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PATIENTS' PRETHERAPY EXPECTATIONS AND THEIR
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BEGINNING PSYCHOTHERAPISTS.

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PATIENTS' PRETHERAPY EXPECTATIONS AND THEIR RELATION
TO EARLY EXPERIENCE ON TREATMENT BY BEGINNING PSYCHOTHERAPISTS

by

JANE BORIN

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CHAPTER 1 HISTORY

An individual's expectations have a strong effect on his future behavior. They affect perceptions and may have aspects of self-fulfilling prophecies. Psychotherapy, with its varied and often amorphous goals, may be especially influenced by expectations. The purpose of this research is to examine the effects of expectations on the outcome of therapy.

Expectations are complex phenomena. They are shaped by a variety of forces which impinge on the past, present, and perceived future of the individual. Expectations of psychotherapy may be affected by pretherapy experiences, such as the nature of the referral, previous treatment and knowledge of the experience of close ones who have been in treatment. The patient's initial level of distress and prognostic expectations may also play a role.

EXPECTATIONS OF PSYCHOTHERAPY

Expectations of psychotherapy may have profound effects on outcome. The research that follows sought to identify and clarify the nature of expectations of psychotherapy. Psychotherapy, like all two person interactions is a process in which the patient and the therapist both bring expectations of what will happen and of each other. Most of the following researchers have studied the expectations of each participant separately. Psychotherapy is a mutual transaction, where the effects of the patient's expectations on the therapist and of the therapist's expectations on the patient are often complexly intermingled.

Patient Role Expectations

Patients and therapists both have expectations about how each other will behave. This affects their behavior in the treatment situation and may also affect outcome. Goldstein (1962) hypothesized that if their expectations are fulfilled, they know what to do next and they have a sense of being in a predictable situation. If their expectations are not fulfilled, the situation appears unpredictable, anxiety-laden and changing. The ability to predict reality is strongly rewarded in one's experience and is accompanied by positive affect (Clemes and D'Andrea, 1965).

Patients' Expectations of Therapists. Apfelbaum (1959)

designed a Q sort composed of statements about a therapist's personality and administered it to one hundred patients who fell into three clusters on this Q sort:

1. Nurturant- Patients in this group expect a giving, guiding, supportive and uncritical therapist who does not expect his patients to shoulder their own responsibilities.
2. Model- These patients expect a well-adjusted, diplomatic non-judgmental therapist who is a permissive listener.
3. Critic- Patients of this type expect the therapist to be critical, analytical, one who wants his patients to assume considerable responsibility. He is neither gentle nor indulgent. Studies by Reusch (1948) and Deskins et.al. (1960) each yielded clusters of patient expectations which were highly similar to Apfelbaum's findings.

Congruence of Expectations

Therapists also have expectations of how they will behave in therapy (Goldstein and Heller, 1960), and of how their patients will

behave (Chance,1959; Fiedler,1953; Mowrer,1953). The literature suggests that patients' and therapists' expectations interact and affect each other. In this area of mutual expectations a major dimension is the degree of congruence between the two. When patient and therapist expectations are similar, or congruent, there is less strain and dissatisfaction (Lennard and Bernstein, 1960) and less anxiety (Clems and D'Andrea, 1965). Appel (1960) found that more successful patients change in order to become more congruent with their counselor's "ideal patient". Thus, congruence of expectations can facilitate the outcome of therapy.

Manipulation of Congruence

Primary Role System Communications. Lennard and Bernstein (1960) defined primary role system communications as the references both the therapist and the patient make as to what they expect. They found that when there is dissimilarity in expectations, there is a larger proportion of primary role system communications. Therapists, who consider themselves "active", produce more primary role system propositions than their "passive" counterparts. Active therapists initiate these conversations in the beginning of treatment. However, by the fourth month, patients of passive therapists engaged in two times as much discussion of expectations. This implies that much backtracking can be avoided if therapists take an active role in teaching or socializing their patients. The role of a patient does not come automatically but is a learned quantity.

Pre-training Interview. Stone et.al.(1961)

addressed themselves to the role of training of patients. They

reasoned that, if patients were told what to expect from treatment, they would make better patients and there would be a more favorable patient-therapist relationship. They actively initiated primary role system communications in the beginning of therapy.

The patients were given an intake by an experienced therapist and were rated as either "attractive" or "unattractive" on the basis of class, age and education. The patient was then randomly assigned to either the control group or the experimental group. Patients in the experimental group were given a pre-training interview which covered four areas: 1. a general exposition of psychotherapy. 2. a description and explanation of the expected behavior of a patient and a therapist. 3. a preparation for certain typical phenomena in the course of therapy (e.g. resistance) 4. an induction of a realistic expectation for improvement within the four months of treatment planned.

The outcome measures used were rating scales filled out by both the patient and the therapist, and patient attendance. They found, that, in general, those patients who had received the interview improved more and had better attendance. Attractive patients made more progress than unattractive patients regardless of sex, but all females did much better than unattractive males. Role induction was especially helpful to unattractive patients, especially males. The role interview was a stronger determiner of outcome than attractiveness. This highlights the potent effects

of expectations.

An interesting side light was that therapists with control patients made significantly more role induction statements in the first session than therapists with experimental patients. This dovetails with Lennard and Bernstein's findings (1960).

Yavis and Non-Yavis Patients

The acronym yavis, stands for, "young, attractive, verbal, intelligent and successful." It was coined by Schofield (1964) and refers to the type of patients most therapists he studied preferred. Yavis patients have congruent expectations with their therapists and form favorable psychotherapeutic relationships.

The non-yavis patient is middle-aged, or elderly, physically ordinary or unattractive, verbally reticent, intellectually unexceptional or dull, and typically from a lower socioeconomic level. These were like the patients in Gleidman's (1957) study who had non-congruent incentives for participating in psychotherapy. Heine and Troseman (1960) describe a similar type. Stone et.al. (1961) labelled these patients "unattractive". These are the patients who expect the therapist to assume an active medical role. Surveys of three large outpatient clinics serving individuals of lower socioeconomic status report dropout rates of over fifty percent after the initial interview (Imber et.al., 1955; Overall and Aronson, 1963; Rosenthal and Frank, 1958).

In sum, both the therapist and the patient come to psychotherapy with expectations of how the other will behave. When patient and therapist expectations are similar, the process of therapy proceeds

smoothly with less strain and anxiety. Congruent role expectations have been found to be an important ingredient in the successful outcome of psychotherapy. The high dropout rate among non-yavis patients has been attributed to their lack of congruent role expectations.

PATIENTS' FAVORABLE EXPECTATIONS

Whether or not a person looks forward or dreads a coming event has definite consequences and shapes that person's experience. Many patients are favorably disposed towards their future therapist and towards the therapy process in general. Some, however, are doubtful that therapy is the answer to their problems (Brady et.al., 1959). They may have apprehensive anticipations of an overbearing or disinterested therapist (Apfelbaum, 1959) and may suspect that they will never really get better (Lipkin, 1954).

Favorable expectations of psychotherapy are complex phenomena. Among the forces that shape a patient's expectations are initial distress, pre-therapy experiences and prognostic expectations.

The Placebo Effect

One aspect of the role of expectations in influencing the response to a treatment is illustrated by the placebo effect. Positive placebo responders and patients with favorable expectations have a great deal in common. Both tend to be described in such general terms as optimistic, hopeful and as having faith in their doctor and his cure. Favorable expectations of somatic treatment have led to improved outcome. Rosenthal and Frank (1956) argue that, "patients entering psychotherapy have varying degrees of belief in it's efficacy,

and this belief or set of expectations may be an important determinant of the results of therapy."

Physicians and psychologists have been reluctant to accept the efficacy of the placebo effect. To suggest that some of the results of psychotherapy are due to a placebo effect is not to say that psychotherapy is an invalid process due only to suggestion. This merely specifies a mechanism which facilitates successful outcome, i.e. hope, optimism, trust, faith, and, in general, favorable expectations.

Arthur Shapiro (1960) defined placebo effect as

"...The psychological, physiological or psychophysiological effect of any medication or procedure given with therapeutic intent, which is independent of or minimally related to the pharmacological effect of the medication or to the specific effect of the procedure and which operates through a psychological mechanism."

Placebo Responsiveness may be analogous to the response of a patient to psychotherapy. Responsiveness to a placebo showed marked variability for any given individual. It was not correlated with any enduring personality traits, there was an inconsistency in the response of the same person at different times, and it was highly dependent on immediate circumstances, (Goldstein, 1962).

The positive placebo reactor can best be described compositely as:

A mildly psychoneurotic individual, although rarely of the conversion hysteric type, whose anxiety level is high and who tends to be more religious, younger and less educated than patients unresponsive to placebo administration. He also tends to be more depressed, have more minor sicknesses, place more value on medications and physicians as sources of distress

relief and has, in general, greater confidence in physicians and a greater inclination to recommend to others what he has found to be helpful with his own complaints. Positive placebo reactors are more dependent on outside stimulation than on their own mental processes. They tend to be habitual consumers of aspirins and a wide variety of other medications. In contrast, placebo responsiveness has been found to be unrelated to chronicity of symptoms, marital status, sex, intelligence and work history. In an in-patient schizophrenic population, placebo reactivity appeared to be unrelated to both number of admissions, and length of hospitalization. (Goldstein, 1962; p. 109).

Placebo reactivity was also related to improvement and to greater initial distress (Frank et.al., 1963). Shapiro (1960) found that any response to a placebo, be it positive or negative, was a hopeful prognostic sign.

Positive placebo responsiveness was also a function of a positive doctor-patient relationship. Haimowitz (1958); Goldstein, (1962) found that when patient-therapist pairs had a poor rapport, the patients tended to have a negative placebo response and then dropped out of treatment.

In summary, placebo responders have been found to be more religious, more depressed, to have greater initial distress and a hopeful prognosis. Since positive placebo responders and patients with favorable expectations have a great deal in common, characteristics of placebo responders may apply to patients with favorable expectations of psychotherapy.

