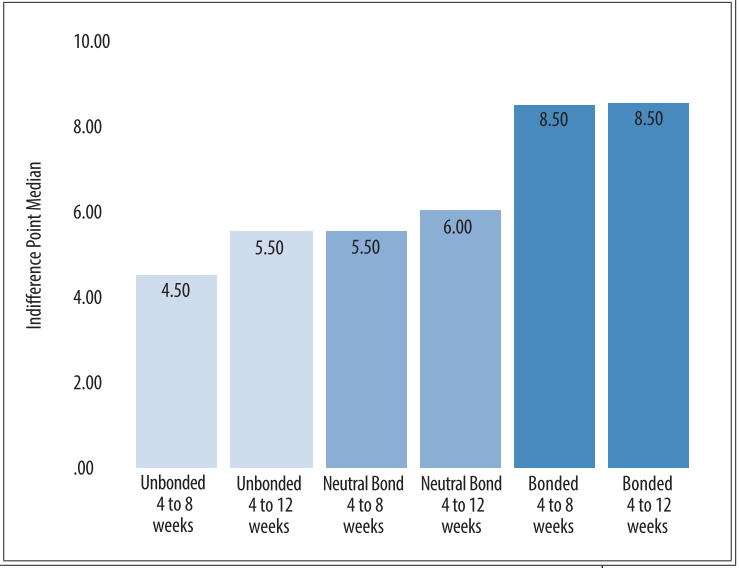
A single sample Wilcoxon signed-rank test determined that the median change in indifference point when subjects reported on willingness to continue from 4- to 8-week treatment (Mdn = 5.50) was significantly different than the hypothetical value for the neutral bond (Mdn = 5.00), Z = 4.15, p < .001, N = 104. Similarly, another single sample Wilcoxon signed-rank test determined that the median change in indifference point when subjects reported on willingness to continue from 4- to 12-week treatment (Mdn = 6.00) was significantly different than the hypothetical value for the neutral bond (Mdn = 5.00), Z = 6.72, p < .001, N = 104.

Hypothesis 1c: Bonded

A single sample Wilcoxon signed-rank test determined that the median change in indifference point when subjects reported on willingness to continue from

FIGURE 1

Therapeutic Bond Level and Willingness to Continue Treatment Across Time



4- to 8-week treatment (*Mdn* = 8.50) was significantly different than the hypothetical value for the "bonded" bond (*Mdn* = 10.00), $Z = -7.67$, $p < .001$, $N = 104$. Similarly, a single sample Wilcoxon signed-rank test determined that the median change in indifference point when subjects reported on willingness to continue from 4 to 12-week treatment (*Mdn* = 8.50) was significantly different than the hypothetical value for the bonded bond (*Mdn* = 10.00), $Z = -7.67$, $p < .001$, $N = 104$.

Hypothesis 2: How Different Therapy Program Lengths (8 vs 12 weeks) Affect Alliance Preferences at the Unbonded, Neutral, and Bonded Bond Levels

For Hypothesis 2, three subhypotheses were formed to assess how people's preferences for therapeutic alliance change when they are offered therapies of different lengths. Before testing these hypotheses, data assumptions were evaluated. The data were not normally distributed for DD values for weeks 4 to 8 and for weeks 8 to 12, despite attempts to normalize the data using log transformations. Therefore, Wilcoxon signed-rank tests were conducted for all three levels of therapeutic bond. See Figure 1.

Hypothesis 2a: Unbonded

A total of 101 participants were analyzed to understand the extent of DD indifference points at an unbonded bond for willingness to continue therapy from 4 to 8 weeks, vs. 4 to 12 weeks. Data refers to indifference point medians unless otherwise stated. The unbonded elicited an increase in DD in the willingness to continue therapy from 4 to 12 weeks compared to the participants moving from 4 to 8 weeks for 61 participants, whereas 30 participants reported no change in willingness to continue therapy, and 10 participants were unwilling to continue treatment beyond 8 weeks. A Wilcoxon signed-rank test determined that there was a statistically significant median decrease in indifference point when subjects reported on willingness to continue from 4- to 12-week treatment (*Mdn* = 5.5) compared to willingness to continue from 4- to 8-week treatment (*Mdn* = 4.5), $Z = -5.79$, $p < .001$.

