ARTICLE

CLIENT CHOICE OF TREATMENT AND CLIENT OUTCOMES

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Participants in this study suffered from severe mental illness and were homeless at baseline. They were given their choice of five different treatment programs. The current study investigated two major questions: (1) what is the impact of positive expectancies about the efficacy of the chosen program on number of contacts with the chosen program and client outcomes; and (2) what is the impact of positive views about nonchosen programs (alternative choice variables) on contact with the chosen program and client outcomes. Client outcomes assessed were psychotic

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symptoms, days homeless, and client satisfaction. Positive expectancy variables were the number of reasons for choosing a program and confidence that the program would help. Alternative choice variables were the number of nonchosen programs visited and the attractiveness of a nonchosen program. Only the number of reasons for choosing the program was significantly related to program contact with the chosen program. Both of the positive expectancy variables and program contact were significantly correlated with consumer satisfaction. In general, neither the positive expectancy variables nor the alternative choice variables predicted changes in psychotic symptoms nor days homeless. © 2003 Wiley Periodicals, Inc.

Client advocates have been demanding more client choice in the selection of psychiatric treatment in the United States for several years. Many of the arguments advanced for the right of clients to choose their preferred method of treatment have their roots in American values of personal freedom and the right of self-determination. More recently, free market concepts have been used to advocate for more client choice in selecting psychiatric treatments. Free market proponents believe that treatment programs that operate as monopolies, whether publicly or privately funded, are less motivated by client needs than programs that operate in a competitive environment where clients can choose from several treatment providers. The study of commitment by social psychologists provides another argument for promoting client choice of treatments. A number of studies have shown that people become more committed to a course of action if they are allowed to choose between alternatives rather than being forced to select a given option (Brigham, 1979). Regardless of their theoretical or ideological heritage most advocates for greater client choice of treatment believe that client outcomes will be better if clients select their own treatment program.

Research on the efficacy of providing clients with a choice of treatment has assessed two categories of dependent variables: treatment process variables and client outcomes. Most research has shown that providing clients with a choice of treatment produces positive results on the treatment process variables. For example, researchers have reported that clients who had a choice of treatment were more likely to work harder (Langer & Rodin, 1976), have more contact with their treatment program (Calsyn, Winter, & Morse, 2000), were more likely to adhere to their treatment program (Thompson & Wankel, 1980), and were less likely to drop out of treatment (Rokke, Tomhave, & Jocic, 1999).

Past research on the effect of client choice on client outcomes, on the other hand, has produced mixed results. Positive effects of client choice have been demonstrated in weight loss of children (Mendonca & Brehm, 1983), increased sense of control and competence in older adults (Langer & Rodin, 1976), and reduced snake phobia (Devine & Fernald, 1973). However, client choice of treatment had no effect on outcomes with clients who had more serious and pervasive problems such as depression in older adults (Rokke, Tomhave, & Jocic, 1999), psychiatric symptoms in homeless clients (Calsyn et al., 2000), or cocaine addiction (Sterling, Gottheil, Glassman, Weinstein, & Serota, 1997).

The current study is not an experimental comparison of the effects of choice versus no choice. All clients in the current study were given their choice of five

different treatment programs. This study uses correlations and multiple regression to examine the relationship of various choice-related constructs on frequency of contact with the chosen program and client outcomes in a sample of individuals with severe mental illness who were homeless at intake. We divided the choice-related constructs into two categories: (1) positive expectancies about the chosen treatment program, and (2) alternative choice variables. The positive expectancy variables were: (a) number of reasons for choosing the program, and (b) confidence that the chosen program would help. The two alternative choice variables were: (a) the number of treatment options visited before selecting the chosen program, and (b) the attractiveness of the client's second choice. Client outcomes included client satisfaction, change in days homeless, and change in psychotic symptoms. Specific hypotheses and supporting rationale are provided below.