Referral Source and Expectations

The nature of a patient's referral to psychotherapy may

heighten the patient's favorable expectations. Goldstein and Shipman (1961) assumed that referral sources in mental health fields (psychiatrists, psychologists, social workers, etc.) would be more likely to impart favorable attitudes toward psychotherapy than other referral sources (general practitioners, friends, parents). This was not substantiated. However, the referral source did influence the patients' confidence in the clinic. Patients were given a list of fifty common symptoms and were asked to respond to each symptom by ranking five alternative sources of help (friend, parent, no one, clinic, clergyman) in the order he would recommend them to a friend if the latter had the given complaint. Thus, referral sources had some favorable effect.

Frank (1959) discussed the factors contributing to favorable patient expectancies of improvement in psychotherapy. First, there is a cultural acceptance that if one is mentally ill, psychotherapy is the treatment of choice. Secondly, if the referring physician evidences respect toward psychotherapy and if the intake social worker and the psychologist who test the patient seem to understand him, the patient will be more favorably disposed toward therapy.

In sum, a positive attitude on the part of the referring agent may enhance the success of psychotherapy.

Prognostic Expectations

Prognostic expectations refer to the patient's anticipation of outcome. Lipkin (1954) used TAT protocols and focused interviews to

measure patients' prognostic expectancies. He found that his data, "Strongly suggests that the client who is positively oriented toward the counselor and the counseling experience and who anticipates that his experience in counseling will be a successful and gratifying one undergoes more change in personality structure than does the client who has reservations about the counseling experience". (Lipkin, 1954, p. 26).

Frank et.al. (1959) assigned patients to group therapy, individual therapy and individual "minimal contact" therapy one half hour every two weeks. Patients in all three groups reported a drop in subjective discomfort. Two years after treatment some of these same patients again reported discomfort. They were given a two week placebo trial and again they reported a significant decrease in subjective discomfort. The authors interpret the results as being consistent with the assumption that, "the effects of treatment are partially dependent upon the potentiation and activation of the patients' favorable expectancies regarding improvement." Gleidman et.al. (1958) found similar results.

There were, however, contradictory results in this area. Brady, Reznikoff and Zeller (1960), measured expectations of improvement with a Picture Attitudes Test and a Sentence Completion Test. The patient sample was highly heterogeneous with regard to a variety of background factors, amount of pre-hospitalization and length, severity and type of illness. The nature of the psychiatric treatment also varied greatly across patients. The finding that there was no statistically significant relationship between expected and "actual"

patient improvement may have been due to the heterogeneity of the sample and treatment characteristics.

Goldstein (1960), using an experimental group of treated patients and a control group of non-treated patients administered present-self and expected-self Q sorts. The correlation of client expected and perceived personality change was computed for sessions five, ten and fifteen. He found that none of the experimental group correlations were significantly greater than the corresponding correlations for the control group. This study, along with Brady et.al. (1960) does not support the hypothesized linear relationship between patient expected and perceived change in psychotherapy.

In a later study, Goldstein (1962) suggested the following explanation for the contradictory findings:

"..expected and perceived improvement in psychotherapy have been found not to relate in a linear manner. Level of aspiration research indicates a reality-irreality dimension of goal-setting behavior. Moderate expectation of improvement in psychotherapy logically appears to be the most realistic of the range of possible patient expectancies. The most 'therapy ready' patients are more likely than others to have realistic expectations of improvement. Hence, it is suggested, it should be those patients with moderate prognostic expectancies who should change the most in therapy. This prediction is also in accord with the recurrent finding that very high and very low aspiration levels are associated with a high degree of maladjustment. " (Goldstein, 1962, p. 27).

Goldstein supports his hypothesis with the research of Chance (1960), Janis (1958), Goldstein and Shipman (1961), and Brady et.al. (1959).

In sum patients' favorable prognostic expectations may be related to the outcome of psychotherapy. Realistic or moderate rather than extremely optimistic prognostic expectations yielded

more change in psychotherapy. This non-linear relationship was used to explain the contradictory results in this area. Presumably, a patient who has positive prognostic expectations is favorably disposed toward therapy. Thus, knowledge of the effects of prognostic expectations will enhance our understanding of the factors which shape favorable expectations of psychotherapy.

Distress and Motivation for Therapy

High motivation for therapy may have much in common with favorable expectations of therapy. Initial distress may be one factor which shapes patients' expectations of psychotherapy. When patients have greater distress, they are more motivated for psychotherapy and have greater expectations of relief. Lipkin (1954). Frank (1959) cites two possible explanations for this phenomenon:

"..presumably the more wretched a person is, the greater his predisposition to put faith in what is offered. The other possibility is that the patient's revelation of distress is in itself a sign that he is favorably disposed to trust the therapist and therapy: that is, it may indicate a willingness on the part of the patient to emphasize aspects of himself which show his vulnerability or weakness." (Frank, 1959, p.22).

Gleidman et.al. (1957) theorized that distress signifies a state of disequilibrium and an effort to restore equilibrium. Thus, distress implies an attempt to get better.

EXPECTATIONS AND THE OUTCOME OF THERAPY

INTERPERSONAL ATTRACTION

Much research and thinking has delved into the problem of

what makes therapy work. Goldstein (1971); Strupp and Bergin (1969); and Truax and Carkhuff (1967), think that a successful patient-therapist relationship is the crucial ingredient. Interpersonal attraction, or mutual liking is a key to developing a successful psychotherapeutic relationship. The research reviewed below examined patients' favorable expectations of their therapists, and vice-versa as they affect and create conditions which facilitate the success of psychotherapy.

The Manipulation of First Impressions

Asch (1946) presented two groups of subjects with almost identical lists of personality traits, except that one list included the trait "warm" while "cold" appeared in the other. S's personality sketches of the two persons described showed consistent differences which clearly appeared to be associated with the warm vs. cold structuring. Kelley (1950) supported this finding.

Greenberg (1968); Goldstein (1971) applied the above research to psychotherapy. His subjects, one hundred and twelve undergraduates, listened to a taped therapy session and rated the therapist on attractiveness and persuasibility dimensions. Subjects were assigned to four experimental conditions varying on warm-cold and also experienced-inexperienced induced expectations. He found that S's given "warm" or "experienced" induced expectations were more attracted to their therapist, were more receptive to his influence attempts and evaluated his work more positively. They were willing to commit themselves to actually meeting with the therapist when told he was

probably coming to campus and were more persuaded by his communications as measured by an opinion shift questionnaire. Simonson (1968); Goldstein (1971) has replicated these results.

Increased Acceptance of Influence

Interpersonal attraction facilitates the acceptance of influence. Goldstein et.al. (1966) underline this, "Our general proposition is that by heightening the favorableness of patient attraction toward his therapist, to that degree does the patient become more receptive to therapist influence attempts." (Goldstein, 1966, p. 81). Back (1951), Sapolsky (1960) and Goldstein (1971) have attempted to increase patient attraction to the therapist with the use of pre-therapy attraction enhancing messages to the patient.

Premeeting Instructions. Back (1951)

manipulated interpersonal attraction with premeeting instructions. The S's in the low attraction group were told: "We tried to find a partner with whom you could work best. Of course, we couldn't find anybody who would fit the description exactly, but we found a fellow who corresponded to the main points, and you probably will like him." In contrast, the members of the high attraction group were told, "Of course we usually cannot match people the way they want but for you we have found almost exactly the person you described." The experimental task was to write a story about three pictures and then to discuss it. Under the high

attraction condition, Back found that the subjects made more of an effort to reach an agreement.

The Effects of Conditioning and Interpersonal Attraction.

Sapolsky (1960) found further support for the relationship between attraction and influence. His subjects took the FIRO-B (Schutz, 1958). High and low interpersonal attraction was then induced with the use of a modified version of Back's instructions.

S's met individually with E who, "provided reinforcement by saying 'mm-hmm' in a flat, unemotional tone at the end of any sentence that began with the 'I' or 'We' pronouns." Following the conditioning trials, as a check on the effectiveness of the attraction inducing instructions, a self anchored sociometric scale by Gardner et.al. (1956) that was administered to the two groups of S's demonstrated a significant difference in their attraction to E. S's in the high attraction group used the reinforced pronouns significantly more frequently than did the low attraction S's.

Krasner (1959) comments that, "The subtle cues provided by a therapist's use of 'mm-hmm' are likely to be effective only when the interpersonal relationship between him and the patient is positive or compatible." Other concurring results have been reported by Burdock and Burnes (1958), Gerard (1954), Gordon (1952), Rasmussen and Zander (1954), and Schachter et.al. (1960).

Pre-therapy Instructions. Goldstein (1971) recently published a series of experiments examining the effects of influence attempts

on interpersonal attraction. Using Back's high and low inducing attraction structuring, he found that patients processed through high attraction structuring increased in attraction toward their therapist but patients processed through low attraction structuring did not respond accordingly.

On the basis of the initial interview, Goldstein (1971) found that when patient attraction to the therapist is high, the patient:

"1. is less covertly resistive, 2. talks more, 3. is self descriptively sicker and 4. has more favorable prognostic expectancies for himself. The more attractive the therapist is to the patient 1. The more the patient talks, 2. the more open he is in his communications and 3. the less covertly and overtly resistive he is." (Goldstein, 1971, p.164).

Increased Communication

Expectations of interpersonal attraction enhance acceptance. This can be seen in the Sapolsky study where the subtle 'mm-hmm' has an apparently greater reinforcing effect under conditions of high interpersonal attraction. Goldstein et.al. (1966) paraphrases Freud, "The early psychoanalytic view held that clearly favorable feelings on the part of the patient toward the therapist are a precondition to patient receptivity to therapist communications and instructions." (Goldstein et.al., 1966, p.82). Newcombe (1956) maintains that accurate communication is rewarding and positive and thus leads to greater attraction.