Hypothesis 2b: Neutral Bond

A total of 104 participants were analyzed to understand the extent of DD indifference points at a neutral bond for willingness to continue therapy from 4 to 8 weeks, vs. 4 to 12 weeks. Data are indifference point medians unless otherwise stated. The neutral bond elicited an increase in DD in the willingness to continue therapy from 4 to 12 weeks compared to the participants moving from 4 to 8 weeks for 47 participants, whereas 46 participants reported no change in willingness to continue therapy, and 11 participants were unwilling to continue treatment beyond 8 weeks. A Wilcoxon signed-rank test determined that there was a statistically significant median increase in indifference point when subjects reported on willingness to continue from 4 to 12-week treatment (*Mdn* = 6.0) compared to willingness to continue from 4 to 8-week treatment (*Mdn* = 5.5), $Z = -5.04$, $p < .001$.

Hypothesis 2c: Bonded

A total of 104 participants were analyzed to understand the extent of DD indifference points at a bonded bond for willingness to continue therapy from 4 to 8 weeks, vs. 4 to 12 weeks. Data are indifference point medians unless otherwise stated. The high bond elicited an increase in DD in the willingness to continue therapy from 4 to 12 weeks compared to the participants moving from 4 to 8 weeks for 21 participants, whereas 54 participants reported no change in willingness to continue therapy, and 29 participants were unwilling to continue treatment beyond 8 weeks. A Wilcoxon signed-rank test determined that there was no statistically significant median change in indifference point when subjects reported on willingness to continue from 4- to 12-week treatment (*Mdn* = 8.50) compared to willingness to continue from 4- to 8-week treatment (*Mdn* = 8.50), $Z = -1.65$, $p = .10$.

Discussion

The purpose of this study was to assess the extent to which the level of therapeutic bond or alliance is related to preferences for time spent in therapy. This study used DD and the Prochaska and Diclemente's Stages of Change Model (Prochaska & DiClemente, 1983) to investigate the point (i.e. indifference point) at which therapeutically-motivated clients chose an effective, long-duration therapy that offered a higher therapeutic alliance as opposed to an equally effective, short-duration therapy that offered a lower therapeutic alliance. More specific summaries and implications about each two sets of hypotheses are described below.

Hypothesis 1a: Unbonded

Hypothesis 1a predicted that, when offered a 4-week therapy with an unbonded therapist or a longer therapy (8 or 12 weeks) with an increasingly higher bond with their therapist, people in a short therapy with an unbonded therapist would switch to the longer therapy if it offered a significantly higher bond. As predicted, people's indifference points were significantly larger than 1/10 for both the 8-week and 12-week switches, with indifference points of 4.5 and 5.5 respectively.

This means that people were willing to stay in a short, 4-week therapy with an unbonded therapist until the bond increases to a neutral bond, at which point they were willing to go to therapy for a longer period of time. The fact that participants wanted to switch from a short therapy with an unbonded therapist to a longer therapy when the therapeutic bond was neutral shows that clients value therapeutic alliance in therapy to a certain degree, and it did affect their preference for retention in therapy as supported by previous literature (Meier, 2024; Sijercic et al., 2021).

Hypothesis 1b: Neutral Bond

Hypothesis 1b predicted that, when offered a 4-week therapy with a neutral bonded therapist (5/10) or a longer therapy with an increasingly higher bond with their therapist (6–10/10; via DD), people would switch to the longer therapy (8 or 12 weeks) at a bond significantly larger than a neutral bond (5/10) in order to pursue a stronger bond with their therapist. This hypothesis was supported when participants were asked to switch to both the 8- and 12-week therapy programs, with indifference points being 5.5 and 6.0 respectively. This means that people are willing to stay in a short, 4-week therapy with a neutral therapist until a longer therapy offers a slightly above-neutral therapeutic alliance, at which point they are willing to switch to a longer therapy program. This, combined with Hypothesis 1a, suggests that people solely require a neutral bonded therapist or slightly above a neutral bonded therapist to justify attending therapy for a longer period of time.