HYPOTHESIS 1: POSITIVE EXPECTANCIES ABOUT THE CHOSEN TREATMENT PROGRAM WILL BE POSITIVELY CORRELATED WITH FREQUENCY OF CONTACT WITH THE CHOSEN PROGRAM

Both laboratory and field research has consistently found that that individuals who have positive expectancies about the efficacy of an intervention work harder (Ajzen & Fishbein, 1974; Vroom, 1982). Similarly, psychotherapy researchers have found that expectancies about the efficacy of treatment correlate with therapy involvement (Garfield, 1994).

HYPOTHESIS 2: THE ALTERNATIVE CHOICE VARIABLES WILL BE POSITIVELY CORRELATED WITH FREQUENCY OF CONTACT WITH THE CHOSEN PROGRAM

We believed that higher scores on the two alternative choice variables would lead to greater commitment to the chosen program. Laboratory research has found that individuals increase their commitment more to the chosen option when choices were equally attractive than in the situation when the chosen option was a lot more attractive than the nonchosen option (Harvey, Harris, & Lightner, 1979). When two choices are nearly equal in attractiveness respondents experience the greatest amount of freedom, and consequently the greatest amount of personal responsibility for their choice. Like the laboratory researchers, we believed that clients would perceive the maximum amount of freedom when at least one of the nonchosen programs was nearly as attractive as the chosen program. This greater perceived freedom should result in clients assuming more responsibility for their own treatment and lead to more contact with their chosen program. We also believed that clients who visited more of the five treatment options prior to choosing their program were displaying greater involvement in their psychiatric care (commitment), which also would lead to more frequent contact with the chosen program.

HYPOTHESIS 3: POSITIVE EXPECTANCIES ABOUT THE CHOSEN PROGRAM WILL BE CORRELATED WITH CLIENT OUTCOMES

Psychotherapy researchers have generally found a positive relationship between positive expectancies and improvement in client outcomes, although some studies have

found no relationship between expectancies and client outcomes in therapy (Garfield, 1994). We believed that the impact of positive expectancies would be greater on client satisfaction than on days homeless and psychotic symptoms. Client satisfaction, like positive expectancies, is a subjective feeling that is more under the control of the respondent than either days homeless or psychotic symptoms. Decreasing homelessness requires external resources such as subsidized housing. Psychotic symptoms are a response to a biological disease that requires medication. Thus, positive expectancy variables may not be powerful enough, by themselves, to reduce psychotic symptoms and reduce homelessness.

HYPOTHESIS 4: THE ALTERNATIVE CHOICE VARIABLES WILL BE NEGATIVELY RELATED TO CLIENT OUTCOMES

We believed that clients who scored higher on the two alternative choice variables would be more likely to experience "consumer regret" than other clients. Typically, consumer regret is stronger (or more likely) when a consumer initially had a difficult time choosing between two attractive options (Beasley & Joslyn, 2001; Inman & Zeelenberg, 2002; Tsiros & Mittal, 2000). Thus, in the current study, consumer regret should be greater for: (1) clients who visited more programs before making their choice, and (2) for clients whose second favorite program was nearly as attractive as the chosen program. We believed that feelings of consumer regret would be activated when clients became angry or disappointed with their chosen program. Such disappointments might occur if the program did not provide a requested service (e.g., transportation), or took some action against the client that was perceived as punitive (e.g., banned the client from the office for attacking another client). We believed that client disappointment or anger with the chosen program would lead to less program contact by the client. Less program contact, in turn, would lead to a reduction in client satisfaction and poorer client outcomes (see Hypothesis 5).

HYPOTHESIS 5: MORE FREQUENT CONTACT WITH THE CHOSEN PROGRAM WILL BE POSITIVELY CORRELATED WITH CLIENT OUTCOMES

Support for this hypothesis is mixed. In general psychotherapy research has found a modest relationship with the number of sessions attended and client outcomes (Anderson & Lambert, 2001; Propst, Paris, & Rosberger, 1994). More relevant to the current study, however, is a study by Morse, Calsyn, Allen, and Kenny (1994), which evaluated the effectiveness of assertive community treatment with individuals who were homeless and suffered from severe mental illness. That study found a positive correlation between program contact and client satisfaction, but no relationship between program contact and other outcome variables.