Festinger et.al. (1950) induced an expectation of attitudinal similarity. The S's were asked to indicate their opinion on a given issue. Some were led to believe that the other group members'

opinions were congruent with their own and others were led to believe that the groups' opinions were different than their own. Following the actual meeting the S's were asked how well they liked the other members of their group. S's anticipating congruent member opinions were significantly more attracted to the group.

Therapist Response

It is likely that a patient who is favorably disposed towards his therapist elicits favorable feelings from the therapist. Rosenthal (1966), in his studies on experimenter bias, found that E's feelings of liking or disliking their subjects tended to vary positively with the degree of success with which the E's biased their subjects. Thus, positive feelings on the part of the experimenter increased communication, or experimenter bias. On the other side of the coin, Russell (1961); Goldstein et.al. (1966) found that negativistic patients generated significantly greater anxiety in their therapists than did more positively oriented patients. Goldstein, Heller and Sechrest (1966) conclude that, "There is strong reason to suspect that procedures introduced into psychotherapy to increase patient attraction to the therapist would, to the extent they are successful, lead the therapist to have a more favorable view of the patient." (Heller and Sechrest, 1966, p.137).

Therapists who give patients high ratings of success in psychotherapy may not be evaluating real personality change, but may be responding more to the receptiveness of the patient and the fluidity

of the interaction. This may or may not be considered an adequate estimate of the outcome of treatment.

Resistance

It may seem strange that a person would seek to enter therapy and yet still be unfavorably disposed to it. This reluctance has been termed resistance. Frieda Fromm-Reichmann (1950) explains the dynamics involved. "The patient is resistive to psychotherapeutic collaboration and interpretation for fear that the anxiety which the material in question or originally barred from awareness may be reactivated by the interpretive dissolution of the dissociations and repressions." (Fromm-Reichmann, 1950, p.110). Sometimes, the resistance is conscious. Fromm-Reichmann (1950) describes some behavioral manifestations of conscious resistance. "Lack of communication, lack of interest in following the suggestions of the psychiatrist, 'drawing blanks' which interfere with any give-and-take in psychotherapeutic exchange, and failure to appear on time or at all for scheduled psychotherapeutic interviews are most common means of intentionally defeating the psychotherapeutic process". (Fromm-Reichmann, 1950, p.119). A patient of this kind could be labelled unfavorably disposed towards psychotherapy.

Temporal Variables

Duration of Psychotherapy: Researchers generally measure brief rather than long term psychotherapy, (Meltzoff and Kornreich, 1970). Roger's (1960) survey of 10,904 referrals in six states showed an average number of 12.9 interviews. Garfield and Affleck (1959) found a median of twelve visits. Although number of sessions and number

of weeks are highly correlated, number of sessions is a much more common way of measuring length of therapy than is total duration, (Meltzoff and Kornreich, 1970).

Cartwright (1955) discovered the presence of a "failure zone" ranging between the thirteenth and the twenty first interviews. He suggested that there may be two kinds of processes, short (one to twelve interviews) and long (thirteen to seventy-seven interviews). Short term clients explore personality problems. The failure zone could be associated with resistance that prevents the individual from continuing in long term therapy.

Terminators. Katz and Solomon (1958) reported that one third of the patients, at the Yale U. Outpatient Clinic come only once, and one third less than five times. Frank et.al. (1957) reported that thirty-one percent leave treatment before the fourth session at the Henry Phipps Clinic. Gallagher and Kanter (1961), examining a low-cost evening clinic, found that twenty-three percent dropped out after one session and only forty-four percent remained for four or more interviews.

Terminators are generally from a low socioeconomic class. They tend to be hostile, independent and somatically oriented as opposed to remainers, who tend to be anxious, curious and less defensive. Therapists generally rate terminators as less successful although the term "drop out" or "terminator" may indicate a disagreement between the patient and therapist about the goals to be achieved, (Meltzoff and Kornreich, 1970).

Expectations may play a large role in this high early drop out rate. The patient who terminates after such a brief contact with his therapist may be reacting to his unmet expectations, i.e. non congruence, or to his own original ambivalence about coming to psychotherapy in the first place.

In sum, resistance, or unfavorable expectations of psychotherapy can manifest itself by affecting patients' attendance. Researchers have found that the average patient attends a median of twelve sessions. Those who terminate before five sessions are called terminators and are thought to have an unsuccessful outcome.

Hospitalized Patients' Expectations and the Outcome of Therapy

Brady et.al. (1959) utilized a battery of tests, both projective (The Libo PIT, Libo, 1957) and objective to assess hospitalized patients' attitudes towards the therapeutic situation, the psychiatrist and the hospital. They found that objective tests tapping conscious attitudes rather than projective tests tapping unconscious attitudes were significantly related to outcome. There was a more favorable therapy outcome if the patient perceived therapy as a neutral rather than distinctly pleasurable experience. Outcome was measured solely by a one item therapist rating scale. A favorable outcome corresponded to the patients' perceiving the hospital as protective rather than frightening. Favorableness of attitudes did not relate to background factors of age, occupation, previous treatment, educational level, religion, duration of present illness,

history of previous hospitalization, or history of hospitalization among relatives. Patients who had no history of previous psychiatric treatment had significantly more favorable attitudes. Neurotics were more favorably disposed than psychotics.

Brady et.al.'s (1959) efforts were most relevant to the topic of this research. The study, however, had some serious flaws. Firstly, the expectations measured were highly heterogeneous. The questions addressed themselves to the therapeutic situation, the psychiatrist and the hospital. Questions measuring the degree to which expectations were favorable were intermingled with questions measuring role expectations. Similarly, a one item therapist rating scale of outcome is hardly an adequate assessment of the success of treatment.

The current research will focus on the affective component of expectations and will utilize outpatient college students rather than hospitalized patients.

PILOT STUDY: THE MEASUREMENT OF FAVORABLE EXPECTATIONS

In order to examine the effect of patients' favorable expectations on the outcome of psychotherapy adequate measures of expectations must be developed.

The Libo Picture Impressions Test

The Libo Picture Impressions Test used by Brady et.al. (1959) consisted of four TAT like cards. Subjects' responses were rated for degree of anticipated involvement with the therapist and the intensity of attraction toward the therapist. The Libo PIT was originally designed to predict whether or not a patient would return

after his first therapy interview. Libo (1957) found a significant relationship between total test score of the patients and their actual rate of return for a second scheduled clinic visit. Mullen and Abeles (1967) replicated these results and found, furthermore, that in a follow up study six months later, the original PIT score classified accurately thirty-three out of thirty-four who did return and eleven of fifteen who did not return for the follow-up questionnaire, a predictive relationship significant at the .02 level. This test has been used in several psychotherapy research studies (Heller and Goldstein, 1961; Mullen and Abeles, 1967; Pope and Siegman, 1966).

Semantic Differential

The evaluative factor of the Semantic Differential has been used to assess attitudes toward psychologists. Nunnally (1969) canvassed popular attitudes with the Semantic Differential. Psychologists are held in high esteem, receiving high ratings on the evaluative factor.

Pilot Study

The purpose of the pilot study was to develop adequate measures of patients' favorable expectations of psychotherapy. With twenty-three subjects at the City College Psychological Center, the Libo PIT and the Expectations of Therapist Semantic Differential yielded a low correlation of .35. An Expectations of Therapy Questionnaire was devised by the author but has since been revised so that no comparative data was available. The two scales entailed different

levels of measurement, structured and projective. In an outcome study Brady et.al. (1959) also found different results for these two levels of measurement.

The content of the three tests seemed to measure somewhat different, although overlapping concepts. The Libo PIT measured expectations toward the therapist and therapy through projective stories, the Expectations of Therapist Semantic Differential undertook to measure patients' expectations of their therapist and the Expectations of Therapy Measure sought to measure patients' expectations of therapy.

HYPOTHESES

(1) Initial Distress and Expectations

Patients' pre-therapy expectations were hypothesized to be positively related to their level of initial distress. The Depression and Anxiety scales of the MMPI provided measures of distress. Expectations regarding therapy and the therapist were determined by three questionnaires.

(2) Pre-therapy Experiences and Expectations

Patients' pre-therapy expectations were hypothesized to be positively related to their pre-therapy experiences. Pre-therapy experiences were measured by four items of the Pre-Therapy Questionnaire (see Appendix) dealing with the attitudes of referral sources and friends and relatives who have been in therapy.

(3) Prognostic Expectancy and Expectations

The more realistic regarding duration and optimistic regarding

outcome the patients' prognostic expectancies, the more positive the pre-therapy expectations. These two elements of prognostic expectations, realism and optimism, were measured by three items of the Pre-Therapy Questionnaire (see Appendix).

(4) Expectations and Outcome

Patients' pre-therapy expectations of psychotherapy and of their therapist were hypothesized to be directly related to the outcome of psychotherapy.

CHAPTER 2 METHOD

SUBJECTS

One hundred and thirty-three clients successively applying for psychotherapy at the City College Psychological Center and at the Teachers' College Psychological Consultation Center comprised the study population. The patients were offered relatively long term psychoanalytically oriented psychotherapy. At City College psychoanalytically oriented psychotherapy was the major mode of treatment. At Teachers' College patients recommended for group therapy or behavior therapy were not included in this sample.

Locale and Age. The demographic characteristics of the patients at the two centers are described in Table 1. Sixty-seven percent of the sample was at City College. Subjects at City College were younger (mean=22.07) and more homogeneous in age (S.D.= 4.69) than those at Teachers' College (mean= 26.03, S.D.= 7.00). In all other respects the subjects at City College and at Teachers' College were not different.

Socioeconomic Status. was determined by the Hollingshead Two Factor Index of Social Position (1957). Education and occupation were weighted differentially and the subject was assigned to one of five social classes with one being the highest (professional) class. Subjects were asked to describe both their own and their parents' SES. Generally, SES was based on the subject's education and occupation. If, however, the subject was a student and had no occupation,

his SES was based on the father's education and occupation.