These results suggest that therapist alliance does play a role in client retention in therapy; however, the DD technique reveals that people who are motivated to attend therapy only need a slightly above-neutral bond to justify attending therapy for longer. Motivated clients having this relatively low indifference point is supported by a study by Brocato (2004), which found that, in prisoners attending therapy, people's motivations for change were a higher predictor of therapy retention than the therapeutic alliance. This brings us back to this study's application of the Stages of Change Model (Prochaska & DiClemente, 1983), suggesting that this study's population may not require as strong of a therapeutic alliance to remain in therapy for longer because they are already self-motivated (i.e., in the Action and Maintenance stages) to improve. In all, these results suggest that the therapeutic alliance does play a significant role in retention, but only to a certain degree—people who are motivated to attend therapy really only need slightly above neutral alliance to justify switching to a longer therapy.

Hypothesis 1c: Bonded

Hypothesis 1c predicted that, when given the option of a 4-week therapy with a highly bonded therapist (10/10), people will always prefer this therapy over a longer therapy (8 or 12 weeks) with a less bonded therapist (1–9/10), and there will therefore be no significant change in indifference point. These results were not supported for 8 weeks and 12 weeks (with indifference points being 8.5 and 8.5 respectively), which is particularly interesting because this went against our initial hypothesis and normal human tendencies in DD to choose an immediate reward that is higher over a delayed reward that is lower. The results suggest that clients preferred a longer therapy and/or ability to build a connection with their therapist over time over a short therapy with the highest possible bond with their therapist. In other words, clients could be willing to discount a little bit of the therapeutic relationship so that they attend therapy longer, either because they prefer a longer therapy, or so that they can build the therapeutic relationship over time. This is supported in Prusiński (2024), who found that, for adults with adaptation disorders, the therapeutic alliance increased by a stable linear trend over time, and that the therapeutic alliance was correlated to positive therapeutic outcomes. Based on these findings, clients may associate longer therapy sessions with a higher therapeutic bond and better therapeutic outcomes. Additionally, client willingness to discount some of the therapeutic alliance to attend a longer therapy program is supported by Bose et al. (2023), who found that increased session attendance is significant in enhancing therapeutic outcomes, while building an early, strong therapeutic alliance does not.

Going off of these findings, it can be concluded that clients may feel that a longer therapy program will help them recover more than the highest therapeutic alliance possible could. Although participants discounted a shorter therapy program with the highest bond possible, participants still wanted a relatively high therapeutic bond with their therapist in order to switch to a longer therapy (8.5) as opposed to the neutral/slightly above neutral bond (5–6/10) that was observed with Hypotheses 1a and 1b. This result could be supported by previous research findings that developing a therapeutic alliance early in therapy will increase the sessions that clients attend (Meier, 2024), and even that overall ratings of therapeutic alliance (as opposed to initial alliance, late alliance, and change in alliance over treatment) is a significant predictor of client dropout in a cognitive processing therapy therapy for clients with PTSD (Sijercic et al., 2021), as clients prefer the longer therapy with a "bonded" therapeutic relationship over the short therapy with a "bonded" therapeutic relationship.

Hypothesis 2a: Unbonded

Hypothesis 2a predicted that people would want a significantly higher bond to switch to a 12-week therapy program than the bond it would take them to switch to an 8-week therapy program when they were in a 4-week therapy with an unbonded therapist. The results for Hypothesis 2a were supported, as the indifference points for switching to 8 weeks (4.5) and 12 weeks (5.5) were significantly different. This means that people discounted more of the therapeutic relationship when given the option of the 12-week program, more preferring to stay in a short therapy with an unbonded therapist than people given the option of an 8-week program. This suggests that therapeutic alliance does play a significant role in how long people are willing to go to therapy when the bond with their therapist is "unbonded." This is supported by previous findings that the overall therapeutic alliance does affect client's retention in therapy, as found in Meier (2024) and Sijercic et al. (2021), both who compared the therapeutic alliance within therapy with the participant's dropout rate within therapy. Although this study had similar findings, this study specifically analyzed the point in the therapeutic relationship clients are willing to go to therapy for longer periods of time. Specifically, this finding showed that, although the point in which participants switched to an 8-week program and the point in which they switched to a 12-week program were significantly different, it was only a 1-bond point difference, and both conditions switched when the bond level was around neutral. This shows that people do need a higher bond level to switch to a longer therapy session (8 weeks vs 12 weeks) from a short therapy with an unbonded therapist, but both are willing to switch around the neutral bond level (4.5 vs 5.5).

