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Assessment of Subjective Client Agency in Psychotherapy: A Review

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MAJOR CONTRIBUTION

Assessment of Subjective Client Agency in Psychotherapy: A Review

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Theoretical accounts of psychotherapy, especially of a constructivist or humanistic sort, often assert the importance of the client's active efforts in "making therapy work." Psychotherapy research also supports the importance of the client's contribution to therapy outcomes. Research on subjective client agency, defined as a client's expectations for taking an active role in psychotherapy, is limited, however. This review describes and evaluates the psychometric qualities of six measures of this construct and provides recommendations for future research. Three of these measures are particularly suitable for further work by constructivist investigators of therapy process and outcome, a topic too rarely studied in the literature to date. Those studies that exist suggest that agency is positively related to the therapeutic alliance but does not directly affect therapy outcome. Additional process-outcomes studies in this area are warranted and could benefit from placing client agency in a broader framework that views therapy, and even therapy supervision, as an active process of mutual inquiry.

A medical model of psychotherapy in which "patients" with discrete disorders receive "treatment" from technical experts has been a major force in applied psychology in past years. At the same time, all major psychotherapy theories, and constructivist theories in particular, appear to value and actively seek to facilitate the personal agency of therapy consumers (Williams & Levitt, 2007). Although the medical model has proven culturally compelling, there is much evidence to suggest that it is drastically incomplete, if not incorrect (Cooper, 2008; Hubble, Duncan, & Miller, 1999; Wampold, 2001). As has long been recognized by constructivists (Bannister & Fransella, 1986), the contrasting conception of "inquiring man" casts psychotherapy clients, no

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less than scientists, as active, hypothesizing, and experimenting agents seeking to envision, enact, and evaluate alternative constructs for organizing their identities in the social world. Similarly, proponents of a contextual or common factors model of therapy have suggested that mastery, or a sense of control, is an essential aspect of mental health, and that regaining mastery after a period of demoralization is a basic mechanism of therapeutic change (Frank, 1982).

A view of the client as using psychotherapy as part of an “active self-healing” effort (Bohart, 2000; Bohart & Tallman, 1999) fueled by intrinsic internal resources has been especially emphasized in humanistic and constructivist therapies. In these traditions, clients are considered experts on their own needs and are often seen as competent to determine the best way to achieve their goals. Humanistic models allow that clients’ self-healing systems may be temporarily impaired (Frank, 1982), but even at such times, the function of therapy and the therapist is to augment or help restore the client’s own power (Orlinsky, 1989). Both classical (Kelly, 1955) and contemporary (Neimeyer, 2009) constructivist therapies likewise accord clients considerable agency in the construction and deconstruction of the problem, as do solution-focused perspectives (Hoyt, 2003). Ecker’s coherence therapy (Ecker & Hully, 1996; Ecker, Ticic, & Hully, 2012) is perhaps the most explicit of constructivist perspectives in underscoring agentic intentionality of therapy clients, even when this is seen as partly or wholly unconscious and implicated with symptom production.

Although humanistic and constructivist therapies have been the most conspicuous champions of client agency, most, if not all, other approaches appear to value it highly as well. Therapies rooted in depth psychology, such as the San Francisco Psychotherapy Research Group’s control mastery theory (Rappoport, 2002) and Bandura’s (1997) cognitive behavioral focus on the construct of self-efficacy, consider clients as agents seeking greater competency in the context of therapy. Frequent discussion in clinical conferences about whether a client is “working,” and the related question of whether a therapist is working harder than the client—usually viewed negatively—is another indicator of the transtheoretical value placed on client agency. The goal of the present article is to synthesize research on several alternative measures of subjective client agency to facilitate further process-outcome research on psychotherapy in general and on constructivist psychotherapy in particular.

SUBJECTIVE CLIENT AGENCY

Beyond this general agreement about the importance of the client’s role in effecting change, Bohart and Tallman (1999) have made a formal case for client agency as a “common factor” leading to positive psychotherapy outcome. Relying mostly on indirect evidence, they argue that clients’ ability to use the conceptual and practical resources provided by therapists helps account for the similar effect sizes observed across therapeutic modalities in outcome research. Extending this argument one step further leads to a focus on subjective client agency. If clients are active self-healers, it may be that viewing themselves and their role in this way can lead them to use therapy more effectively. Several factors might mediate a connection between subjective client agency and outcome measures, including increased client activity, experiencing mastery, and therapist perceptions. Subjective client agency is the focus of this review.

Recent overviews of psychotherapy research have concluded that client factors account for a substantial proportion of variance in therapy outcome, and that this proportion likely exceeds

that due to the specific techniques given center stage by the medical model (Asay & Lambert, 1999; Cooper, 2008). For example, Orlinsky, Ronnestad, and Willutski (2004) identified multiple aspects of clients' active involvement in treatment that were linked to more positive outcomes, including verbal activity, "cooperation," and contribution to the therapeutic bond. These authors argued that "the quality of the patient's participation in therapy appears to emerge as the most important determinant of outcome" (p. 324).

Evidence for the importance of client attitudes congruent with these findings is limited in both quantity and quality, however. Comparatively little research has used the term "client agency." A series of qualitative studies by Rennie (1992, 1994, 2000, 2001, 2008) documents instances in which clients exert "covert" control over aspects of the therapy process, especially by choosing what and when to share with their therapists. Another program of research by Adler and colleagues identified personal agency as a key theme in written narratives of an earlier therapy for study participants with the highest levels of both well-being and ego development (Adler & McAdams, 2007). A subsequent study (Adler, Skalina, & McAdams, 2008) replicated these findings with a new batch of therapy narratives and found that higher agency ratings were positively associated with subjective well-being after controlling for multiple other factors, including current mood and narrative coherence, as well as satisfaction with treatment and participants' ratings of the therapist's competence.

In contrast to the coherence of these two programs of research, quantitative literature on agency is characterized by diverse measures that may not be directly comparable. In addition, only a small subset of studies that included operational definitions of subjective client agency has tested the relationship between this construct and therapy outcome. Research on client expectations has distinguished clients' "role expectancies" from "outcome expectancies." Role expectancy research examines clients' expectations about both their own role in the therapy process and the role of their therapist. However, actual operational measures of client agency remain rare within this body of work. Similarly, role induction studies that have manipulated client expectations for psychotherapy prior to treatment have usually failed to distinguish client agency from other client expectations. A recent review by Delsignore and Schnyder (2007) introduced an additional category of client expectancies labeled "control expectancies," which is related to but still broader than the subjective client agency construct. This category draws on research within the locus of control tradition, and encompasses global expectations for control as well as specific expectations for control over one's problems.