METHODS

Sample

St. Louis was one of 18 sites chosen to participate in the national ACCESS project funded by the Center for Mental Health Services (Randolph et al., 2002). The ACCESS

project evaluated the efficacy of case management and systems integration strategies for improving the lives of persons with severe mental illness who were also homeless. During the first year of the project St. Louis participants were given their choice of five different treatment programs: (1) a community support model of case management operated by the local community mental health center; (2) a community support model of case management that served primarily African American consumers; (3) a program developed specifically for homeless individuals that used a modified version of the assertive community treatment model (Morse, Calsyn, Allen, Tempelhoff, & Smith, 1992); (4) a program based on the clubhouse model of psychiatric rehabilitation (Beard, Propst, & Malamud, 1982): (5) a well-established psychosocial rehabilitation program that provided a social club, supported housing, and vocational assistance (Sandall, Hawley, & Gordon, 1975).

Sixty-five of the 102 clients enrolled in the first cohort of the St. Louis ACCESS project provided data for from this study. Seventeen clients did not complete the initial choice questionnaire. Eight individuals were never linked to one of the five programs; four individuals moved out of the area before completing the initial choice questionnaire; five individuals who did receive treatment did not complete the initial choice questionnaire. An additional 20 clients who received some services did not complete the follow-up questionnaire that contained questions regarding program contact and client satisfaction.

The 65 clients who remained in the study (i.e., completed both questionnaires) were compared to the 37 clients who were dropped from the study on 23 background characteristics measured at intake. The two groups were significantly different ($p < .05$) on only two related variables. The clients who remained in the study had longer histories of homelessness and had been stably housed for fewer days in the past 2 months than the other consumers.

Measures

Positive Expectancies. Two positive expectancy variables were measured. One variable indicated the total number of reasons (maximum of eight) for selecting the chosen program; possible reasons included location, staff, housing services, mental health services, employment services, reputation of program, physical amenities, and other. Clients also indicated on a five-point scale how confident they were that the chosen program would help them solve their problems. On both scales higher scores indicated more positive expectancies.

Alternative Choice. The number of other programs (0–4) that clients visited prior to selecting their treatment program was one alternative choice variable. In addition, clients were asked to rate the attractiveness of their second favorite program compared to their chosen program. Clients were told to rate the second choice on a scale from 1–50 with the attractiveness of the chosen program set at 50.

Program Contact. Three months after intake clients indicated the number of times that they had had contact with the chosen program.

Outcome Measures. Psychotic symptoms and days homeless were assessed at intake and 12 months later. The psychotic symptom measure included 10 symptoms such as hearing voices, or delusions (Dohrenwend, 1982). Respondents reported on a five

point scale how frequently that they experienced each symptom (0 = never to 5 = very often); thus, scores could range from 0 to 50. Days homeless was measured as the number of nights out of the last 60 spent in emergency shelters, institutions (e.g., jail or hospital) and on the streets (e.g., abandoned buildings, parks, bus depots). At 3 months clients rated their satisfaction with the chosen program using the following three questions: (1) To what extent has the program met your needs? (2) If a friend were in need of similar help, would you recommend this program to him or her? (3) Have the services you received helped you deal more effectively with your problems? Clients responded to each question on a four-point scale with higher scores indicating more satisfaction. Coefficient alpha for this three item scale was .82.

Analysis Strategy

Bivariate correlations and multiple regression analyses were used to investigate the study hypotheses. In the regression equations predicting psychotic symptoms at 12 months and days homeless as 12 months, the baseline scores on these outcome variables were entered into the regression equation prior to entering the other predictor variables.

RESULTS

Table 1 displays means, standard deviations, and correlations for all of the variables. Table 2 summarizes results of the regression equations. There was a positive correlation ($r = .45$) between the two positive expectancy variables, number or reasons for choosing the program, and confidence that the program would help. Similarly, there was a positive correlation ($r = .32$) between the two alternative choice variables, the number of sites visited, and attractiveness of the nonchosen program. However, there was very little relationship between the positive expectancy and alternative choice variables.