Hypothesis 2b: Neutral Bond

Hypothesis 2b predicted that people would want a significantly higher bond to switch to a 12-week therapy program than the bond it would take them to switch to an 8-week therapy program. This hypothesis was supported, as the indifference point for switching to an 8-week (5.50) or a 12-week (6.00) therapy was significantly different. This suggests that clients are willing to go to a therapy with a neutral bonded therapist for 8 weeks, but they require a more bonded relationship with their therapist to justify going to therapy for 12 weeks. This suggests that therapeutic alliance does play a significant role in how long people are willing to go to therapy when the bond with their therapist is neutral. This is supported by previous findings that therapeutic alliance does affect client's retention in therapy, as found in Meier (2024) and Sijercic et al. (2021); these studies, however, compared the therapeutic alliance within therapy with the participant's dropout rate within therapy, while this study assessed client preferences for the point in the therapeutic relationship they were willing to go to therapy for longer. This was done by finding the median indifference point at which participants switched to the 8-week and the 12-week therapy program. Specifically, although the difference was significant, there was only a 0.50 point difference in therapeutic bond between when people were willing to switch to an 8-week program than a 12-week program, and both conditions switched when the bond level was slightly above neutral. This shows that people do need a higher bond level to switch to a longer therapy session (8 weeks vs 12 weeks) from a short therapy with a neutral therapist, but both are willing to switch when the therapeutic alliance is slightly above neutral bond level (5.50 vs. 6.00).

Hypothesis 2c: Bonded

Hypothesis 2c predicted that, when participants are offered a 4-week program with the highest bonded therapeutic alliance possible (10/10), there will be an insignificant difference between people switching to 8- and 12-week programs because people will always want the higher, more immediate reward. The results supported this hypothesis, showing that there was no significant change in indifference point between 8 and 12 weeks. This suggests that clients did not prefer a higher bond for 12 weeks as opposed to 8 weeks, suggesting that the additional 4 weeks in therapy does not matter for people who are therapeutically motivated as long as the bond is relatively high/bonded. This shows that therapeutic alliance affects client retention in therapy, as shown by Meier (2024) and Sijercic et al. (2021), but only up until a certain point. Once clients perceive therapeutic alliance to be relatively high, it may not play a huge role in whether a client chooses to terminate therapy or not.

Limitations

This study included limitations that might have impacted the findings. One limitation included this study's limited time points of 8 and 12 weeks, which prevented an analysis using Area Under the Curve (AUC). As demonstrated in Myerson et al. (2001), the AUC measure consists of calculating the area under the empirical discounting function at multiple points of delay (more than the two points in this study), which is a commonly used measure of calculating the degree of discounting. Although calculating the median indifference point is a valid form of DD measurement, as seen in Swift and Callahan (2009, 2010a) and Chadwell (2019), future research could conduct the current study again with more data points in order to run an AUC analysis. This AUC analysis would then yield a single number between 0 and 1 to characterize the extent to which participants

discounted the therapeutic alliance to attend shorter or longer therapy sessions (with numbers closer to 1 suggesting maximum discounting and numbers closer to 0 suggesting minimum discounting; Odum, 2011). Although we would not be able to determine the point in the therapeutic alliance that clients actually switched therapy programs (i.e., indifference point), this form of analysis would allow us to see the data in a new way, yielding the rate in which participants discounted the therapeutic alliance for different therapy lengths. Furthermore, adding more time points would yield a better understanding of people's decisions around therapy, as different lengths of therapy may alter people's decisions around retention.

