Cooper-Norcross Inventory of Preferences (C-NIP): Guidelines for Use (June 2019)

www.c-nip.net

Background

Research suggests that eliciting—and accommodating—clients' psychotherapy preferences make valuable contribution to outcomes. It is associated with large reductions in drop-out rates and medium improvements in clinical change[1,2].

The Inventory of Preferences (C-NIP) was developed by Drs. Mick Cooper (University of Roehampton) and John Norcross (University of Scranton) in 2015[3, 4] . The 4 scales were based on factor analysis and normed on both United Kingdom and United States samples. The measure was designed for use in clinical practice as a means of facilitating discussion with clients about their desired style of therapeutic engagement. It can also be used in supervision, research, and training.

About the C-NIP

The C-NIP can be used in an initial assessment or early session of psychotherapy/ counselling to facilitate an initial dialogue with clients about their therapy preferences. It can also be used in farther sessions at regular intervals (for instance, session 5 and session 10) and is particularly useful during a review session or routine outcome monitoring.

The C-NIP consists of two parts. The first part invites clients to indicate their preferences for how they would like a psychotherapist/counsellor to work with them on 18 items. The items are grouped into 4 bipolar scales: Therapist Directiveness vs. Client Directiveness, Emotional Intensity vs. Emotional Reserve, Past Orientation vs Present Orientation, and Warm Support vs. Focused Challenge. At the end of each scale is a scoring key, which calculates strong preferences in both directions.

The second part asks multiple open-ended questions about client preferences. For instance, clients are asked if they have strong preferences for the number of therapy sessions, the type of therapy format/modality, or anything they would particularly dislike.

Completion and scoring of the C-NIP typically takes 5 minutes. The length of the subsequent discussion and treatment planning varies considerably.

The C-NIP measure is free to use and is licensed under the Creative Commons Attribution-NoDerivatives 4.0 International licence. No permission is required. However, you are asked not to alter the form and to use the latest version (currently 1.1). The C-NIP developers are pleased to hear about your experiences using it; both good and bad.

Several studies provide evidence of the instrument's reliability and clinical validity[3,4]. For more information, see (3).

Completing the C-NIP

Administration formats.

The C-NIP can be completed online or on paper. Clients can complete the measure on a desktop, laptop, handheld device, or on their own phone (www.c-nip.net). The site will take the client through a series of questions, automatically score their responses, and produce a

brief report of the client's scores. This report serves the basis for the subsequent dialogue with the therapist (see below).

It can also be administered as a paper copy (which can be downloaded on the website) and scored by hand. Clients are handed the form and asked to circle one response for each of the 18 items. They are told to ignore, for now, the coloured scoring boxes. Clients are asked to check or circle any of the open-ended additional preferences at the end of the measure. When completed, the clinician scores the 4 scales and reviews the checked or circled open-ended preferences.

The initial invitation.

Clients can be verbally invited to complete the C-NIP in a variety of ways. For 4 examples:

- I have been conducting and researching psychotherapy for XX years, and we have learned the importance of tailoring or personalizing psychotherapy specifically to you. Here is a brief instrument that can help us do just that.
- We really want counselling to be as suited as possible to what you want. So we'd be grateful if you could spend a few minutes completing this questionnaire to tell us what that is.
- Let's determine your strong preferences for this therapy. Would you kindly take a few minutes to complete this form?
- Research attests that psychotherapy works best when it matches clients' preferences. Here's a brief, efficient way that we can begin that discussion.

Consistent with the C-NIP's emphasis on honouring client preferences, we do not *require* clients to complete the C-NIP. If a client indicates that they are not willing, interested, or ready to complete the form, then we respect that decision. The form can either be completed later in the psychotherapy/counselling or not at all.

Scoring.

Scoring the C-NIP is straightforward. Sum/total the 5 items constituting each scale (3 items for the past/present orientation scale). Then determine whether that scale score indicates a strong preference in either direction or no strong preference.

Scores which are marked with a minus should be subtracted from the total. For instance, if a client scores 3, 0, and -2, the total would be 1; if they score -2, -3 and 2, the total would be -3. For each scale, circle in the coloured scoring box whether clients have indicated a strong preference (in either direction) or no strong preference.