Given the limitations of the current evidence base, our review focused on evaluating existing options for assessment of subjective client agency, as well as on providing recommendations for future research that can support stronger conclusions about the nature of this construct and its relation to outcome, particularly in the context of constructivist psychotherapy.

METHOD

Development of a preliminary definition of client agency was an initial step in defining the scope of the review. Client agency was conceptualized as expectations related to the active, purposeful use of psychotherapy to meet needs, solve problems, and make life changes. A search of PsycINFO was conducted to identify relevant measures. Search terms included role expectancies or expectations, locus of control, perceived control, self-efficacy, responsibility,

autonomy, involvement, and engagement. In addition, several categories of outcome studies identified by Orlinsky and colleagues (2004) that may pertain to aspects of the client's agentic involvement in therapy were reviewed. These included studies of patient expectations, patient verbal behavior, resistance vs. cooperation in therapeutic work, patient's overall contribution to bond quality, patient role engagement/motivation, patient collaboration vs. directiveness/control, felt autonomy, and self-efficacy/personal growth.

RESULTS

Six measures were identified that bear on the construct of subjective client agency. Several related measures were determined not to fit the definition of agency used here, including those that assess clients' willingness to take general responsibility for finding solutions to their problems (e.g., Stepleman, Darcy, & Tracey, 2005) and autonomous motivation for treatment (e.g., Pelletier, Tuson, & Haddad, 1997). Measures of client expectations regarding the therapist's role, which may imply but do not directly assess clients' expectations about their own role, were excluded, as were observer and therapist-rated measures. Only published studies were considered, with one exception. Dissertation studies were used to help provide a preliminary characterization of the Self-Efficacy for Client Behaviors (SECB) scale, because they comprised five of six existing studies using this measure.

Sixty-three studies using the six measures were located. The Expectations about Counseling (EAC) and Psychotherapy Expectations Inventory–Revised (PEI-R) are older instruments that have been used extensively in psychotherapy research, although many studies do not report results separately for their subscales. In contrast, the other four measures are new or have been little used. An overview of the reliability and validity of each measure is provided below. In addition, data relating each measure to therapy process and outcome are summarized. Measures are presented in the order they were developed. An evidence table containing detailed information about all studies included is available upon request from the first author.

Audience Factor of the Psychotherapy Expectations Inventory–Revised

The original Psychotherapy Expectations Inventory (PEI; Rickers-Ovsiankina, Geller, Berzins, & Rogers, 1971) was designed to measure basic psychotherapeutic role expectations identified in previous empirical work. The authors conceptualized client expectations of “being taken care of,” “being straightened out,” and “being helped to help oneself” in terms of a developmental progression from client dependency to autonomy. Using this theoretical framework, they also created items to assess a final, fourth category of role expectation, designated “cooperative,” in which clients expect a relatively equal relationship with the therapist. In a subsequent study, Berzins (1971) created additional items and used principal component analysis to produce a revised form of the measure. The PEI-R includes four factors corresponding to the original taxonomy, labeled Approval, Advice, Audience, and Relationship. Audience is the only one of the four that qualifies as a measure of client agency as defined in this review. Respondents are asked to rate their role expectations using a 7-point scale anchored by *not at all (1)*, and *very*

strongly (7). Sample items include, “How strongly do you expect to feel as though you were ‘in charge’ of the hour?” and, “How strongly do you expect to lead the way in bringing up topics to talk about?” Audience portrays a client who sees therapy as an opportunity to initiate and direct a purposeful conversation. This role expectancy was labeled Self-Reliant in the original PEI (Rickers-Ovsiankina et al., 1971).

PEI-R Audience: Psychometric Properties

One additional exploratory factor analysis (Wallach & Farbshtein, 2001) and one confirmatory factor analysis (Bleyen, Vertommen, Steene, & Audenove, 2001) using translated versions of the PEI-R (Hebrew and Dutch) have been published since the original validation study by Berzins (1971). Both analyses generally supported the original factor structure of the instrument, although they found that “How strongly do you expect to feel like opening up without any help from your therapist?” loaded higher on the Relationship factor than on the Audience factor. Internal consistency statistics reported for Audience have been fairly good, however, with Cronbach’s alphas ranging from .73 (Scholl, 2002) to .93 (Tracey & Dundon, 1988). Test–retest reliability has been measured less often, but Tracey and Dundon reported that counseling center clients’ first-session Audience scores were correlated .60 with second-session scores obtained the following week.

Construct validity data for the PEI-R are somewhat unenlightening. Berzins (1971) concluded that Personality Research Form (PRF) scores and client and therapist ratings of pretreatment symptoms provided evidence of convergent and discriminant validity for the Audience role expectancy, depicting those who endorsed higher Audience scores as more dominant and less defensive, aggressive, and impulsive as well as less anxious and depressed, and more likely to be experiencing interpersonal problems that suggest relatively high functioning. However, none of these relationships was particularly strong, with Pearson correlation coefficients ranging from .11 to .18. Audience was not significantly related to the PRF Autonomy scale. More recent studies have failed to find associations for Audience with depression and anxiety (Aubuchon-Endsley & Callahan, 2009) and with college student autonomy and capacity for mature relationships (Scholl, 2002). Tracey and Dundon (1988) found that Audience was not significantly related to the corresponding factor of the Behavioral Correlates–Revised scale, which measures therapists’ perceptions of the PEI-R items.

Berzins (1971) also argued that the PEI-R is interpretable in terms of two broader underlying dimensions, “dependency upon others” (Approval and Advice factors) and “turning toward self and others” (Audience and Relationship factors). For example, whereas Audience and Relationship were not correlated with the Autonomy subscale of the PRF, Approval and Advice were both negatively related to it.