Another limitation included the subjectivity of the Therapeutic Alliance scale included in the vignettes, as there were no descriptions for numbers on the scale in between the main values of 1/10, 5/10, or 10/10. People's different perceptions of the numbers in between could have skewed the results, which should be taken into consideration in future DD studies that assign values to a scale. Future research that uses DD in this manner could define every value on the scale so that it is less up to participant interpretation. Finally, another limitation was the participant screening as offered by Prolific, as it included all people "currently receiving or waiting to receive treatment for symptoms of a mental health condition." These two groups of people could have different preferences when it comes to therapy length and therapeutic alliance, which could have skewed the data as well. Future research could look at these preferences with just one of these groups, or even see how these groups' preferences differ.

Another limitation of this study included assumptions made about participants' motivation to participate in therapy due to their current state of "receiving therapy" or "waiting to receive therapy." Because clients in these groups might have been forced, coerced, or encouraged to seek treatment, future studies should assess participants on their motivation rather than assuming motivation. Additionally, although therapy durations of 4, 8, and 12 were based on when clients showed improvements in anxiety in Gallagher et al. (2020), the baseline of 4 weeks may be unrealistically short, especially for participants who had already been in therapy for more than 4 weeks. Future research should assess participants on their expectations for therapy duration. Finally, the polarity of the rating scale, with the "unbonded" side meaning that the therapist does not respect or like them, might have pushed clients to the "close to neutral" ground. It is important to consider that this aversive "unbonded" label might have played a role in the findings.

Strengths

This study also included various strengths. First of all, this was one of the first studies to examine preferences for therapeutic alliance and therapy retention in clients who are in the Action and Maintenance stages of the Prochaska and Diclemente's (1983) Stages of Change Model. For this reason, this study grants a unique perspective on client preferences and retention based on people who are ready to attend and stay in therapy, rather than a broad sample that includes people who may not be in the mindset of attending therapy at all. Furthermore, while other studies (Barber et al., 2001; Brocato, 2004; Levin et al., 2024; Meier et al., 2024; Sijercic et al., 2021) have looked at how therapeutic alliance directly affects dropout or therapy outcomes, this study was the first to weigh the levels of therapeutic relationships that clients want against the amount of time that clients want to attend therapy.

Implications

The results of this study indicate that clients are willing to go to therapy for longer when they have at least a moderate bond with their therapist, and that when clients do feel that they have a bonded therapeutic bond with their therapist, they would rather go therapy for a longer period of time than a shorter period of time (4 weeks as opposed to 8 and 12 weeks). This specific timeframe for therapy was specifically selected because of Gallager et al.'s (2020) findings that, in cognitive behavioral therapy for anxiety, people tend to show increases in well-being (and related anxiety) at week 8 and again at week 12 compared to week 4 of treatment, thus we assumed treatment would be comparably effective at this timeframe for this study. Because this study screened its participants to be in the Action and Maintenance stages of the Prochaska and Diclemente's Stages of Change Model (and they therefore had self-motivation to make positive changes in their lifestyle to improve their mental health), this study highlights that therapeutic alliance may not be as important to clients in retention than their own self-motivation to remain in therapy (Brocato, 2004). This could also suggest that, when a therapeutic relationship is high, clients may prefer to attend the therapy for longer in order to maintain an ongoing relationship with their therapist. All of these findings are important for clinicians to consider when they are forming relationships with their clients, as previous literature has been mixed on whether therapeutic alliance affects clients' retention in therapy or not.

Future Directions

Along with the suggestions made in the limitations paragraph above, there are several other future directions

that researchers could take from this study. First of all, the lack of consistency in research findings on whether the client–therapist alliance plays a role in client retention in therapy or not suggests that further research should be done on this topic in general. For example, Meier et al. (2024) and Sijercic et al. (2021) found that the client therapist alliance does play a role in client retention, while Barber et al. (2001) and Brocato (2004) showed that there is no relation between the two. These inconsistencies may be due to various other factors that go into therapy attendance such as client self-motivation to attend therapy and client preferences for the type of therapy itself, as shown in Brocato (2004) and Barber et al. (2001). A study that takes client self-motivation, client preferences for type of therapy, and therapeutic alliance into account when it comes to client retention could give further insight into how these variables interact and influence client retention. In addition, researchers could also look at how individual factors such as age, gender, race, income, and other demographic factors may play a role in people's preferences surrounding therapeutic alliance and length of therapy. For example, it could be hypothesized that females may have a larger preference for a strong bond with their therapist than males, and may be more willing to go to therapy for longer in order to pursue this bond. Also, in terms of income, it could be hypothesized that people with low incomes are more likely to discount the therapeutic bond than people with high incomes, choosing the shorter therapy with a less bonded therapist over the longer therapy with a more bonded therapist because of financial factors. Furthermore, it may be of interest to study how people's current state of stress, depression, and anxiety play a role in how long they are willing to go to therapy and their preferences for a therapeutic alliance. Ultimately, an understanding of the individual client and client–therapist factors that are associated with client retention will result in better clinical outcomes for clients.