Hypothesis 1 had predicted that the two positive expectancy variables would be correlated with frequency of contact with the chosen treatment program. The number of reasons for choosing the treatment program was significantly correlated with frequency of contact ($r = .29$), but confidence in the chosen program was not. Hypothesis 2 had predicted that the alternative choice variables would also be positively

Table 1. Means, Standard Deviations, and Correlations

Variables	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*Mean*	*SD*
Contact (1)	—	—	—	—	—	—	—	—	—	11.88	15.31
Consumer satisfaction (2)	.40**	—	—	—	—	—	—	—	—	9.46	2.32
Days homeless (3)	.05	.02	—	—	—	—	—	—	—	14.72	23.32
Psychotic symptoms (4)	−.11	−.06	.13	—	—	—	—	—	—	8.00	9.68
Baseline days homeless (5)	−.02	.21	.08	−.02	—	—	—	—	—	45.09	17.91
Baseline psychotic symptoms (6)	−.04	−.18	−.12	.51**	−.11	—	—	—	—	12.80	9.18
No. of reasons (7)	.29*	.43**	−.12	−.08	.15	−.12	—	—	—	4.10	1.94
Confidence (8)	.15	.40**	.07	−.14	.30**	−.26*	.47**	—	—	4.31	1.21
Attractive (9)	.04	.07	−.04	.08	−.06	.11	.20	.14	—	37.86	12.50
No. visited (10)	.06	.10	−.05	.19	−.07	−.06	.10	.01	.32**	1.62	1.27

*$p < .05$; **$p < .01$.

Table 2. Regression Analyses: Beta Coefficients

	Dependent Variables			
Predictors	*Contact*	*Consumer satisfaction*	*Days homeless*	*Psychotic symptoms*
Baseline	—	—	.07	.53***
No. of reasons	.28	.23	−.21	−.01
Confidence	.03	.26*	.13	.02
Attractiveness	−.03	−.05	−.01	−.05
No. visited	.04	.08	−.02	.24*
Contact	—	.30**	.09	−.10

*$p < .05$; **$p < .01$; ***$p < .001$.

related to program contact. However, neither of the alternative choice variables correlated significantly with program contact.

Hypothesis 3 had predicted that the positive expectancy variables would be positively related to client outcomes. This hypothesis received partial support. Both the number of reasons for choosing the program and confidence in the program were significantly correlated with client satisfaction (see Table 1). As Table 2 indicates, confidence in the chosen program was a significant predictor of client satisfaction in the regression equation, but the number of reasons for choosing the program was only marginally significant ($p < .08$). Neither of the positive expectancy variables predicted psychotic symptoms at 12 months (see Table 2). Similarly, neither of the positive expectancy variables predicted days homeless at 12 months (see Table 2).

Hypothesis 4 had predicted a negative correlation between the alternative choice variables and client outcomes. This hypothesis received minimal support. Neither alternative choice variable was a significant predictor of client satisfaction in the regression equation (see Table 2). In the regression equation predicting the 12 month psychotic score, the number of other sites visited did predict an increase in psychotic symptoms as hypothesized, but the attractiveness of the nonchosen program did not predict the psychotic score at 12 months (see Table 2). Neither alternative choice variable predicted days homeless at 12 months.

Hypothesis 5 had predicted that program contact would be correlated with client outcomes. This hypothesis received only partial support. Program contact was highly correlated with client satisfaction (see Table 1) and a significant predictor of client satisfaction in the regression equation (see Table 2). However, program contact was not a significant predictor of psychotic symptoms at 12 months or days homeless at 12 months in either regression equation (see Table 2).