Two studies by Scholl (2002, 2006) speak to the question of how PEI-R scores vary with culture and ethnicity. Scholl used the PEI-R to examine role preferences, which have been distinguished theoretically and empirically from role expectations (Hayes & Tinsley, 1989; H. Tinsley & Westcot, 1990; Tracey & Dundon, 1988). Native American college students with a more secure cultural identity had higher preferences for Audience (Scholl, 2006). African-American students at a historically black institution had higher Audience expectations than did European-Americans from other Southeastern universities (Scholl, 2002).

PEI-R Audience: Implications for Therapy Process and Outcome

Although researchers assume that higher scores on Audience are beneficial, few studies have tied Audience to outcome measures. In Berzins's original large-scale validation study, Audience was the only PEI-R factor not related to a measure of client improvement after 1 month of brief therapy. In contrast, expectations for Approval, Advice, and Relationship were weakly but positively related to improvement, r 's .07–.13. However, Audience was positively related to client-rated rapport for this same group, $r = .20$, $p < .001$. Clients scoring higher on Audience were also less likely to be prescribed medication and more likely to be offered long-term treatment. Tracey and Dundon (1988) found that Audience scores were not related to initial client and counselor satisfaction or premature termination for 33 counseling center clients, but that *changes* in anticipations and preferences for Audience differed for a good-outcome versus a poor-outcome group. Expectations for Audience increased for the good-outcome group between the beginning and middle of therapy, and then remained steady between the middle and the end, whereas those for the poor-outcome group remained constant. However, these results were confounded by lower initial Audience expectations in the good-outcome group. Aubuchon-Endsley, and Callahan (2009) determined that both unusually high and unusually low Audience scores increased the likelihood of premature termination for a sample of 53 university clinic clients by a factor of 1.2. Again, however, Audience was a relatively poor predictor of this measure compared to the other PEI-R factors; dropout was 2.4 times as likely for those with unusual Approval scores, 3 times as likely for Advice, and 3.3 times as likely for Relationship. Finally, Lambert and Lambert's (1984) role induction increased both Audience expectations and client ratings of satisfaction and change, but did not directly test the relationship between these two effects.

PEI-R Audience: Summary

The PEI-R is one of the most frequently used expectancy instruments (Arnkoff, Glass, & Shapiro, 2002). The Audience factor appears to be a reliable measure of client expectations or preferences for their own verbal initiative. However, null results call into question the extent to which this construct may coincide with other possible measures of client autonomy or responsibility (Berzins, 1971; Scholl, 2002). In addition, Scholl's research highlights the principle that verbal activity may be valued differently in different cultural contexts. As with the other agency measures assessed here, there is relatively little outcome data available for Audience. What there is, however, does not suggest that Audience expectations have a direct role in producing improvement in therapy.

Responsibility Subscale, Expectations about Counseling—Brief Form

The Expectations about Counseling measure was intended to remedy shortcomings in previous research by surveying all important domains of client expectations, including expectations about the counselor, the client's own role, and the outcome of treatment (H. Tinsley, Workman, & Kass, 1980). H. Tinsley and colleagues (1980) used item analysis to winnow a pool of 203 items down to 135, assigned to 17 intercorrelated subscales. H. Tinsley (1982) subsequently reported psychometric data for a 66-item version of the instrument, whose subscales were all highly

correlated with their original counterparts. The Expectations about Counseling–Form B (EAC-B) has since become the most commonly used instrument for measuring counseling expectations (Hatchett & Han, 2006).

Hayes and Tinsley (1989) described the EAC-B's subscales in terms of four conceptual categories: client attitudes and behaviors (subscales for Motivation, Openness, and Responsibility), counselor attitudes and behaviors (Acceptance, Confrontation, Genuineness, Directiveness, Empathy, Self-Disclosure, and Nurturance), counselor characteristics (Attractiveness, Expertness, Trustworthiness, and Tolerance), and counseling process and outcome (Immediacy, Concrete-ness, and Outcome). Seven items were assigned to the Responsibility subscale in the original EAC, and four of these were retained in the EAC-B. Respondents are asked to rate their expectations using a 7-point scale anchored by *not true* (1), and *definitely true* (7). Sample items include, "I expect to take responsibility for making my own decisions" and, "I expect to ask the counselor to explain what he or she means." In keeping with the subscale's name, the common thread across the rather diverse content of the individual items appears to be a willingness to assume responsibility for actively using psychotherapy.

EAC-B Responsibility: Psychometric Properties

Much psychometric research with the EAC-B has focused on deriving second-order factors from scores on the 17 subscales, in part as a strategy to mitigate the risk of Type I error when running numerous statistical tests (Hatchett & Han, 2006). In contrast, only one study has factor analyzed the EAC-B items themselves. Rather than replicating the subscales identified by H. Tinsley and colleagues (1980), Hatchett and Han (2006) concluded that a 3-factor solution was the best fit for the 66 EAC-B items. Tinsley (1982) reported acceptable internal consistency for the EAC-B Responsibility subscale, $\alpha = .70$. Cronbach's alphas reported in subsequent studies range from .56 to .81 (Balabil & Dolan, 1992; Goldfarb, 2002; Hatchett & Han, 2006; Oliver, Hart, Ross, & Katz, 2001; Tinsley, Holt, Hinson, & Tinsley, 1991). Test–retest reliability was .47 across 2 months in two separate studies (Hatchett & Han, 2006; Tinsley, 1982).

Extensive construct validity data for the Responsibility subscale are available from numerous studies using the EAC and EAC-B. However, most investigated how expectations vary as a function of client and counselor characteristics such as gender, ethnicity, age, and religious beliefs, and the majority used analogue designs with undergraduate samples. Evidence regarding whether EAC-B scores vary according to student vs. client status is inconclusive but indicates a need for caution (Hardin & Subich, 1985; Subich & Coursol, 1985). In particular, Subich and Coursol (1985) found that clients had higher expectations for Responsibility than did an undergraduate group.

About half of the studies that have tested gender effects for the EAC and EAC-B have reported higher average Responsibility scores for women (Bleyen et al., 2001; Carter & Akinsulure-Smith, 1996; Cherbosque, 1987; Hardin & Yanico, 1983; Kunkel & Williams, 1991; Pecnik & Epperson, 1985; Subich, 1983; Subich & Hardin, 1985). Two studies that modeled the effects of both gender role and biological sex using the EAC or the EAC-B indicated that femininity is a better predictor of Responsibility than being female (Johnson & Knackstedt, 1993; Sipps & Janeczek, 1986). Studies of counselor gender have not yielded significant effects for Responsibility (Hardin & Yanico, 1983; Subich, 1983).