The mean SES for the total group was 3.04 (see Table 1 for demographic data). This reflected a partial college education and occupations such as insurance agents, store managers, small business owners and semi-professionals.

Ethnicity and Sex. Eighty percent of the sample were white. There were almost an equal number of men and women.

Therapists. The eleven therapists at City College (mean age= 26.2) and the eighteen therapists at Teachers' College (mean age= 27.0) were third or fourth year graduate students in Clinical Psychology. The overall mean age was 26.7 years. All therapists were supervised by more experienced therapists.

TREATMENT GROUPS

Subjects were classified into five basic groups according to length of treatment and completion of questionnaires by both patient and therapist.

(a) Twenty-six Remainers-Complete finished twelve sessions and returned all questionnaires.

(b) Eighteen Remainers-Incomplete finished twelve sessions but either they (sixteen patients) or, in two cases, their therapists did not complete outcome measures despite several reminders.

(c) The seventeen terminators dropped out of therapy after 2.6 sessions. As a result of telephone contact and payment of two dollars, eight Terminators-Complete were induced to complete outcome measures.

TABLE 1

Demographic Characteristics (Age, Social Class, Ethnicity, Sex) and Treatment Group Classification of the Samples at City College and Teachers' College

Variable	City	T.C.	Combined Sample
<u>Age*</u>			
N	69	33	102
Mean	22.07	26.03	23.35
S.D.	4.69	7.00	5.81
range	17-39	14-54	14-54
<u>Social Class</u>			
N	57	31	88 **
Mean	3.19	3.03	3.14
S.D.	1.27	1.25	2.26
range	1-5	1-5	1-5
<u>Ethnicity</u>			
White	58 (83%)	23 (74%)	81 (80%)
Non-White	12 (17%)	8 (26%)	20 (20%)
<u>Sex</u>			
Male	34 (50%)	17 (52%)	51 (50%)
Female	35 (50%)	16 (48%)	51 (50%)

*The difference between the mean age at City and T.C. yielded a t of 3.38 ($p < .01$). All other comparisons (t tests and Chi Square) were not significant.

**The number in each group varies since subjects did not consistently answer every item.

(d) The other nine Terminators-Incomplete did not complete outcome measures.

(e) The seventy-two subjects in the Preintake Only group completed only the original questionnaire. At City College the Preintake Only group included twenty-three subjects who were tested during the semester prior to the start of the data collection at Teachers' College. Sixteen subjects were placed on a waiting list. Fifteen subjects in the Preintake Only group decided not to come to treatment and eighteen were not appropriate for the treatment facility. Heroin addicts, exhibitionists and patients requiring hospitalization are example of patients rejected by the two college clinics. These applicants were generally referred to other facilities. Since this questionnaire was completed prior to the intake interview, subjects did not know their disposition at the time the test was administered.

There were no significant differences among treatment groups for any of the demographic variables. (See Table 2 for a breakdown of treatment groups.) The number in each group varied since subjects did not consistently answer every item. Since the Preintake Only group at City College was expanded by the inclusion of twenty-three subjects from the prior year, the Preintake Data was excluded from the Chi Square comparison of treatment groups for City College and Teachers' College in Table 2. There were slight differences in percentages, however no differences were significant. More patients (twenty-nine) remained in treatment at City College than at Teachers' College (fifteen). Five patients terminated

Table 2

Demographic Characteristics of the five Treatment Groups:
Remainers-Complete, Remainers-Incomplete, Terminators-Complete,
Terminators-Incomplete and Preintake Only

Variable	Remain Comp.	Remain Inc.	Term. Comp.	Term. Inc.	Prein. Only	Combined Sample
<u>Age</u>						
N	22	13	6	8	52	102
Mean	22.05	24.50	21.50	21.62	24.08	23.35
Range	14-31	17-25	19-25	17-29	14-54	14-54
<u>Social Class</u>						
N	19	14	6	8	41	88
Mean	2.79	3.07	3.83	3.62	3.12	3.14
Range	1-5	1-5	2-5	1-5	1-5	1-5
<u>Ethnicity</u>						
White	21	14	3	7	36	81 (80%)
Non-White	2	1	2	2	13	20 (20%)
<u>Sex</u>						
Male	12	9	4	5	36	66 (50%)
Female	12	8	5	4	36	65 (50%)
<u>Locale</u>						
City	15	14	4	8	59	100 (75%)
T.C.	11	4	4	1	13	33 (25%)

There are no significant differences. All differences exceed the .05 level of probability.

prematurely at Teachers' College, twelve at City College.

PROCEDURE

Before the subject's intake interview, he was asked to complete the one hour Applicant's Preintake Questionnaire. At City College, the Administrative Assistant administered the Preintake Questionnaire before the patient had his first appointment. At Teachers' College the Preintake Questionnaire was mailed before the patient had his first appointment. The return rate was 90%. The Preintake Questionnaire was composed of:

1. MMPI scales of Depression (Welsh, 1952), Anxiety (Bendig, 1956), and Ego Strength (Barron, 1953)

2. Pretherapy Questionnaire

3. Three expectations of therapy and therapists scales, The Libo Picture Impressions Test, the Expectations of Therapy Measure and the Expectations of Therapists Semantic Differential.

Therapists and clients were asked to complete outcome measures. This was done after twelve sessions for the Remainers. The Terminators were contacted by telephone an average of two and a half months after termination.

MEASURES OF EXPECTATION

The Libo Picture Impressions Test (PIT)

Subjects were asked to tell stories about four TAT like cards depicting therapy situations (the four pictures are reproduced in the Appendix). Libo (1957) designed the test to measure "Attraction of a patient toward his therapist and toward the clinical setting which

the therapist represents..to ascertain the nature of the patient-therapist relationship (e.g., expectations of the patient, demands to be made on the therapist, attitudes of the patient toward the therapist)." The test has both a male and a female version.

Two judges, the author and another graduate student in clinical psychology, coded thirty protocols selected at random. Interrater agreement between the two judges, using Pearson's Product-Moment Correlation Coefficient, yielded an r of .72 ($p < .01$). The correlation between raters was deemed sufficiently high to establish workable reliability. The author then coded the remaining hundred and three protocols.

Responses were analyzed for two aspects, the degree of involvement with the therapist was evaluated by the number of cards with scorable responses. In order for a response to be scored, it must include mention of some type of doctor-patient relationship. The maximum score is four. The intensity of attraction toward the therapist was evaluated by the number of statements scored as indicating attraction or repulsion from the therapist. Libo (1957) combined the two variables into a dichotomous indicator of attraction. (See Table 3 for the criteria for attraction and non-attraction.)

Expectations of Therapy Measure

This Likert type scale is composed of items selected from the scales of Reznikoff, Brady and Zeller (1960), and Hollander (1970; Goldstein (1971). Both studies examined favorable expectations of therapy but included other aspects of expectations not relevant to the current investigation. Thirty items which on the basis of content

TABLE 3

A Guide to the Interpretation of Picture Impressions Scores

<u>No. of Stories with a Score</u> (Degree of Involvement with Therapist)	<u>Total Score</u> (Intensity of Attraction toward Therapist)	<u>Interpretation</u>
2,3 or 4	+1 or higher	Attracted
Any	0 or lower	Not Attracted
0 or 1	Any	Not Attracted

appeared to be relevant to the study of favorable expectations of psychotherapy were selected from the above questionnaires. These items were administered by Shiffman (personal communication) to undergraduates attending New Paltz College. In the present study, the fourteen items which appear in the final form of this questionnaire (see Appendix), were selected from Shiffman's questionnaire because they correlated at least .52 with total score ($n=50$). Thus the scale has been tested for homogeneity of items. The corrected split half reliability coefficient for the current sample was .71.

Expectations of Therapist Semantic Differential

Subjects rated their attitudes toward a "psychotherapist" on a seven point Semantic Differential. Adjectives selected from lists prepared by Heise (1965), Jenkins et.al. (1958) and Komorita and Bass (1967) consisted of six items which load highly on the evaluative factor. Heise (1969) has found that the use of four scales all of which load on the same factor was sufficient to obtain test-retest reliability coefficients of .60 to .80. Adding more items which load on the same factor did little to improve reliability. A six item scale was used in the present study (See Appendix for Semantic Differential scale.)

PRETHERAPY QUESTIONNAIRE

The five questions on the pretherapy experiences and the three questions on prognostic expectations were measured by a pretherapy questionnaire. This questionnaire also included two items (items

9 and 10, see Appendix) used by another researcher and one item on the intensity of religious belief.

DURATION OF PSYCHOTHERAPY

The evaluation of outcome entails a number of practical issues relating to duration of treatment. In this study, subjects were followed through a brief period of psychotherapy which has been empirically defined as twelve sessions (Cartwright 1955). By this time patients and therapists have had some basis for evaluating the effectiveness of therapy. All those patients who remained in therapy were asked to complete outcome measures after twelve sessions. The patients who did not stay in therapy for twelve sessions were contacted by telephone and encouraged to complete outcome measures.

MEASURES OF OUTCOME

The major hypothesis stated that patients with favorable expectations of psychotherapy would experience greater success in treatment. The five measures of outcome included patient and therapist questionnaires and MMPI scales. The outcome measures required forty-five minutes for the patient to complete and fifteen minutes for the therapist to complete.

Strupp's Patient Questionnaire

The Patient Questionnaire was composed of seven clusters, or groups of highly correlated items and five discrete items (Strupp et.al. 1969). One of the clusters consisted of the patient's rating of the amount he had changed. All of the other clusters correlated with this patient criterion measure of change (r 's from .20 ($p < .05$))

to .36 ($p < .01$). Ratings of the therapists' final summaries of Overall Success and Symptom Improvement were independent estimates of outcome. These measures correlated with patients' ratings of change, and the patients' perception of the change apparent to others (Strupp *et.al.*, 1969). In sum, all items on this questionnaire were found by previous research to be highly related with each other and with criteria of change in psychotherapy.