DISCUSSION

Substantive Findings and Implications for Future Research

Consistent with previous research positive expectancies correlated with both program contact and consumer satisfaction. However, positive expectancies were not correlated

with longer term outcomes, such as days homeless and psychiatric symptoms. Psychotherapy researchers have also found that positive expectancies are more highly correlated with treatment process variables than longer term outcomes (Garfield, 1994). Similarly, other research has also found that consumer satisfaction frequently does not correlate with other consumer outcomes, including improvement in psychiatric symptoms (Pekarik & Wolff, 1996).

Some of the more interesting results of this study were the no difference findings involving the alternative choice variables. Our data indicated that positive expectancies and the alternative choice variables are fairly independent of each other. Thus, a client can simultaneously have positive expectancies about the chosen program, and still be attracted to another program. Moreover, the alternative comparison process does not appear to interfere with the client's commitment to the chosen program, at least in terms of program contact and client satisfaction. Those clients who visited more sites and/or were highly attracted to another treatment program were no less likely to be in contact with their chosen program than other clients. Thus, it appears that advocates can encourage program administrators to provide clients a choice of treatment options without jeopardizing the amount of contact that the client will have with the chosen program and client satisfaction. Future research should assess how the alternative choice variables, particularly the attractiveness of competing treatment programs, affects the strength of the helping alliance between the client and the staff of the chosen program.

Methodological Limitations

First, some of the study measures had not been used previously; consequently, they had unknown reliability and validity. This is particularly true of the positive expectancy and alternative choice variables. In addition, because of concerns about participant burden, we did not assess client's opinions about the various treatment options (i.e., attractiveness, confidence, etc.) both prior to their selection of the treatment program and after their selection. Thus, we could not adequately test the predictions made by dissonance theory (Festinger, 1957) attribution theory (Harvey et al., 1979), and regret theory (Tsiros & Mittal, 2000) regarding changes in valence after expectancies are confirmed or disconfirmed.

Finally, the generalizability of the study findings are limited by the small sample size that made it more difficult to reach statistical significance. Similarly, the study sample was not representative of all mental health consumers. Compared to other mental health consumers, the individuals in this study, who were both severely mentally ill and poor, may have been more passive and less likely to engage in a thorough search process when offered a choice of treatment than the modal mental health consumer. Similarly, the ability to choose may be a less salient value for this group of disadvantaged American consumers than the typical American. Recent research has illustrated how cultural differences interact with choice dimensions in affecting both commitment and performance. For example, in contrast to Anglo American children, Asian American children actually demonstrated more intrinsic motivation and better performance when choices were made for them by trusted adults or peers (Iyengar & Lepper, 1999). Thus, future research needs to examine how both cultural and individual difference variables (e.g., locus of control) interact with the opportunity to choose one's treatment program in affecting both treatment process and client outcomes.

CONCLUSION

Despite its methodological limitations this study has made several important contributions. It is one of the few studies that has investigated how positive expectancies and the alternative choice variables affect treatment process and client outcomes, particularly in a sample of disadvantaged clients. This study found that positive expectancies are correlated with program contact and client satisfaction in individuals with severe mental illness, replicating results with less seriously ill clients. In addition, the study results clearly suggest that clients can be given treatment options without jeopardizing their commitment to the treatment program that is ultimately chosen. Although many of the study hypotheses were not supported, this study provided important leads for future researchers in studying the impact of client choice on both treatment process and client outcomes.

REFERENCES

Ajzen, I., & Fishbein, M. (1974). Factors influencing intentions and intention–behavior relations. Human Relations, 27, 1–15.

Anderson, E.M., & Lambert, M.J. (2001). A survival analysis of clinically significant change in outpatient psychotherapy. Journal of Clinical Psychology, 57, 875–888.

Beard, J., Propst, R., & Malamud, T. (1982). The Fountain House model of psychiatric rehabilitation. Psychosocial Rehabilitation Journal, 5, 47–53.

Beasley, R.K., & Joslyn, M.R. (2001). Cognitive dissonance and post-decision attitude change in six presidential elections. Political Psychology, 22, 521–540.

Brigham, T. (1979). Some effects of choice on academic performance. In L.C. Perlmuter & R.A. Monty (Eds.), Choice and perceived control. Hillsdale, NJ: Lawrence Erlbaum.