Studies focusing on ethnic and cultural variables have yielded mixed results for differences in Responsibility, suggesting that this is an area that needs further exploration. Kemp (1994) found that students at a historically black university had higher Responsibility scores than black students at a predominantly white university, and interpreted this result as indicating that a supportive environment promotes personal agency. Two studies have found a tendency toward lower expectations of Responsibility for Asians compared to other groups (Balabil & Dolan, 1992; Yuen & Tinsley, 1981). Bilingual students scored lower on a Spanish translation of the Responsibility subscale versus the original English items, suggesting there may be at least some cultural specificity to this construct (Buhrke & Jorge, 1992). However, other studies found no differences for comparisons between American and Mexican or Mexican-American undergraduates (Cherbosque, 1987; Kunkel, 1990). Carter and Akinsulure-Smith (1996) obtained null results for stage of white identity in undergraduates. Responsibility scores also did not vary by counselor race for African-American undergraduates (Watkins & Terrell, 1988).

Tests of most other client characteristics have yielded null results. No effects have been reported for client age (Goldfarb, 2002; Kunkel, Hector, Coronado, & Vales, 1989; Kunkel & Williams, 1991; Tinsley, Hinson, Holt, & Tinsley, 1990; Yuen & Tinsley, 1981), student athletics involvement (Miller & Moore, 1993), or history of trauma (Coursol, Lewis, & Garrity, 2001). Carter and Akinsulure-Smith (1996) identified a socioeconomic effect in an undergraduate sample, with working-class students scoring lowest on Responsibility. Studies focusing on religiosity have found higher expectations for Responsibility among Christian clients when compared with non-Christians (Pecnik & Epperson, 1985) but not for evangelical vs. nonevangelical Christians (Turton, 2004), and not for expectations for a Christian vs. a traditional counselor (Pecnik & Epperson, 1985).

Treatment parameters have also generally not predicted differences in Responsibility, including self-referral vs. supervisory referral (May, 1992), seeking career counseling vs. counseling for personal problems (Hardin, Subich, & Holvey, 1988; Hardin & Yanico, 1983; Lewis, 2001), and help giver type (Tinsley, Brown, St. Aubin, & Lucek, 1984).

Subich and Hardin (1985) found that undergraduates' Responsibility scores did not differ based on the amount they expected to pay for counseling, in contradiction of the traditional psychoanalytic principle that clients take more ownership of therapy when it costs more. Parham and Tinsley (1980) found that undergraduates expected to take more responsibility in consultation with a counselor versus a friend, but the magnitude of this effect was negligible, accounting for only 1% of observed variance. However, students did expect to take more responsibility in individual rather than group therapy (Subich & Coursol, 1985).

Several researchers have drawn attention to a need to go "beyond surface traits" (D. Tinsley, Hinson, Holt, & Tinsley, 1990) by linking theoretically richer constructs to the EAC subscales (Ægisdóttir, Gerstein, & Gridley, 2000; Craig & Hennessy, 1989). The few studies that have used measures conceptually related to the construct of client agency have yielded mixed results. D. Tinsley and colleagues (1990) tested the hypothesis that expectations for counseling would vary with psychosocial maturity in students, and found that more mature educational and career plans were associated with higher Responsibility scores, whereas a measure of mature lifestyle was not. In contrast, Craig and Hennessy (1989) found no relationship between Responsibility and an alternative developmental measure that assessed stage of conceptual functioning in terms of both abstract/concrete thinking and internal/external locus of evaluation in a sample of 60 counseling

center clients. Oliver and colleagues (2001) found that students with higher levels of adaptive perfectionism had slightly higher Responsibility scores.

A final source of construct validity data for Responsibility comes from factor analyses of adults' subscale scores for the English versions of the EAC and EAC-B. In studies reporting detailed results, Responsibility consistently loaded with client Motivation and Openness, as well as with Immediacy in the counseling process, Attractiveness of the counselor, and positive Outcome expectations (Ægisdóttir et al., 2000; Hatchett & Han, 2006; Hayes & Tinsley, 1989; D. J. Tinsley et al., 1991; H. Tinsley et al., 1980). Concreteness of the therapy process also loaded strongly on the same factor in two of these five analyses. Researchers have labeled this factor "personal commitment" or "client involvement." Taken together, the components of the Personal Commitment factor suggest a proactive, agentic, and optimistic client.

EAC-B Responsibility: Implications for Therapy Process and Outcome

Despite the relatively large number of published EAC-B studies, only one that reported subscale data also measured counseling process or outcome. Hardin and colleagues (1988) found that none of the EAC-B subscales predicted premature termination. Process and outcome studies at the factor level are also rare but suggest that higher Personal Commitment is associated with a better working alliance (Patterson, Uhlin, & Anderson, 2008; Tokar, Hardin, Adams, & Brandel, 1996).

EAC-B Responsibility: Summary

The individual subscales of the EAC-B, including Responsibility, have received relatively little focused research attention. Responsibility has shown relatively low internal consistency when administered as part of the whole instrument. It is unclear whether administering the subscale separately from the larger instrument would yield similar results. Parameters that may affect the modest temporal stability of Responsibility are also unknown. Construct validity data for the subscale consist of mostly negative results for theoretically irrelevant constructs. Most importantly, no evidence is available suggesting that Responsibility directly affects therapy process and outcome.

The Self-Efficacy for Client Behaviors Measure

The Self-Efficacy for Client Behaviors (SECB) scale (Longo, Lent, & Brown, 1992) operationalizes the construct of self-efficacy (Bandura, 1997) in the context of psychotherapy. Bandura's social cognitive theory defines self-efficacy as confidence in one's ability to perform a desired action. Self-efficacy is conceptualized as applying to one or more specific domains rather than as a general or global aspect of self-image. The SECB is treated as a measure of client agency in this review because it assesses clients' confidence in their own ability to perform active behaviors that influence the therapeutic process. Most notably, the SECB includes a cluster of items assessing clients' self-efficacy for communicating assertively with the therapist ("How sure are you that you could tell your counselor when you don't understand something he or she said, are upset with

him or her, or no longer need counseling?”). SECB items are rated on a 10-point scale anchored by *not at all sure* (0) and *completely sure* (9).