Strupp's Therapist Questionnaire

Strupp utilized the Therapist Questionnaire to explore both the therapists' assessment of outcome and his experience of the therapeutic relationship. A shortened version of Strupp's Therapist Questionnaire was used in the current study. The eight items selected bore directly on the issues of the current investigation and correlated significantly with a measure of therapists' rating of Overall Success of therapy (r 's ranged from .54 to .71, $p < .01$.)

Strupp's Patient and Therapist Questionnaires measured both outcome and the quality of the patient-therapist relationship or interpersonal attraction.

Seeman's Case Rating Scale

Seeman's Case Rating Scale (Seeman, 1954) is a Client Centered Therapy measure of the therapist's view of outcome. It correlated highly with other more complex and sophisticated therapist ratings (Cartwright *et.al.*, 1961) and was recommended by Strupp and Bergin (1969). This scale yielded a simple measure of outcome as contrasted with Strupp's more complex Therapist Questionnaire.

Attendance

Subjects who terminated before twelve sessions were classified as Terminators (Katz and Solomon, 1958 ; Frank et.al. , 1957). The mean number of sessions for terminators was 2.58. Those subjects who completed twelve sessions were classified as Remainers. The mean number of sessions for Remainers at the time of evaluation was 13.37. It was expected that Remainers would have a more successful experience than Terminators (Meltzoff and Kornreich, 1970).

The MMPI

Post therapy and Pre-Post difference measures of the Depression and Ego Strength (Barron,1953) scales of the MMPI were used as outcome measures. They have been found to be sensitive to change as a result of psychotherapy. Other measures of change add little to these MMPI scales (Strupp and Bergin, 1969).

CHAPTER 3 RESULTS

The hypothesis investigated relationships between patient experiences and three measures of expectation. To determine these relationships all variables were intercorrelated. The matrix of intercorrelations is presented in Table 6. Because some subjects did not complete the full battery of questionnaires, the number of subjects varied.

MEASURES OF EXPECTATION

The Libo PIT, The Expectations of Therapy Measure and the Expectations of Therapists Semantic Differential yielded essentially zero order intercorrelations. (See Table 6 for correlation coefficients.) The findings are consistent with the results of the pilot study and indicate that the three types of measures cannot be combined.

Libo Picture Impressions Test

The Libo PIT, which yielded a dichotomous score (favorable or unfavorable) based upon a combination of the ratings of the four cards, revealed a small fifty-two percent majority of unfavorable expectations. There were no differences among the four treatment groups. (Remainers-Complete, Remainers-Incomplete, Terminators, and Preintake Only) in the numbers with favorable or unfavorable expectations. (See Table 4 for treatment group comparisons of the measures of expectaions.)

The single Libo PIT scores represented a combination of two aspects: involvement and intensity of attraction. The involvement

TABLE 4

Description of Treatment Groups: Remainers-Complete, Remainers-Incomplete, Terminators and Preintake Only on the Expectations of Therapy Measure, the Expectations of Therapist Semantic Differential and the Libo Picture Impressions Test.

Expectation Measure	N	Mean	S.D.	Range
<u>Expectations of Therapy Measure*</u>				
Total Group	129	31.59	5.58	19-61
Remainers (complete)	25	28.76	8.76	
Remainers (incomplete)	15	32.73	5.62	
Terminators	15	32.67	4.48	
Preintake Only	74	32.09	4.29	
<u>Expectations of Therapist Semantic Differential</u>				
Total Group	123	31.60	4.74	14-42
Remainers (complete)	26	30.04	4.46	
Remainers (incomplete)	15	32.07	5.42	
Terminators	14	32.43	4.75	
Preintake Only	68	31.93	4.66	
<u>Libo Picture Impressions Test</u>				
	N	Favorable	Unfavorable	
Total Group	126	60	66	
Remainers (complete)	26	15	11	
Remainers (incomplete)	14	8	6	
Terminators	16	6	10	
Preintake Only	70	31	39	

* The analysis of variance of treatment groups for the Expectations of Therapy Measure yielded an F of 2.86 ($p < .05$). The significant difference was between Remainers (complete) and Preintake Only ($t=2.59$). The analysis of variance of treatment groups for the Expectations of Therapist Semantic Differential ($F=1.25$) and the Chi Square comparison of treatment groups for the Libo PIT (Chi Square=2.54) were not significant.

with the therapist was evaluated by the number of cards with scorable responses. The intensity of attraction toward the therapist was evaluated by the number of statements scored as indicating attraction or repulsion from the therapist.

Each aspect of the Libo PIT has been examined separately. The degree of involvement is not related to the final dichotomous PIT score ($r=.01$) whereas the intensity of attraction is highly related to the final combined PIT score ($r=.54$). Thus, the Libo PIT score used in this study mainly reflected the intensity of attraction toward the therapist. When examined separately each of the two aspects of the Libo PIT was not related with any of the other variables in the current study.

There was no significant difference between the degree of involvement for Remainers (mean number of stories was 3.0) and for Terminators (mean 3.3). Likewise, there was no significant difference between the intensity of attraction for Remainers (mean score .08) and for Terminators (mean score $-.94$).

Expectations of Therapy Measure

The Expectations of Therapy Measure, constructed by the author, yielded a corrected split half reliability coefficient of .71. A high score indicated a more favorable expectation. The mean item score was 2.8, slightly below the midpoint of a five point scale, suggesting that the current sample of therapy applicants were mildly pessimistic about their prospective experience. There was a high degree of variability in the response to this measure. The mean was 31.59 and the Standard Deviation was 5.58. An analysis of

variance for the treatment groups yielded an F of 2.86 ($p < .05$). Scheffé comparisons were not appropriate due to unequal n 's. A t test comparison revealed a significant difference ($t=2.59$, $p < .05$) between Remainers-Complete ($n=25$) and Preintake Only ($n=72$). Thus, patients who complete all measures are different from the heterogeneous group of patients who either do not come for treatment or are not accepted for treatment at the Centers.

Expectations of Therapists Semantic Differential

The Expectations of Therapist Semantic Differential constructed by the author, yielded a corrected split half reliability coefficient of .78. A high score indicated a more favorable expectation. The mean score was 5.3, above the midpoint of a seven point scale reflecting favorable expectations of therapist. There were no differences among treatment groups. (See Table 4 for a comparison of treatment groups.)

FACTORS WHICH SHAPE EXPECTATIONS

(1) Initial Distress and Expectations

Initial distress, as measured by the Depression and Anxiety scales of the MMPI, was hypothesized to be related to patients' pretherapy expectations. Pretherapy Depression and pretherapy Anxiety scores yielded a zero order correlation. The correlations between the Anxiety and Depression scales and the three measures of expectation were low with only the Libo PIT and the Depression scale attaining a small significant positive r of .26 ($p < .01$). (See Table 6 for intercorrelations.)

(2) Pretherapy Experiences and Expectations

Patients' pretherapy experiences were hypothesized to be related to pretherapy expectations. Four variables were examined: referral source, previous treatment, close ones in treatment and close ones helped. The four measures were unrelated. The Expectations of Therapist Semantic Differential yielded near zero correlations with the four pretherapy experience items. The Libo PIT and the Expectations of Therapy Measure yielded low correlations with five attaining significance. (See Table 6 for a matrix of intercorrelations.)

Positive Referral Source. Patients reported that most sources of referral described the Psychological Center as being "moderately helpful" for them (mean of 4.2 in a five point scale). (See Table 5 for a description of the results of positive referral source.) Patients with positive referral sources had somewhat favorable expectations of the Libo PIT ($r=.23$, $p<.05$) while the other two measures of expectation yielded zero order correlations. (See Table 6 for intercorrelations.)

Previous Treatment. Forty-three percent of the subjects had been in therapy (See Table 5 for a description of the results of previous treatment. There was a low correlation between the Libo PIT and Previous Treatment ($r=.20, p<.05$) with the other two measures of expectation yielding non-significant results. (See Table 6 for intercorrelations.)

Close Ones in Treatment. Fifty-eight percent of the one hundred twenty-seven subjects were acquainted with someone who had been in therapy. (See Table 5 for a description of the results of Close Ones in Treatment.) There was a small correlation ($r=.20, p<.05$) between Close Ones in Treatment and the Expectations of Therapy Measure with the other two measures of expectation yielding zero order correlations. (See Table 6 for intercorrelations.)

TABLE 5

Description of Initial Distress, Pretherapy Experiences and Prognostic Expectations

Variable		N	Mean or Percentage	S.D.	Range
<u>Hypothesis 1.</u>					
<u>Initial Distress</u>					
Pre Depression		133	13.99	2.62	7-19
Pre Anxiety		133	12.19	3.86	1-20
<u>Hypothesis 2.</u>					
<u>Pretherapy Experiences</u>					
Referral Source		97	4.2	1.06	1-5
Previous Treatment	no	73	57%	*	0
	yes	55	43%		1
Close Ones in Treatment	no	54	42%		0
	yes	73	58%		1
Close Ones Helped		72	3.5	1.18	1-5
<u>Hypothesis 3.</u>					
<u>Prognostic Expectations</u>					
Duration		113	3.3 (4-6months)	1.62	1-5
Start of Change		117	1.8 (2 months)	1.57	1-5
Optimism		125	2.5	1.08	1-5

*Not Appropriate

Close Ones Helped. In the opinion of seventy-two subjects, their close ones were "moderately" to "somewhat" helped by psychotherapy (mean score of 3.5 on a five point scale). (See Table 5 for a description of the results for Close Ones Helped.) Those who felt their Close Ones have been helped exhibited favorable expectations on the Expectations of Therapy Measure ($\underline{r}=.35, \underline{p}<.01$) and on the Libo PIT ($\underline{r}=.26, \underline{p}<.05$). A zero order correlation was obtained between Close Ones Helped and the Expectations of Therapist Semantic Differential. (See Table 6 for intercorrelations.)