Calsyn, R.J., Winter, J.P., & Morse, G.A. (2000). Do consumers who have a choice of treatment have better outcomes? Community Mental Health Journal, 36, 149–160.

Devine, D., & Fernald, P. (1973). Outcome effects of receiving a preferred, randomly assigned, or non-preferred therapy. Journal of Consulting and Clinical Psychology, 41, 104–107.

Dohrenwend, B. (1982). Psychiatric epidemiology research interview (PERI). New York: Columbia University Social Psychiatry Unit.

Festinger, L. (1957). A theory of cognitive dissonance. Evanston, IL: Row, Peterson.

Garfield, S. (1994). Research on client variables in psychotherapy. In A.E. Bergin & S.L. Garfield (Eds.), Handbook of psychotherapy and behavior change. New York: John Wiley & Sons.

Harvey, J.H., Harris, B., & Lightner, J. (1979). Perceived freedom as a central concept in psychological theory and research. In L.C. Perlmuter & R.A. Monty (Eds.), Choice and perceived control. Hillsdale, NJ: Lawrence Erlbaum.

Inman, J.J., & Zeelenberg, M. (2002). Regret in repeat purchase versus switching decisions: The attenuating role of decision justifiability. Journal of Consumer Research, 29, 116–128.

Iyengar, S., & Lepper, S. (1999). Rethinking the value of choice: A cultural perspective on intrinsic motivation. Journal of Personality and Social Psychology, 76, 349–366.

Langer, E., & Rodin, J. (1976). The effects of choice and enhanced personal responsibility for the aged: A field experiment in an institutional setting. Journal of Personality and Social Psychology, 34, 191–198.

Mendonca, P.J., & Brehm, S.S. (1983). Effects of choice on behavioral treatment of overweight children. Journal of Social and Clinical Psychology, 1, 343–358.

Morse, G.A., Calsyn, R.J., Allen, G., & Kenny, D.A. (1994). Helping homeless mentally ill people: What variables mediate and moderate program effects? American Journal of Community Psychology, 22, 661–683.

Morse, G.A., Calsyn, R.J., Allen, G., Tempelhoff, B., & Smith, R. (1992). Experimental comparison of the effects of three treatment programs for homeless mentally ill people. Hospital and Community Psychiatry, 43, 1005–1010.

Pekarik, G., & Wolff, C. (1996). Relationship satisfaction to symptom change, follow-up adjustment, and clinical significance. Professional Psychology; Research and Practice, 27, 202–208.

Propst, A., Paris, J., & Rosberger, Z. (1994). Do therapist experience, diagnosis and functional level predict outcome in short term psychotherapy. Canadian Journal of Psychiatry, 39, 168–174.

Randolph, F., Blasinsky, M., Morrissey, J.P., Rosenheck, R.A., Cocozza, J.G., Goldman, H.H., & the ACCESS National Evaluation Team. (2002). Overview of the ACCESS Program. Psychiatric Services, 53, 945–948.

Rokke, P.D., Tomhave, J.A., & Jocic, Z. (1999). The role of client choice and target selection in self-management therapy for depression in older adults. Psychology and Aging, 14(1), 155–169.

Sandall, H., Hawley, T., & Gordon, G. (1975). The St. Louis Community Homes Program: Graduated support for long-term care. American Journal of Psychiatry, 132, 617–622.

Sterling, R.C., Gottheil, E., Glassman, S.D., Weinstein, S.P., & Serota, R.D. (1997). Patient treatment choice and compliance. The American Academy of Addiction Psychiatry, 6, 168–176.

Thompson, C.E., & Wankel, L.M. (1980). The effects of perceived activity choice upon frequency of exercise behavior. Journal of Applied Psychology, 10, 436–443.

Tsiros, M., & Mittal, V. (2000). Regret: A model of its antecedents and consequences in consumer decision making. Journal of Consumer Research, 26, 401–417.

Vroom, V.H. (1982). Work and motivation. Malabar, FL: Krieger Publishing.