The C-NIP was normed so that approximately a quarter of client scores will fall into a strong preference on one side, another quarter into a strong preference on the other side of the scale, and the remaining one-half of scores into the average or no strong preference range.

Discussing the Scores

The subsequent dialogue with clients about any identified strong preferences is generally the most important part of the C-NIP process. Remember that the C-NIP scores are the starting point for a genuine exchange about how clients can get the most out of their psychotherapy. When strong preferences are identified, the clinician can reflect this back to the client and inquire further into its meaning. For instance:

- I can see here that you desire quite an emotionally intense therapy. Can you say more about that?

- Your responses suggest that you want me to challenge you. Is that right? What sort of challenge do you think might be helpful?
- You're keen to meet every two weeks. Do you have a sense of how that would be helpful to you?

It may also prove helpful to inquire into the origins of clients' preferences. This typically generates more context and meaning to their treatment desires. For instance:

Clinician: You indicated here that you want quite a directive approach, with lots of guidance and structure. Do you have a sense of why that is?
Client: Yes. The last counsellor I had was really nice, but she didn't say too much, and I found it all a bit… aimless and meandering. So I think this time I'd like someone who focused me more.
Clinician: So it's about, maybe, having someone to focus you. Is that right? [Client: Mm]. For instance, would it be helpful if I asked you at the start of each session what you'd like to work on?

Of course, there may be times when it is appropriate for clinicians to bring in their own knowledge and experience to the exchange. For example, if a client has been saying she frequently defers responsibility to others, and then on the C-NIP indicates that she has a strong preference for therapist directiveness, the therapist may inquire about potential parallels here. For instance:

Clinician: I can see here that you are asking for a directive approach.
Client: Yes, I feel like I just don't know my own mind.
Clinician: OK. I'm aware that you were saying earlier about being deferential to others and that's a real problem for you. I'm OK about being quite directive here; at the same time, I'm wondering if that's necessarily the best thing for you. Do you know what I mean? I wonder if it's going to end up being like the thing you say is really unhelpful.
Client: Uh… I– I get so lost. Particularly when I feel under pressure.
Clinician: I totally get that. Maybe there'll be something here about your own authority. Making, taking more decisions by yourself. And that might include here in therapy too.

On occasion, the clinician may also bring in research evidence. For instance, when clients indicate a strong preference for emotional intensity, then the psychotherapist may note that, indeed, emotional processing tends to be associated with improved outcomes[5, 6].

This discussion presents a valuable opportunity, particularly during an assessment session, for clinicians to indicate if they believe, or do not believe, that they can accommodate the client's strong preferences. When a client expresses a strong preference for therapist directiveness, for example, and the counsellor is committed to classical person-centred therapy, the clinician might say something like:

> I can see you strongly desire a psychotherapist who is going to structure and lead. That's not what I offer in my practice. My approach tends to be much more about allowing the client to take the lead. Is this something you would like to try, or should we talk about other options that better suit you?

It is essential that the therapist does not convey judgement about the client's therapeutic preferences. Clients should feel that their preferences are valued, whatever they indicate.

Using the C-NIP in Supervision

The client's C-NIP scores can be brought in to supervision to inform a discussion about treatment planning and selection—the best way of working with that particular client. Although patients' preferences represent a single consideration, an awareness of what the client wants can provide valuable insights into the best way forward. For instance:

Clinician:	I think, with Jasmine, she's finding it hard to connect with her emotions and a lot of what we do feels very 'heady.'
Supervisor:	Mm. Any sense of what might help her connect more emotionally?
Clinician:	I did think about two chair work. Just– I'm not sure whether she'd go for that or not.
Supervisor:	What did she put on her C-NIP about emotional intensity?
Clinician:	[Checks C-NIP]. Yes, she did say she wanted something emotionally intense.
Supervisor:	So she's mentioning that that is something she might be up for.

Frequently Asked Questions

Do I have to do whatever a client asks on the C-NIP?
Definitely not. As indicated above, the C-NIP serves as the basis for a dialogue, not as a set of commands. So if a client asks for things you can't do, don't want to do, or don't believe would be helpful, that all needs discussing.