Thus there was some support for the hypothesis that patients with positive referral sources, experience in psychotherapy and Close Ones who were helped in therapy had favorable expectations of psychotherapy.

(3) Prognostic Expectancies and Expectations

It was hypothesized that patients' realistic and optimistic prognostic expectations would be related to expectations of psychotherapy. There were three items which dealt with prognostic expectations: expectations of Duration, Start of Change and optimism regarding outcome. Duration and Start of Change correlated ($\underline{r}=.29, \underline{p}<.05$). All correlations between prognostic expectations and measures of expectations were low with two positive significant correlations between the Expectations of Therapy Measure and Duration ($\underline{r}=.26, \underline{p}<.05$) and Optimism ($\underline{r}=.22, \underline{p}<.05$). Due to Goldstein's (1962) discovery of a curvilinearity of prognostic expectations the three prognostic expectations items were tested for linearity. All three were linear.

TABLE 6

Intercorrelations (Decimals omitted) among the Measures of Expectations and the Four Hypotheses

Measure	Expect.		Dep. Anx.		Pre. Exper.				Progn. Exp.			Expec. & Outcome					Ego Strength			Depress.		Anxiety		
	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
<u>Measures of Exp.</u>																								
1. Libo PIT. N=126	03	-05	26b	-12	23a	20a	08	26a	07	11	-08	39b	41b	15	-47b	-30	28b	39a	39a	26	28	-22	15	
2. Expect. of Therapist S.D. N=123		-04	05	-11	04	02	01	01	05	15	05	-10	11	07	00	-11	14	36a	07	04	04	-24	12	
3. Expect. of Therapy N=129			13	06	05	11	20a	35b	26a	-02	22a	22	10	-22	00	37a	07	33a	09	13	05	05	17	
<u>Hypothesis 1 Initial Distress</u>																								
4. Pre Depression N=133				-02	02	07	-05	01	10	00	12	08	12	13	25	09	17a	38a	08	60b	57b	01	-06	
5. Pre Anxiety N=133					-13	30b	-01	19	-00	-11	26	11	11	17	01	15	59b	48b	-15	06	-14	78b	-11	
<u>Hypothesis 2 Pretherapy Exper.</u>																								
6. Referral Source N=97						07	03	12	00	07	12	15	-04	05	-05	52b	-11	12	-20	45b	15	-18	-08	
7. Previous Treatment N=128							17	-09	48b	18	00	24	36b	30a	-05	15	-08	12	17	25	10	27	-13	
8. Close ones in Treatment N=127								03	43b	02	07	31a	26a	-05	22	37a	-16	20	00	20	-01	46b	-27	
9. Close ones Helped N=72									13	-01	03	51b	48b	45b	11	-27	-01	18	-12	-21	32	29	13	
<u>Hypothesis 3 Prognostic Expectations</u>																								
10. Duration N=113											29b	11	24	32a	-07	06	13	-10	-03	31	33a	-16	25	01
11. Start of Change N=117												-09	-07	-15	-13	-18	19	-01	29	-17	01	05	-22	42a
12. Optimism													-09	-09	-27a	21	14	07	-05	15	06	-03	-00	11
<u>Hypothesis 4 Expectations and Outcome</u>																								
13. Strupp Therapist N=59													69b	43b	-09	14	05	-05	15	06	-03	16	10	
14. Seeman Rating Scale N=59														65b	-26a	-10	08	07	04	-02	22	12	-08	
15. Sessions Attended N=56														15	-09		-19	-26	02	02	13	36a	-37a	
16. Sessions Missed N=56															10		-17	-20	-03	-10	-22	-04	00	
17. Strupp Patient Questionnaire N=36																	-08	11	-43b	02	-07	24	-33	
<u>MMPI Scales</u>																								
18. Pre Ego Strength N=133																			78b	33a	31	21	-59b	32
19. Post Ego Strength N=36																				-33	03	47b	-67b	61b
20. Pre-Post Ego Strength N=32																					48b	-39a	20	-44b
21. Post Depression N=36																						-29	27	-26
22. Pre-Post Depression N=32																							-20	18
23. Post Anxiety N=32																								-69b
24. Pre-Post Anxiety N=32																								

a p of <.05
b p of <.01

Duration. Expectations of duration assessed the reality of the patients expectations. Realism has been empirically defined by Goldstein (1962) by analyzing patients' prognostic expectations in conjunction with the Cassel Group Level Aspiration Test (1957). In the present study the realism of expectations was evaluated in light of the actual service offered. Most patients in the current study expected therapy to be a four to six month process. (See Table 5 for a description of the results for Duration.) Since the two college clinics, which function on the basis of a nine-month school year, accept most of the patients in September and October, the mean score indicated that although patients can be considered to have realistic expectations, they tend to underestimate the actual duration of treatment offered at the clinics. The assessment of the duration of therapy correlated .26 ($p < .05$) with the Expectations of Therapy Questionnaire but did not correlate with the other two measures of expectation. (See Table 6 for intercorrelations.)

Start of Change. The patients expected to notice results on the average of almost two months after they began therapy. (See Table 5 for a description of the results of Start of Change.) Start of Change did not correlate with any of the measures of expectation. (See Table 6 for intercorrelations.)

Optimism. This question assessed the patients' level of faith in treatment outcome. The mean score of 3.5 on a five point scale indicated that most patients rated themselves somewhat above the midpoint in their expectations that results in therapy would be

achieved.

Pearson Product Moment Correlations between Optimism and the three measures of expectations yielded a small r of .22 ($p < .05$) between Optimism and the Expectations of Therapy Measure. Zero order correlations were obtained between Optimism and the Libo PTT and Expectations of Therapist Semantic Differential. (See Table 6 for intercorrelations.)

MEASURES OF OUTCOME

There were five measures of outcome. After twelve sessions the therapist completed (1) Strupp's Therapist Questionnaire, and (2) Seeman's Case Rating Scale. (3) The Patient's attendance record was noted. (4) The patient completed Strupp's Patient Questionnaire and (5) post MMPI measures of Depression and Ego Strength.

Strupp's Therapist Questionnaire

For the sample of fifty-nine therapists, Strupp's Therapist Questionnaire yielded a corrected split half reliability coefficient of .83. The therapists' mean item rating of patient success of 3.1 was slightly above the midpoint of a five point scale. There was no difference between therapists' ratings of patients who completed questionnaire and those who did not. These Remainers-Complete and Remainers-Incomplete were combined. Therapists rated Remainers as having a better outcome (mean=21.11) than Terminators (mean=13.40). (See Table 7 for means, standard deviations, ranges, and t test comparisons of the results of Strupp's Therapist Questionnaire.)

Seeman's Case Rating Scale

Therapist's mean rating of all clients was at the midpoint of moderate degree of success in treatment with a mean of 4.6 on this single nine point rating scale. The Seeman Case Rating Scale clearly differentiates between Remainers (range 2-8) and Terminators (range 1-3). Therapists rated Remainers as having a better outcome (mean =5.43) than Terminators (mean=2.07).

(See Table 7 for a description of the results for Seeman's Case Rating Scale.) The Pearson Product Moment Correlation of the therapists' assessment of outcome on the Strupp Patient Measure and the Seeman Case Rating Scale was .69 ($p < .01$). (See Table 6 for intercorrelations.) The moderately high correlation underlines the similarities between Strupp's measure of interpersonal attraction and Seeman's general estimate of the success of treatment.

Attendance

There were two groups of patients, those who remained for an average of 13.3 sessions and missed an average of 1.5 sessions (11% of their sessions) and those who terminated prematurely after an average of 2.6 sessions and missed an average of 2.1 sessions (84% of their sessions). (See Table 7 for a description of the results for Attendance.)

Both Strupp's Therapist Questionnaire ($r = .43$, $p < .01$) and Seeman's Case Rating Scale ($r = .65$, $p < .01$) correlated with the number of Sessions Attended. This suggested that therapists considered patients Remainers to have a more successful outcome.

Strupp's Patient Questionnaire

After twelve sessions the total group of patients reported they were fairly satisfied with the results of treatment and with their therapeutic relationship. A high score indicated a favorable experience of therapy. The mean item score of 3.4 fell somewhat above the midpoint of 3.1 for the entire scale * (See Table 7 for a description of the results of Strupp's Patient Questionnaire.) Patient's favorable views of outcome correlated with an increase in Ego Strength ($r = -.43, p < .01$) (score calculated by subtracting the post score from the pre score). (See Table 6 for intercorrelations.) The questionnaire yielded a corrected split half reliability coefficient of .63.

MMPI - Ego Strength and Depression

Results of the MMPI as a measure of outcome indicated no significant differences in pre, post or change scores in Ego Strength or Depression for either Terminators or Remainers. (See Table 8 for a description of MMPI data.)

The data was examined for evidence of regression toward the mean by comparing pre scores with difference scores. Pre Ego Strength scores were divided into three approximately equal groups with Low Ego Strength scores ranging from 24-36 ($n=12$), Medium Ego Strength scores ranging from 37-44 ($n=9$), and High Ego Strength scores ranging from 45-54 ($n=12$). When compared with post scores, low pre Ego Strength scores tended to increase an average of 2.0 points, medium pre Ego Strength scores tended to increase an average of 2.78 points and high pre Ego Strength scores tended to

*Four out of twenty-eight items had six and seven point scales rather than five point scales. These were simply added along with the twenty-four five point scales to arrive at total score.