SECB: Psychometric Properties

Following an initial validation study (Longo, 1991; Longo et al., 1992), five unpublished dissertations have used the SECB. The SECB's 20 items were conceived as belonging to three categories, addressing clients' confidence in their ability to manage obstacles to therapy attendance, perform difficult in-session behaviors, and “take personal initiative in solving problems” (Longo et al., 1992). However, data available to date do not suggest the presence of more than one factor. Cronbach's alphas for the SECB have ranged from .90 to .97 (Longo et al., 1992; Matthews, 1997; McCreary, 1999; Pickus, 2000; Sheu, 2007). Two-week test–retest reliability for the SECB was .94 in the initial validation study (Longo, 1991).

Construct validity data reported in the original validation study (Longo, 1991; Longo et al., 1992) were generally consistent with the predictions of social cognitive theory. The SECB was positively associated with EAC Outcome and Motivation, and negatively associated with problem severity. The authors interpreted the lack of a significant relationship between the SECB and a measure of client self-esteem as a desirable confirmation of the new instrument's domain specificity. Dissertation studies have replicated the positive relationship with outcome expectations (Matthews, 1997; McCreary, 1999) and motivation (McCreary, 1999), as well as reporting positive associations for the SECB with measures derived from Prochaska and DiClemente's (1982) stages of change model (McCreary, 1999) and likelihood of seeking counseling (Matthews, 1997). Positive affect was also associated with higher SECB, whereas negative affect and attachment style were not (Sheu, 2007).

SECB: Implications for Therapy Process and Outcome

Longo and colleagues (1992) reported that client self-efficacy as measured by the SECB was associated with a reduced rate of client dropout, defined as the failure to return for a second session. This finding was partially replicated in one subsequent study (Pickus, 2000) but not in another (McCreary, 1999). Despite using a relatively small sample, Pickus (2000) obtained several significant results from testing the relationship of individual SECB items with attrition. Feeling confident about being able to remove obstacles to session attendance and cope with unpleasant feelings was associated with reduced dropout. The direction of the effect of a third SECB item was reversed: Higher self-efficacy for telling the counselor about being upset with him or her was associated with increased dropout. McCreary's (1999) study suggested a possible connection between client self-efficacy and termination of counseling due to successful resolution of presenting problems.

Sheu (2007) found that SECB scores predicted client ratings of session depth after the second session. In this study, the SECB was also related to second-session Working Alliance Inventory (WAI) ratings for both clients (Bond and Goal subscales) and therapists (Bond and Task subscales), as well as to collective counseling efficacy ratings for both groups. No relationship was found between SECB scores and session smoothness or change in the severity of target problem after the second session.

SECB: Summary

As a component of client agency, the construct of client self-efficacy is conceptually distinct yet complementary to explicit expectations of control or responsibility (EAC-B, TBK) and initiative (ARM, PEI-R). The most notable strength of the SECB is its theoretical relationship to a well-established body of research. Another strength is that the SECB's items refer to specific behaviors, although it does not necessarily follow that these are important to producing positive therapy outcomes. In fact, although the SECB has exhibited high internal consistency, the content of its items is quite diverse. In addition, only some of these items directly connote an agentic role for the client in the therapeutic process. Findings from the original validation study are promising but need to be augmented with further work. As with several other measures reviewed here, there is simply too little evidence to support definite conclusions about the SECB's relationship to therapy process and outcome measures. However, the results of the dissertation studies indicate that more work is warranted, especially to follow up on the associations observed with dropout and alliance.

Client Initiative Subscale of the Agnew-Davies Relationship Measure

The Agnew-Davies Relationship Measure (ARM; Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998) was created in an effort to improve on previous measures of the therapeutic relationship by designing a more comprehensive and focused measure of the alliance between client and therapist. Parallel versions of the ARM were developed for client and therapist: Each item refers to the same phenomenon from one or the other perspective.

Five ARM scales were formed using factor analysis, including the Client Initiative (CI) scale, which the authors described as concerning "the client's taking responsibility for the direction of the therapy" (p. 163). An earlier version of this scale was labeled "empowerment." In contrast to the other measures of client agency discussed in this review, the ARM is not a measure of expectations, but rather, asks participants to rate how they actually behaved in a session that has just taken place.

ARM CI: Psychometric Properties

Following a simultaneous components analysis, four items were assigned to the CI subscale. Two have redundant content and are highly correlated ("I take the lead when I'm with my therapist" and, "I take the lead and my therapist expects it of me"). Another two items were included with CI based on their content, although they did not load highly on any ARM factor ("I look to my therapist for solutions to my problems" and "My therapist expects me to take responsibility rather than be dependent on him/her"). ARM items are rated using a 7-point scale, anchored by *strongly disagree* (1) and *strongly agree* (7). Initial psychometric data for the current version of the ARM come from a British study comparing psychodynamic-interpersonal and cognitive-behavioral interventions for depression (the Second Sheffield Psychotherapy Project; Agnew-Davies et al., 1998). Internal consistency for the CI was relatively low, $\alpha = .55$. Test-retest reliability data are not available.

Client and therapist CI ratings were moderately correlated in this initial study. CI was less strongly related to the ARM's other components than those were to each other, and CI ratings had

the lowest average values. In subsequent studies, CI also had generally weaker relationships with alliance and outcome measures compared to the other ARM subscales (Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998; Stiles et al., 2002). In addition, CI was the only ARM subscale unaffected by a brief psychoeducational intervention for personality-disordered clients (Banerjee, Duggan, Huband, & Watson, 2006).

ARM CI: Implications for Therapy Process and Outcome

ARM CI data have been published in three studies since the initial report on the instrument, but two of these used data from the same sample and only one linked the ARM to therapy outcome. For clients taking part in the Second Sheffield Psychotherapy Project, CI was associated with improved self-rated social adjustment at posttreatment, $r = .34$, but not with depression, the Global Severity Index of the SCL-90-R, Inventory of Interpersonal Problems scores, or self-esteem (Stiles et al., 2002). At 3-month and 1-year follow up, CI was not significantly related to any outcome measure.