References

Anderson, S. R., Tambling, R., Yorgason, J. B., & Rackham, E. (2018). The mediating role of the therapeutic alliance in understanding early discontinuance. *Psychotherapy Research, 29*(7), 882–893. https://doi.org/10.1080/10503307.2018.1506949

Barber, J. P., Luborsky, L., Gallop, R., Crits-Christoph, P., Frank, A., Weiss, R. D., Thase, M. E., Connolly, M. B., Gladis, M., Foltz, C., & Siqueland, L. (2001). Therapeutic alliance as a predictor of outcome and retention in the National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Journal of Consulting and Clinical Psychology*, *69*(1), 119–124. https://doi.org/10.1037//0022-006x.69.1.119

Bose, D., Pettit, J. W., Silk, J. S., Ladouceur, C. D., Olino, T. M., Forbes, E. E., Siegle, G. J., Dahl, R. E., Kendall, P. C., Ryan, N. D., & McMakin, D. L. (2023). Therapeutic alliance, attendance, and outcomes in youths receiving CBT or client-centered therapy for anxiety. *Journal of Clinical Child and Adolescent Psychology,* 1–11. https://doi.org/10.1080/15374416.2023.2261547

Brocato, J. (2004). *Predictors of client retention in alternative-to-prison substance abuse programs* [ProQuest Information & Learning]. In Dissertation Abstracts International Section A: Humanities and Social Sciences (Vol. 65, Issue 5–A, p. 1963). https://digitalcommons.fiu.edu/dissertations/AAI3134099/?utm_source=chatgpt.com

Calsyn, R. J., Klinkenberg, W. D., Morse, G. A., & Lemming, M. R. (2006). Predictors of the Working Alliance in Assertive Community treatment. *Community Mental Health Journal*, *42*(2), 161–175. https://doi.org/10.1007/s10597-005-9022-7

Chadwell, M. R., Sikorski, J. D., Roberts, H., & Allen, K. D. (2019). Process versus content in delivering ABA services: Does process matter when you have content that works? *Behavior Analysis: Research and Practice*, *19*(1), 14–22. https://doi.org/10.1037/bar0000143

Cheng, T. C., & Lo, C. C. (2018). A longitudinal analysis of factors associated with therapeutic alliances. *Community Mental Health Journal*, *54*(6), 782–792. https://doi.org/10.1007/s10597-017-0229-1

da Matta, A., Gonçalves, F. L., & Bizarro, L. (2012). Delay discounting: Concepts and measures. *Psychology & Neuroscience, 5*(2), 135–146. https://doi.org/10.3922/j.psns.2012.2.03

Dimic, T., Farrell, A., Ahern, E., & Houghton, S. (2023). Young people's experience of the therapeutic alliance: A systematic review. *Clinical Psychology & Psychotherapy*, *30*(6), 1482–1511. https://doi.org/10.1002/cpp.2885

Flückiger, C., Del Re, A. C., Wampold, B. E., Symonds, D., & Horvath, A. O. (2018). How central is the alliance in psychotherapy? A multilevel longitudinal meta-analysis. *Journal of Counseling Psychology, 65*(4), 601–617. https://doi.org/10.1037/cou0000258

Gallagher, M. W., Phillips, C. A., D'Souza, J., Richardson, A., Long L. J., Boswell, J. F., Farchione, T. J., & Barlow, D. H. (2020). Trajectories of change in well-being during cognitive behavioral therapies for anxiety disorders: Quantifying the impact and covariation with improvements in anxiety. *Psychotherapy*, *57*(3), 379–390. https://doi.org/10.1037/pst0000283

Giallorenzo, J. (2024). Cultural preferences in the therapeutic alliance [ProQuest Information & Learning]. In *Dissertation Abstracts International: Section B: The Sciences and Engineering* (Vol. 85, Issue 6–B).