TABLE 7

Outcome measures: Means, Standard Deviations, Ranges and t Test Comparisons of differences between the treatment groups: (Remainers and Terminators)

Outcome Measure	N	Mean	S.D.	Range	t
<u>Strupp Therapist Questionnaire</u>					
Total Group	59	19.15	6.34	2-30	
Remainers	44	21.11	5.44	7-30	4.77**
Terminators	15	13.40	5.30	2-20	
<u>Seeman's Case Rating Scale</u>					
Total Group	59	4.58	1.98	1-8	
Remainers	44	5.43	1.47	2-8	8.01**
Terminators	15	2.07	.70	1-3	
<u>Sessions Attended</u>					
Total Group	56	10.98	6.25	1-40	
Remainers	44	13.27	4.92	6-40	7.37**
Terminators	12	2.58	1.68	1-7	
<u>Sessions Missed*</u>					
Total Group	56	1.56 (14%)	3.92	0-8	
Remainers	44	1.46 (11%)	1.81	0-6	
Terminators	12	2.08 (84%)	2.54	0-8	
<u>Strupp Patient Questionnaire</u>					
Total Group	36	43.56	15.07	4-72	
Remainers	28	41.39	15.38	4-72	1.38
Terminators	8	51.13	11.80	29-64	

*percentage refers to the number of broken or cancelled appointments over the total number of sessions attended

** p of $<.01$

decrease an average of 4.17 points. (See Figure 1 for a picture of the relationship between Ego Strength and Pre-Post Ego Strength.) There is a tendency for extreme scores to approach the mean upon retest. There was an overall tendency for Ego Strength to increase during therapy. Eighteen subjects increased in Ego Strength (mean=4.77 while fifteen subjects decreased in Ego Strength (mean=3.20).

Similarly, pre Depression scores were divided into three approximately equal groups with low Depression scores ranging from 7-12 (n=12), medium Depression score ranging from 13-15 (n=11) and high Depression scores ranging from 16-19 (n=10). When compared with post scores, low pre-Depression scores tended to increase an average of 1.5 points, medium pre-Depression scores tended to decrease an average of 1.87 points and high pre-Depression scores tended to decrease an average of 1.80 points. (See Figure 2 for a picture of the relationship between pre-Depression and Pre-Post Depression.) As with Ego Strength, there was a tendency for extreme scores to approach the mean upon retest.

(4) EXPECTATIONS AND OUTCOME

The major hypothesis stated that patients' expectations of psychotherapy and their therapist would be positively related to the

TABLE 8

MMPI measures of outcome: Means, Standard Deviations, Ranges and t Test Comparisons of Differences between the Two Treatment Groups: Remainers and Terminators

MMPI Measure	N	Mean	S.D.	Range	t
<u>Pre Ego Strength</u>					
Total Group	133	40.47	7.48	24-54	
Remainers	41	40.32	8.04	26-53	.25
Terminators	17	39.76	5.88	29-52	
<u>Post Ego Strength</u>					
Total Group	36	41.39	8.22	27-57	
Remainers	28	41.34	8.15	30-53	1.05
Terminators	8	41.34	8.15	30-53	
<u>Pre-Post Ego Strength</u>					
Total Group	32	-1.44	6.67	-19-1	
Remainers	26	-1.62	5.93	-19-9	.55
Terminators	6	-.67	4.76	-9-5	
<u>Pre Depression</u>					
Total Group	133	13.99	2.62	7-19	
Remainers	41	13.98	2.54	9-18	.79
Terminators	17	13.35	3.14	9-19	
<u>Post Depression</u>					
Total Group	36	13.19	2.62	7-19	
Remainers	28	13.32	2.57	9-18	1.56
Terminators	8	12.75	2.19	10-17	
<u>Pre-Post Depression</u>					
Total Group	32	.50	5.55	-5-4	
Remainers	26	.62	3.19	-5-4	.04
Terminators	6	0	3.16	-4-4	

FIGURE 1

Relationship between Pre Ego Strength and Pre-Post Ego Strength
 $r = .33$

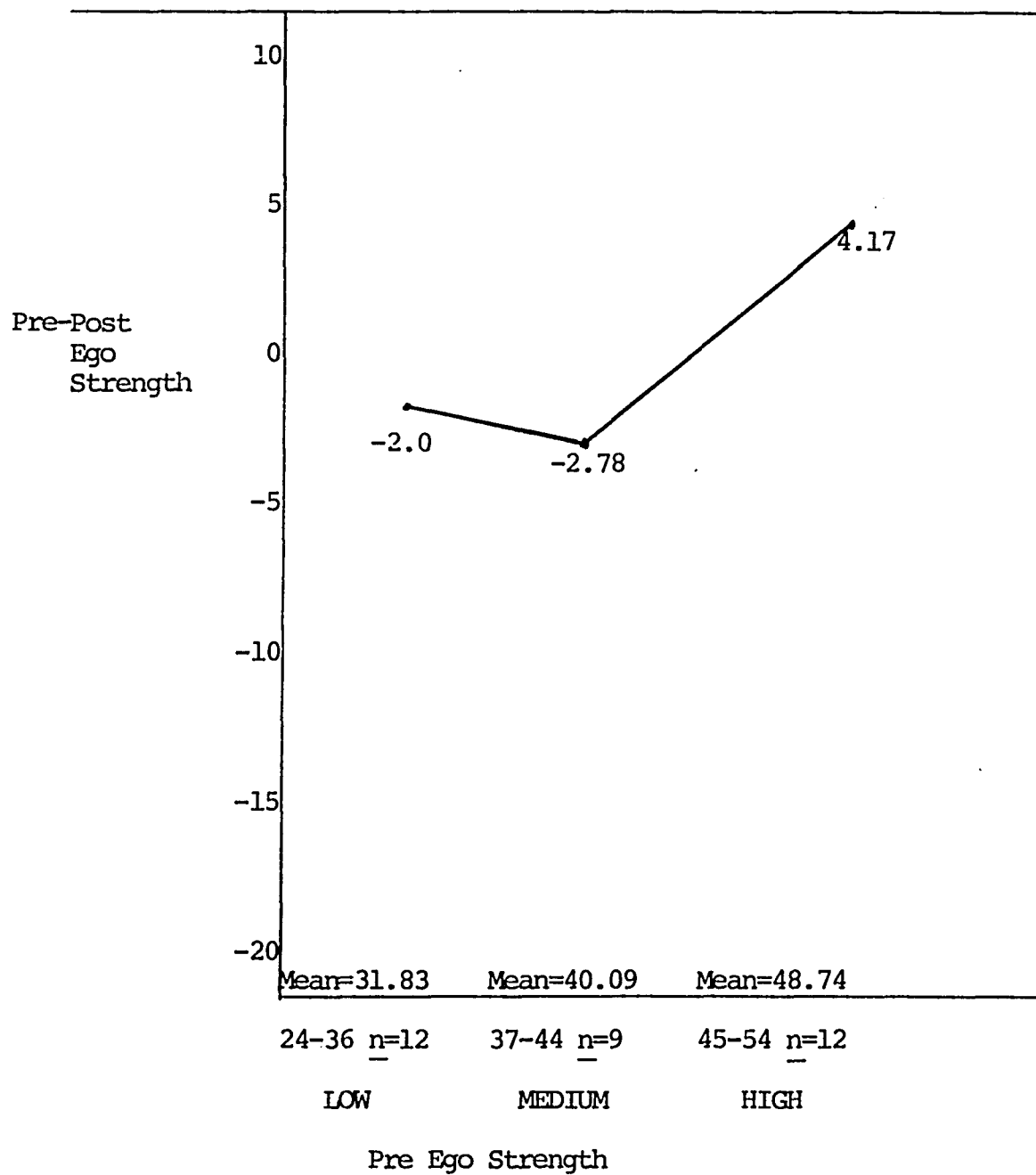
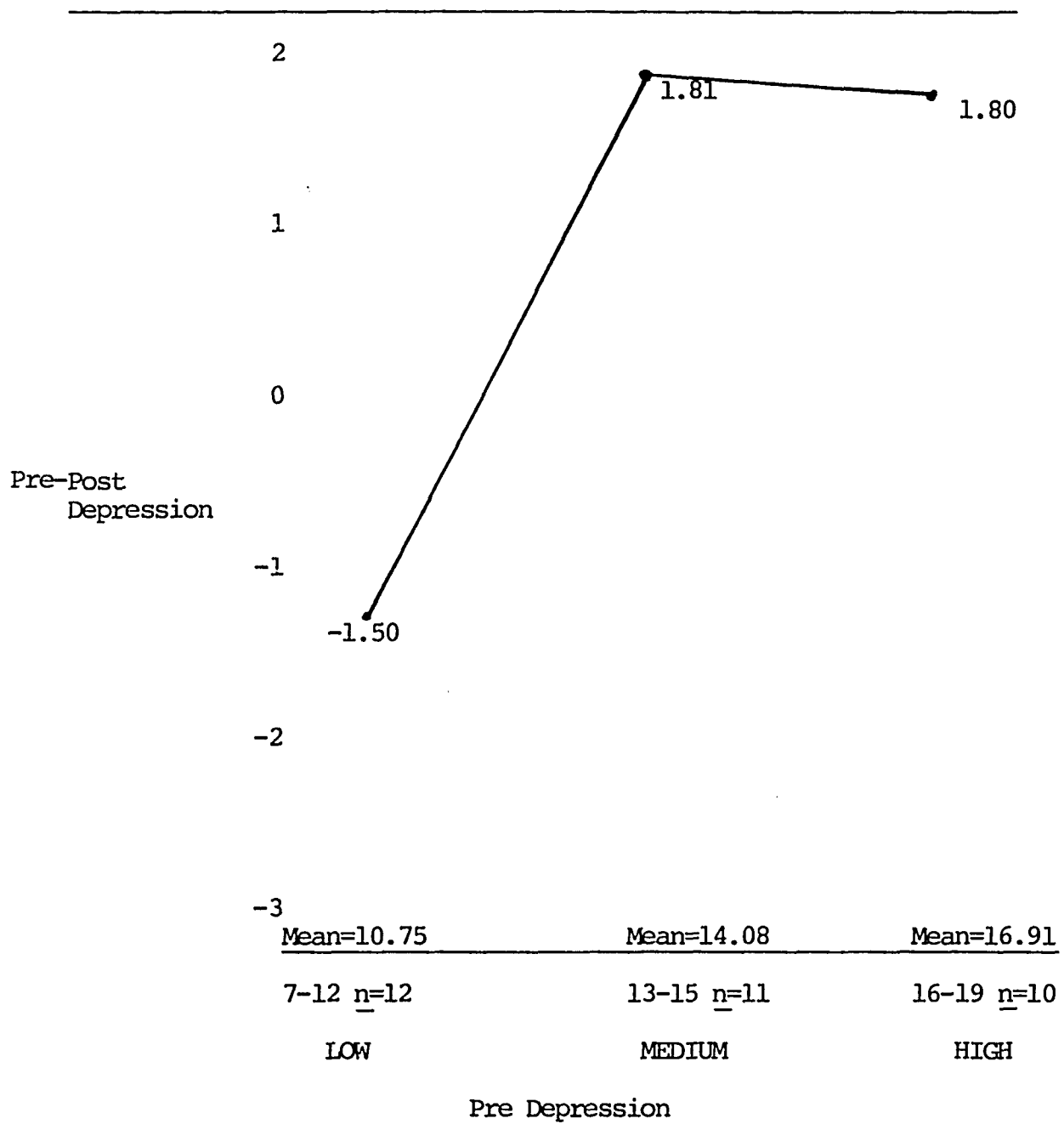


FIGURE 2

Relationship between Pre Depression and Pre-Post Depression $r = .52$



outcome of psychotherapy.