In a study comparing the ARM to the Working Alliance Inventory (WAI; Stiles et al., 2002), client-rated CI averaged over the course of treatment was correlated with client-rated WAI Tasks scale, $r = .50$, but not with WAI Bond or Goals. When session-by-session ratings were compared, client ratings of Initiative were weakly correlated with all three client-rated WAI scales. As often observed in previous alliance research, there were no significant cross-perspective associations (client vs. therapist vs. observer ratings) in this analysis.

ARM CI: Summary

Agnew-Davies and colleagues (1998) intentionally sought to create an ARM scale that reflects client agency, and conceptualized this as an aspect of the therapeutic alliance. However, they rightly characterized the CI scale as needing further development, especially in light of its low internal consistency. Based on the two of its four items that are highly correlated (but also literally redundant), “initiative” appears to be an appropriate label for this measure. But existing data are insufficient to support conclusions about the CI’s utility. At a minimum, the CI’s relatively low intercorrelations with the other ARM components and the WAI subscales indicate that it may not be best understood as an alliance component. In addition, preliminary results from the Second Sheffield Psychotherapy Project revealed mostly null results for tests of CI’s effect on outcome measures.

Patient Process Contribution Factor, Role Behavior Expectancy Ratings Measure

The Role Behavior Expectancy Ratings measure (Joyce, McCallum, Piper, & Ogrodniczuk, 2000) was designed to test how client and therapist expectancies affect alliance in time-limited, transference-focused therapy. Twelve items were created to refer to observable behaviors that can be verified by a lay observer. Both clients and therapists were asked to rate how frequently they expected themselves and their counterparts to perform these behaviors in session using a 6-point scale anchored by *very seldom* (1) and *very frequently* (6). Sample items include, “I expect that I

will suggest topics to talk about” and, “I expect that I will ask questions.” This measure does not appear to have been used since the initial validation study.

Patient Process Contribution: Psychometric Properties

Factor analysis for clients’ pretreatment role expectancy ratings resulted in the retention of one factor, named Patient Process Contribution (PPC). However, the authors emphasized that this analysis requires replication with larger samples. Items retained reflect general verbal initiative, whereas items that were excluded mainly referred to expectations of talking about particular subjects, such as “my sexual life” or “my childhood.” Cronbach’s alpha for the PPC items was .76. Test–rest data were not reported.

Construct validity data from the initial study are limited. The PPC factor was positively related to clients’ expectations for an active therapist, but not to their expectations about the content of the therapist’s discourse. PPC scores were also negatively related to congruence between clients’ and therapists’ expectations for a “supportive therapist.” Clients’ PPC scores were unrelated to therapists’ expectations for their own or their clients’ role behaviors.

PPC: Implications for Therapy Process and Outcome

In the initial study, Joyce and colleagues (2000) tested the relationship of the PPC factor against alliance over the course of therapy for clients with low vs. high quality of object relations (QOR). Alliance measures that failed to show significant variance were not analyzed further. For high QOR clients, expectations for contributing to the therapy process were positively associated with clients’ overall alliance ratings. In addition, for this high-functioning group, the alliance increased more over the course of therapy for those with lower PPC. Joyce and colleagues interpreted this finding by equating low PPC with pretreatment demoralization that may be relatively quickly ameliorated when clients feel understood by the therapist and become oriented to the therapy process. Conversely, they described clients with the highest PPC scores in terms of counterdependence, hypothesizing that this stance and therapists’ reactions to it might obstruct alliance growth. A curvilinear relationship in which both extremely low and extremely high expectations for agency may be maladaptive is implicitly posited here. There was no relationship between PPC and change in alliance ratings for the low QOR group. PPC scores were not tested against average alliance for this group, due to null results for the tests of alliance change.

PPC: Summary

Like the ARM and the SECB, the Role Behavior Expectancy Ratings scale has not yet been widely used and needs further validation. The connection between the PPC factor and client-rated therapeutic alliance demonstrated by Joyce and colleagues (2000) provides a rationale for further work using this measure, given that the positive link between alliance and therapy outcome is one of the best replicated findings in psychotherapy research (Orlinsky et al., 2004). This link was confirmed in an earlier study based on the same clinical trial for both overall alliance and alliance change (Piper, Boroto, Joyce, McCallum, & Azim, 1995).

Internality Scale of the Questionnaire on Control Expectancies in Psychotherapy (*Der Fragebogen zu Therapiebezogenen Kontrollerwartungen*, TBK)

Delsignore, Carraro, Mathier, Znoj, and Schnyder (2008) framed this instrument as a measure of control expectancies, which are distinguished from outcome expectancies and role expectancies. Building on locus of control research, control expectancies are defined as “the expectation that a consequence (e.g., clinical improvement) depends either on the patient’s own efforts (internality), on the therapist’s competence (powerful others), or on the influence of unforeseeable factors (chance).” In their 2007 review, Delsignore and Schnyder concluded that specific control expectancies (i.e., for problem behaviors) are positively related to therapy outcome, whereas global locus of control measures are not. Accordingly, the TBK was designed to assess the strength of clients’ beliefs about the determinants of specific aspects of therapy.

The TBK’s Internality subscale includes six items that address the client’s own agency in the therapeutic process. Items are rated using a 6-point scale anchored by *strongly disagree* (0) and *strongly agree* (5). Sample items include, “Whether I can handle my problem better after treatment ultimately depends on me” and, “It’s up to me to get the necessary support from my therapist to address my problem.”¹ Two additional related subscales were developed but have not been described in as much detail in studies published to date: six items assessed clients’ self-efficacy for the role described by the Internality items (*Handlungsbereitschaft*; TBK-H) and six measured the subjective importance ascribed to the same role (*subjektiven Wichtigkeit einer aktiven Beteiligung*; TBK-W).

TBK Internality: Psychometric Properties

Delsignore, Schnyder, and Znoj (2006) reported the first TBK data in a study of 221 outpatients receiving an initial assessment in a Swiss clinic. The authors reported that both exploratory and confirmatory factor analyses supported the theoretically expected three-factor structure; however, one limitation of their approach is that the same data were apparently used for both types of analyses. Cronbach’s alpha for the resulting version of the Internality subscale was .81. The test–retest correlation for a subsample of the validation study participants retested after 1 week was .76.