Lempert, K. M., Porcelli, A. J., Delgado, M. R., & Tricomi, E. (2012). Individual differences in delay discounting under acute stress: The role of trait perceived stress. *Frontiers in Psychology*, *3*. https://doi.org/10.3389/fpsyg.2012.00251

Levin, A. W., Lancelotta, R., Sepeda, N. D., Gukasyan, N., Nayak, S., Wagener, T. L., Barrett, F. S., Griffiths, R. R., & Davis, A. K. (2024). The therapeutic alliance between study participants and intervention facilitators is associated with acute effects and clinical outcomes in a psilocybin-assisted therapy trial for major depressive disorder. *PLOS ONE*, *19*(3). https://doi.org/10.1371/journal.pone.0300501

Littauer, H., Sexton, H., & Wynn, R. (2005a). Qualities clients wish for in their therapists. *Scandinavian Journal of Caring Sciences*, *19*(1), 28–31. https://doi.org/10.1111/j.1471-6712.2005.00315.x

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*(3), 438–450. https://doi.org/10.1037/0022-006X.68.3.438

Meier, P. S., Donmall, M. C., Barrowclough, C., McElduff, P., & Heller, R. F. (2005). Predicting the early therapeutic alliance in the treatment of Drug Misuse. *Addiction*, *100*(4), 500–511. https://doi.org/10.1111/j.1360-0443.2005.01031.x

Meier, S. T. (2023). A model of the early therapeutic environment: Predicting client attrition. *Journal of Psychotherapy Integration, 33*(3), 235–247. https://doi.org/10.1037/int0000293

Meier, S. T. (2024). Replication of relations among working alliance, distress and attendance variables. *Counseling & Psychotherapy Research, 24*(4), 1345–1356. https://doi.org/10.1002/capr.12754

Myerson, J., Green, L., & Warusawitharana, M. (2001). Area under the curve as a measure of discounting. *Journal of the Experimental Analysis of Behavior, 76*(2), 235–243. https://doi.org/10.1901/jeab.2001.76-235

Odum, A. L. (2011). Delay discounting: I'm a k, you're a k. *Journal of the Experimental Analysis of Behavior, 96*(3), 427–439. https://doi.org/10.1901/jeab.2011.96-423

Paap, D., & Dijkstra, P. U. (2017). Working Alliance Inventory-Short Form Revised. *Journal of Physiotherapy, 63*(2), 118. https://doi.org/10.1016/j.jphys.2017.01.001

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51*(3), 390–395. https://doi.org/10.1016/j.jphys.2017.01.001

Prochaska, J. O., & Norcross, J. C. (2002). Stages of change. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 303–313). Oxford University Press.

Prusiński, T. (2024). The linear pattern of therapeutic alliance development: Exploring the relationship between alliance trajectories over time and the

outcomes of systemic psychotherapy treatment for adaptation disorders. *Counselling and Psychotherapy Research, 24*(4), 1322–1336. https://doi.org/10.1002/capr.12753

Sijercic, I., Liebman, R. E., Stirman, S. W., & Monson, C. M. (2021). The effect of therapeutic alliance on dropout in cognitive processing therapy for posttraumatic stress disorder. *Journal of Traumatic Stress, 34*(4), 819–828. https://doi.org/10.1002/jts.22676

Sharf, J., Primavera, L. H., & Diener, M. J. (2010). Dropout and therapeutic alliance: A meta-analysis of adult individual psychotherapy. *Psychotherapy Theory, Research, Practice, Training, 47*(4), 637–645. https://doi.org/10.1037/a0021175

Swift, J. K. (2010). *Client preferences and the specific versus common factors debate* (Doctoral Dissertation, Oklahoma State University). https://shareok.org/bitstream/handle/11244/6978/Swift_okstate_0664D_10400.pdf?sequence=1