What if a client has no strong preferences?
That may often be the case, particularly if the client has not had counselling/psychotherapy before. It is something that can be fed back to the client and discussed (without conveying that they *should* or *must* have strong preferences). A psychotherapist might say, "I noticed that you didn't have any strong preferences for therapy at this time, is that about right?"

The absence of strong initial preferences can denote many impressions, from clinical inexperience, to an unassertive interpersonal style, to cultural proscriptions, and the like. In many cases, it may reflect the fact that the client is intent on 'getting on' with psychotherapy and doesn't feel too strongly about how that's done (provided it works). In that case, prolonging a discussion about patient preferences may prove ineffective and, paradoxically, against what the client wants!

What if a client doesn't know what he or she prefers in psychotherapy?
That's fine, particularly among those new to psychotherapy. Again, clients should not be pressured into stating preferences if they are not ready or real. After a few sessions, many clients will determine what works and what does not work for them. Thus, we recommend periodically returning to assessing preferences.

My clients say that they want both of the things at the different ends of the dimensions.
As the C-NIP instructions specify, when clients hold equal or both preferences, they should circle 0. That indicates that there is not a strong preference in one direction or the other.

Why do I need to ask explicitly? Isn't it better to trust my intuitive sense of what a client's want?

Probably not. Clinicians no doubt pick up a lot from clients, but research consistently demonstrates that psychotherapists who intuit or assume their clients' treatment preferences, experiences, and outcomes are frequently incorrect[7, 8]. There may be a particular danger that we project or generalize onto our clients our own preferences for therapy. Research also shows that what mental health professionals desire, as clients, can be very different from what lay clients prefer[4].

But surely I can just talk about it with my clients? Why use a form?
Talking in session about preferences is fine; indeed, the overarching purpose of the C-NIP is to stimulate such discussions. Like many forms of clinical assessment, using a more comprehensive, standardized instrument with norms probably proves superior to talk alone. Clinical experience and research studies also attest that some clients find it easier to write than to tell it directly.

How do clients respond to taking the C-NIP?
In a study of clients' experiences of using the C-NIP, 10 of 15 clients (67%) described helpful aspects of using the measure. They said that it focused the therapy, facilitated communication with their clinician, supported the personalising of treatment, and allowed them to express themselves. Three of the 15 clients (20%) gave more mixed responses; for instance, 'I found it OK.' Five clients also highlighted unhelpful elements; in particular, that it was difficult to record preferences because they didn't know what their preferences were.

On a 1 (*very unhelpful*) to 5 (*very helpful*) scale, the clients gave the C-NIP an average score of 3.8. This suggests that typically clients find the C-NIP helpful, but there are some clients who do not. As indicated above, therefore, clients should be *invited* to use the measure, rather than *instructed* to. Care is particularly needed with clients who are new to psychotherapy.

And what about therapists?
In an interview study on an earlier version of this measure, the Therapy Personalisation Form[9], we found that clinicians were generally positive about its clinical utility. They thought that it was a helpful means of assessing what clients wanted from psychotherapy such that it could be tailored accordingly, and could also serve as valuable sources of reflection and learning about their own practices. In addition, therapists believed that the measure was empowering for clients and helped to move the therapeutic relationship forward. In terms of limitations, they thought that the form could lead to increased therapist self-criticism and over-moulding to the clients' wishes.

Is the measure valid and reliable in psychometric terms?
In our original study, we found adequate levels of internal reliability for the 4 C-NIP scales[3]. Subsequent research has suggested that the internal reliability may be weaker than we originally reported[4]. We are currently examining means to enhance the reliability of the scales while preserving the small number of items.

In future research, we will assess the patient utility and predictive validity of the measure. At the same time, remember that the C-NIP was primarily developed as a means of supporting dialogue on patient preferences, rather than as a definitive measure of wants. As such, we accord primary importance to the clinical utility of the inventory.

Why doesn't the C-NIP ask about things that a lot of my clients want, like empathy and acceptance?

Exactly. We know that nearly all clients want to be understood, valued, and not judged. Hence, we did not believe it would prove particularly informative to ask those questions.

Instead, we developed the scales by reviewing the responsiveness research and by asking therapists about practices that they would vary[9, 10]: that is, when knowing patient preferences could make a genuine difference in clinician practices and psychotherapy success.

References

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