Across the TBK subscales, Internality was positively related to the subscales measuring therapy-specific self-efficacy (TBK-H) and importance of taking an active role (TBK-W), negatively related to expectations for the therapist’s control (Powerful Others), and not associated with Chance. In a subsample of anxiety-disordered clients, the TBK’s therapy-specific Internality scale was moderately positively correlated with general Internality, general self-efficacy, and life satisfaction, and moderately negatively correlated with depression and a short measure of overall psychological distress (SCL-9-K). Beck Anxiety Inventory scores did not affect TBK Internality in this sample. Internality did not vary across gender or age.

TBK Internality: Implications for Therapy Process and Outcome

A single additional published study using the TBK tested the association between pretreatment control beliefs and outcome following group treatment for social anxiety. No effects were observed

for social anxiety, global symptom severity, depression, or self-esteem at posttreatment. At 3-month follow up, Internality was associated with reduced social anxiety, and this relationship was partially mediated by global self-efficacy. However, in a regression model that controlled for pretreatment values of the outcome measures and included all three control expectancy factors, the relationship between Internality and social anxiety was no longer significant.

TBK Internality: Summary

As intended by its authors, the uniqueness and potential value of the TBK appear to derive from its specificity. Not only does the TBK assess internal locus of control with respect to the specific domain of psychotherapy, but the items also refer to specific aspects of therapy. The authors do not describe the basis for the formulation of these items, although for the most part they correspond to components of active participation seen in other measures. In the only treatment study that has used the TBK, some support was indicated for an association between Internality and one specific outcome measure; no relationship was observed for three other outcomes measures, two specific and one general. The usefulness of the TBK remains to be demonstrated in further work.

DISCUSSION

The content of the six measures identified in the psychotherapy research literature appears to encompass multiple facets of subjective client agency. The TBK Internality scale and CI factor of the ARM assess the construct most directly by explicitly measuring the extent to which clients see positive psychotherapeutic processes and outcomes as determined by their own activity or report “taking the lead” in a recent session. The Audience factor of the PEI-R and Patient Process Contribution factor of the measure developed by Joyce and colleagues (2000) assess subjective agency somewhat more indirectly, containing items that mainly reflect the clients’ verbal initiative or expectation that they will determine the direction of the therapeutic dialogue. In contrast, the items of the SECB and EAC-B Responsibility scale are more heterogeneous and denote additional types of active client behavior. The SECB is particularly notable in this respect, and is also unique in assessing client agency via the self-efficacy paradigm.

Psychometric Strengths and Weaknesses of Existing Agency Measures

From a psychometric perspective, the oldest and newest measures reviewed share several strengths (see Table 1). The PEI-R Audience factor and the TBK Internality scale are both internally consistent factors of a larger role expectancy instrument. The PEI-R was developed from within a clear and comprehensive theory of client role expectations, and several factor analyses have supported its current structure. Thus, comparison with the PEI-R’s other factors—Approval, Advice, and Relationship—can provide particularly interesting construct validity data for Audience. Similarly, the TBK Internality scale was developed using locus of control theory, and can be profitably compared with its own sister factors.

Like the TBK, the SECB derives from a strong research tradition and has produced promising initial construct validity data. The SECB also has excellent internal consistency, which is somewhat surprising given the wide range of its item content. The three other agency measures

TABLE 1
Reliability and Validity Data Quality for Six Measures of Client Agency

Measure	Internal consistency	Factorial validity	Construct validity
PEI-R Audience	++	+	+
EAC-B Responsibility	-	0	0
ARM Client Initiative	—	0	0
SECB*	++	+	+
PPC	+	+	0
TBK	++	+	+

Note: — = Poor; - = Questionable; 0 = Insufficient/Mixed; + = Acceptable; ++ = Good. PEI-R = Psychotherapy Expectancy Inventory-Revised; EAC-B - Expectations About Counseling-Brief; ARM = Agnew-Davies Relationship Measure; SECB = Self Efficacy for Client Behaviors; PPC = Patient Process Contribution; TBK = Control Expectancies in Psychotherapy-Internality.

* Includes unpublished dissertations.

reviewed have related strengths and weaknesses. The ARM CI subscale and EAC-B Responsibility scale both have rather lower internal consistency. In addition, in both cases the scope of the larger instrument they belong to is much broader than role or control expectancies. The EAC-B aims to measure *all* important domains of counseling expectations, whereas the ARM is intended to comprehensively survey dimensions of the therapeutic alliance. Thus construct validity data for CI and Responsibility based on the interrelations of the factors of their respective measures are less informative about client role expectations. The PPC factor developed by Joyce and colleagues (2000) has acceptable internal consistency and is notable for its association with alliance in high-functioning clients. Overall, however, the PPC appears to be substantially redundant to the PEI-R's Audience without offering unique advantages over it.

Summary of Substantive Findings

In general, construct validity data available for the six measures are weak. However, a handful of variables investigated to date may deserve further attention as possible predictors of client agency, including femininity (EAC-B Responsibility), global symptom severity (SECB and TBK Internality), depression (TBK Internality and PEI-R Audience), positive affect (SECB), and life satisfaction (TBK Internality). Studies of the EAC-B and SECB also suggest that agency is associated with higher motivation for counseling and more positive counseling outcome expectations, which are in turn associated with more positive therapy outcome (Arnkoff et al., 2002; Greenberg, Constantino, & Bruce, 2006).

More studies relating client agency to psychotherapy process and outcome data are needed. Only 13 of the studies reviewed tested agency against process and outcome measures. Agency did not predict global or specific outcome measures in these studies, with the exception of the TBK Internality factor's effect on social anxiety assessed 3 months following group treatment for this condition. In contrast, studies using several different measures suggest that client agency is associated with more positive client ratings of therapeutic alliance (PEI-R Audience, Berzins, 1971; SECB, Sheu, 2007; ARM CI, Agnew-Davies et al., 1998; Stiles et al., 2002; PPC, Joyce, et al., 2000). As noted above, there is strong empirical support for the positive relationship between