Swift, J. K., & Callahan, J. L. (2009). A delay discounting model of psychotherapy termination. *International Journal of Behavioral Consultation and Therapy, 5*(3–4), 278–293. https://doi.org/10.1037/h0100889

Swift, J. K., & Callahan, J. L. (2010). A comparison of client preferences for intervention empirical support versus common therapy variables. *Journal of Clinical Psychology, 66*(12), 1217–1231. https://doi.org/10.1002/jclp.20720

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APPENDIX A

Vignette Based on the Delayed Discounting Framework to Set Up Preference Questions for Therapeutic Alliance and Length of Therapy

Instructions:
For each question, imagine you have been struggling with anxiety in your everyday life. You will be given the option of choosing a treatment that lasts 4 weeks with a therapist you would rate your bond with as a 10/10 (see scale below), or a treatment that lasts 8 weeks with a therapist you would rate your bond with as a ___/10 (see scale below). Keep in mind that both therapies have high recovery rates, and that you are estimated to make the same amount of progress by the end of both. Please base your rating using the scale below.

1 = You do not feel bonded with your therapist. You do not believe that your therapist likes you, nor do you like your therapist. You do not feel as though you and your therapist work together to solve your problem nor do you have similar goals for the therapy. Overall, you do not feel like your therapist respects you.

5 = You feel neutral towards your therapist. You do not think your therapist likes or dislikes you, and you do not necessarily like or dislike your therapist. You kind of feel like you and your therapist work together to solve your problem and have similar goals, but you aren't really sure. You are unable to tell if your therapist respects you or not.

10 = You feel very bonded with your therapist. You believe your therapist likes you, and you like your therapist. You feel as though you and your therapist work together to solve your problem and that you share similar goals for the therapy. You feel as though your therapist respects you.

APPENDIX B

Delayed Discounting Preference Questions Following Vignette

This Participant chose to remain in the 4-week therapy with a neutral bond (5/10) with their therapist until the longer, 8-week therapy offered a 7/10 bond with their therapist. In this case, the person made the switch to the longer therapy when it could offer in between a 6/10 and a 7/10 level bond. Their indifference point would therefore be 6.5 (the average of 6 and 7), indicating that the person would rather stay in a shorter, 4-week therapy with a neutral therapist (5/10) until the longer, 8-week therapy offered a therapeutic bond of 6.5/10.

Which would you prefer?
☒ ~~4 week treatment with a therapist you would rate your bond with as 5/10~~
☐ 8 week treatment with a therapist you would rate your bond with as a 1/10

Which would you prefer?
☒ ~~4 week treatment with a therapist you would rate your bond with as 5/10~~
☐ 8 week treatment with a therapist you would rate your bond with as a 2/10

Which would you prefer?
☒ ~~4 week treatment with a therapist you would rate your bond with as 5/10~~
☐ 8 week treatment with a therapist you would rate your bond with as a 3/10

Which would you prefer?
☒ ~~4 week treatment with a therapist you would rate your bond with as 5/10~~
☐ 8 week treatment with a therapist you would rate your bond with as a 4/10

Which would you prefer?
☒ ~~4 week treatment with a therapist you would rate your bond with as 5/10~~
☐ 8 week treatment with a therapist you would rate your bond with as a 5/10

Which would you prefer?
☒ ~~4 week treatment with a therapist you would rate your bond with as 5/10~~
☐ 8 week treatment with a therapist you would rate your bond with as a 6/10

Which would you prefer?
☐ 4 week treatment with a therapist you would rate your bond with as 5/10
☒ ~~8 week treatment with a therapist you would rate your bond with as a 7/10~~

Which would you prefer?
☐ 4 week treatment with a therapist you would rate your bond with as 5/10
☒ ~~8 week treatment with a therapist you would rate your bond with as a 8/10~~

Which would you prefer?
☐ 4 week treatment with a therapist you would rate your bond with as 5/10
☒ ~~8 week treatment with a therapist you would rate your bond with as a 9/10~~

Which would you prefer?
☐ 4 week treatment with a therapist you would rate your bond with as 5/10
☒ ~~8 week treatment with a therapist you would rate your bond with as a 10/10~~

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