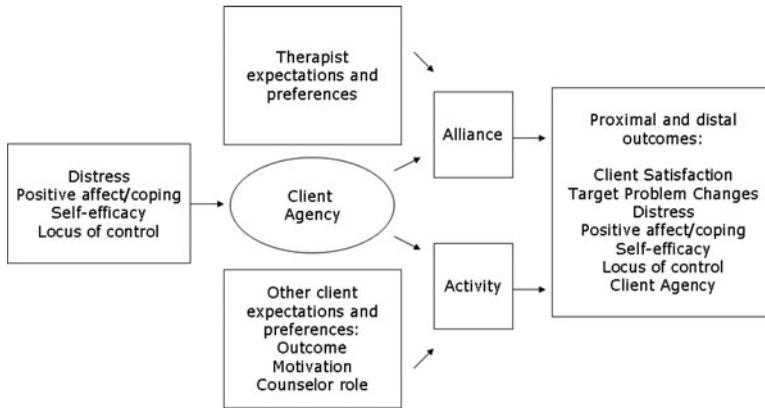


FIGURE 1 Elements of a model of client agency in psychotherapy.

alliance and therapy outcome. Overall, the research reviewed here also suggests that client agency may have a role in predicting dropout from therapy, although results are mixed, likely due to the notorious complexity of the phenomenon of dropout (Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008; Hatchett & Park, 2003).

Future Directions for Client Agency Research

To date, client agency has proven more theoretically than empirically compelling. However, additional work seems clearly warranted, especially given the positive associations with alliance observed in four of the six measures reviewed here. The PEI-R, TBK, and SECB are particularly suitable for immediate use in future research, which should prioritize linking agency directly with therapy process and outcome measures. Experimental designs that include both process and outcome measures, allowing testing of complex models of agency's impact (see Figure 1) on the therapy process, are optimal.

A basic model of client agency in psychotherapy should account for variables that may affect clients' initial subjective agency, especially distress and coping resources present at the outset of treatment. Agency should also be measured in concert with expectations for other therapeutic factors, such as outcome expectations and perceptions of counselor expertise. Another promising direction is the investigation of how subjective client agency may relate to clients' expectations concerning the therapist's role. For example, given Kelly's (1955) analogy between the relation of client and therapist on the one hand and student researcher and research supervisor on the other, clients with a strong sense of personal agency would be hypothesized to be especially predisposed to treatment orientations like the constructivist, which encourages bold testing of the implications of one's constructs.

Once therapy has begun, the basic prediction that client agency should lead to increased client effort and productive activity can be tested if measures of engagement, compliance, and verbal activity and initiative are included. In constructivist therapy, for instance, client agency would be expected to contribute to engagement in exploratory and elaborative procedures conducted both within sessions (e.g., laddering and experience cycle methodology) and between them in the

form of therapeutic homework (e.g., mirror time and fixed role therapy; Caputi, Viney, Walker, & Crittenden, 2012; Neimeyer & Winter, 2006), which would in turn be expected to contribute to more favorable outcome. It may be useful to investigate these process variables from multiple perspectives, as client, therapist, and observer ratings may not necessarily converge.

Based on existing research, it is also vital to further investigate how subjective client agency affects the therapeutic alliance, again as assessed by clients, therapists, and observers. Obtaining both proximal (postsession) and distal (posttreatment and follow up) outcome measures is also essential. Outcome measures should include both subjective and behavioral outcomes, for instance, by combining the strengths of repertory grid ratings in mapping resolution of cognitive conflicts in particular disorders (e.g., Dada, Feixas, Compañ, & Montesano, 2012) with well-validated measures of symptomatic improvement. In addition, assessing subjective client agency, global self-efficacy, and locus of control at posttreatment will allow modeling of how therapy itself affects these variables.

For practical reasons, developing procedures for increasing client agency should receive special attention. Subjective client agency is conceptualized here as an attitude that can change, rather than as a personality trait. Agency may be influenced directly using role induction procedures with clients before therapy begins or indirectly by asking therapists to alter their own behaviors to encourage client activity. Although the literature suggests that manipulating client expectations is quite feasible (H. Tinsley, Bowman, & Ray, 1988), previous attempts to manipulate the agency measures reviewed here have had mixed results (Lambert & Lambert, 1984; Sutton, 1998). In this regard, it would be interesting to evaluate whether constructivist counseling programs that incorporate several narrative and performative procedures for fostering clients' activity (e.g., DiLollo & Neimeyer, 2014) are more consistently successful in increasing their sense of agency, and with it contributing to more favorable outcome and maintenance of treatment gains.

ADDITIONAL METHODOLOGICAL CONSIDERATIONS

A wide range of methodological sophistication is represented in existing research on client agency. A few studies have directly addressed methodological problems in research on expectations (Hardin & Subich, 1985; Hayes & Tinsley, 1989; Subich & Coursol, 1985; H. Tinsley & Wescot, 1990), but there are many issues that need further attention. Delsignore and colleagues (2008) demonstrated that it may be important to investigate how agency expectations interact, for example, by assessing clients' expectations for their own agency in combination with their expectations for the therapist's role. Other work points to the value of modeling curvilinear as well as linear relationships between agency and outcomes (Aubuchon-Endsley & Callahan, 2009; Joyce et al., 2000; H. Tinsley, Bowman, & Barich, 1993; H. Tinsley et al., 1980).

Another methodological issue is the one addressed in Tracey and Dundon's (1988) and Joyce et al.'s (2000) studies, which examined changes in agency over time. In both studies, change measures had a different relationship with outcome measures than did initial or average levels of agency. Test-retest data for the measures reviewed are scarce but suggest that client agency may vary considerably over even brief intervals. Finally, more complex designs that consider how client agency may interact with or mediate the impact of therapeutic tasks or procedures, rather than have a simple linear impact on outcome, are worth considering. Further refinement

of the stronger measures identified in this review could provide the tools to pursue such research agendas.

In conclusion, although client agency is important in psychotherapy theory in general, and in constructivist and humanistic theories in particular, relatively little empirical study has focused on this construct. Existing measures have notable strengths but have not yet seen enough use to answer basic research questions, such as whether client agency relates directly or indirectly to therapy outcome. Future research should prioritize process-outcome studies to model how agency affects client behaviors, the therapeutic alliance, and short- and long-term outcomes of psychotherapy, especially in orientations that emphasize the role of client intentionality and activity in using therapy to effect personal change.

NOTE

1. The TBK is a German-language measure. For the purposes of this review, a preliminary English translation was created with the help of Aba Delsignore, from which the present sample items were drawn.

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