Attraction toward the therapist on the Libo PIT corresponded with fewer missed sessions ($r = -.47, p < .01$) therapists' feelings of attraction toward the patient ($r = .39, p < .01$) and the therapist's rating of success of the outcome of treatment ($r = .41, p < .01$). (See Table 6 for intercorrelations.) The Expectations of Therapy Measure correlated with Strupp's Patient Questionnaire ($r = .37, p < .05$).

The MMPI as a Measure of Outcome

The differences between the pre and post measure of the MMPI scales of Ego Strength and Depression have been used as measures of change in psychotherapy (Strupp and Bergin, 1969). The Pearson Product Moment Correlation between the difference scores yielded an r of .39 ($p < .05$) between pre-post Ego Strength and the Libo PIT. Zero order correlations were obtained in the remaining five instances. (See Table 6 for intercorrelations.)

The hypothesis must be examined in the light of a possibly confounding influence of regression to the mean. This can be illustrated in the case of Ego Strength scores.

Over time,

regression toward the mean would tend to inflate extreme Ego Strength scores below the mean and deflate extreme Ego Strength scores above the mean. The hypothesis that Ego Strength increases as a result of psychotherapy would predict that all Ego Strength scores would increase.

Ego Strength scores are expected to change over time whereas

expectations maintain a steady value. If the hypothesis is operating, expectations would correlate more highly with final Ego Strength score. Although only one measure of expectations, the Libo PIT correlates ($r=.28$, $p<.01$) with Pre Ego Strength, all three measures of expectation correlate with the Post Ego Strength measure. (See Table 6 for intercorrelations.)

Data supporting the hypothesis, rather than regression to the mean, can be illustrated with the use of Partial Correlations. (See Table 9 for Partial Correlations.) Here, if we eliminate the effects of post scores, we see that only the Expectations of Therapy Measure correlates ($r=-.33$, $p<.05$) with initial Ego Strength. On the other hand, if we eliminate the effects of pre scores, we see that all three measures of expectation correlate with Final Ego Strength scores and that all partial correlations in which the effects of Pre scores are eliminated are larger than those in which the effects of post scores are eliminated.

The negative partial correlations with Pre Ego Strength, holding Post Ego Strength constant and the positive partial correlations with Post Ego Strength holding Pre Ego Strength constant suggest an increase in Ego Strength as a result of therapy.

In sum, due to the lack of a control group, a series of calculations were performed in order to determine whether regression toward the mean contaminated the results of the MMPI. Evidence

TABLE 9

The MMPI as a Measure of Outcome: Partial Correlations with Measures of Expectations: the Libo PIT, Expectations of Therapist Semantic Differential, and the Expectations of Therapy Measure.

<u>Holding Post Scores Constant</u>			
	Libo PIT	Expectations of Therapist S.D.	Expectations of Therapy Measure
Pre Ego Strength <u>n=36</u>	-.03	-.08	-.33*
Pre Depression <u>n=36</u>	.22	.03	-.09
<u>Holding Pre Scores Constant</u>			
	Libo PIT	Expectations of Therapist S.D.	Expectations of Therapy Measure
Post Ego Strength	.48**	.41**	.46**
Post Depression	.22	.12	.15

** p of $<.01$, $r=.424$ d.f.=34

* p of $<.05$, $r=.329$

based on correlations with measures of expectation and partial correlations with measures of expectation suggested that, as predicted, Ego Strength scores increased as a result of psychotherapy rather than being determined by regression toward the mean.

POST HOC ANALYSES

Pretherapy Experiences

In order to expand the understanding of the impact of pretherapy experiences, these were intercorrelated with other therapy related variables. (See Table 6 for intercorrelations.) Of the fourteen correlations of interest, the following two correlations were not in the predicted direction. Positive referral sources corresponded with an increase in Depression ($\underline{r}=.45$, $\underline{p}<.01$) and patients who were close with someone who has sought psychological help experienced more anxiety after twelve sessions ($\underline{r}=.46$, $\underline{p}<.01$) than patients who did not have close ones in treatment.

The remaining correlations, on the other hand, implied that patients with positive pretherapy experiences undergo more successful psychotherapy.

A more hopeful attitude on the part of referral sources corresponded with the patients' experience of a more favorable outcome. ($\underline{r}=.52$, $\underline{p}<.01$).

Patients who have previously been in therapy had greater initial anxiety ($\underline{r}=.30$, $\underline{p}<.01$) expected to be in therapy longer ($\underline{r}=.48$, $\underline{p}<.05$), were more likely to complete twelve sessions ($\underline{r}=.30$, $\underline{p}<.05$) and were rated by their therapists as having a more

successful outcome ($r=.36, p<.01$) than patients who had not been in therapy. In sum, the data suggested that experienced patients were somewhat more motivated for therapy and had a slightly better outcome.

Patients who were close with someone who had sought psychological help rated therapy as having a more successful outcome ($r=.31, r=.26, p<.05$) and expected to be in therapy longer ($r=.43, p<.01$) and felt that the therapy had been more successful ($r=.37, p<.01$) than patients who were not close with someone who has sought psychological help.

Patients who felt that their close ones were helped in therapy were rated by their therapist as having a more successful outcome ($r=.51, r=.48, p<.01$) and were more likely to continue in treatment ($r=.45, p<.01$) than those who thought their close ones were not helped in therapy.

Intensity of Religious Belief

Intensity of religious belief was explored because it may contribute to the formation of favorable expectations of psychotherapy. This was measured by a direct self rating item (See Appendix for Pretherapy Questionnaire.) This routine aspect of the intake procedure was included on the assumption that the tendency to place unquestioning faith in an omnipotent supernatural being would be similar to belief in a potent authority figure. It was hypothesized that religious patients would demonstrate similar faith in a therapist. Placebo responders, who believe in their medical

treatment, have been found to be more religious (Shapiro, 1960).

The mean score of 3.78 indicated a "slight" belief in religion. The small standard deviation of 1.13 indicated little variability in response. Zero order correlations were obtained between intensity of religious belief and the three measures of expectations, and other therapy related variables.

The MMPI

The three scales of the MMPI were used both as measures of initial distress and of outcome. The two measures of distress, anxiety and depression, were not related. Pre and post scores correlated highly for all three scales. (See Table 6 for intercorrelations.)

It is interesting to note that question 22 of Strupp's Patient Questionnaire, "How severely disturbed did you consider yourself at the beginning of your therapy?" correlated .37 with Pre Anxiety. Thus, patients' retrospective estimate of their level of pretherapy disturbance corresponded with the degree of anxiety actually experienced at that time.

Demographic Variables

Socio-economic Status. No clear cut trends were found between SES and MMPI measures (See Table 10 for intercorrelations with SES.)

SES was related to the outcome of psychotherapy. Seeman's Case Rating Scale ($r=.53, p<.01$) directly correlated with SES. Similarly subjects with higher SES attended at least twelve sessions ($r=.45, p<.01$).

The older patient, the higher his class ($r=.34, p<.05$). Older patients' SES was computed on the basis of their own occupation whereas younger patients' SES was based on their parents' status.

Age. Older people obtained lower anxiety scores prior to treatment ($r=.22, p<.05$) but higher Depression scores after twelve sessions ($r=.41, p<.01$). They expected to wait longer before seeing results in treatment ($r=.20, p<.05$) and were more likely to have been in therapy previously ($r=.20, p<.05$). (See Table 10 for intercorrelations with age.)

Ethnicity. As compared with whites, the present sample of non-whites had less favorable expectations of therapy ($t=2.30, p<.05$) were more likely to have close ones in treatment ($t=2.73, p<.01$), were rated by their therapists as having a less successful outcome of therapy ($t=2.42$) missed more sessions ($t=2.42$) and experienced an increase in Depression after twelve sessions ($t=2.49$). (See Table 11 for the results of Ethnicity).

Sex. Women admitted to greater Anxiety before treatment ($t=2.68$) (See Table 11 for results of Sex).

TABLE 10

Correlations between Demographic Variables of Socioeconomic Status: Subjects' Education, Subjects' SES Score, Parents' SES Score, Age and other Dependent Variables

Variable	Subjects' Education n=104	Subjects' SES score n=35	Parents' SES Score n=82	Age n=102
Previous Treatment (128)				.20*
Start of Change (117)				.20*
Optimism (125)			-.25	
Age (102)	.32*	.34*		
Strupp Therapist Quest. (59)		.37*		
Seeman Case Rating (59)		.53**		
Sessions Attended (56)		.45**		
Pre Ego Strength(133)		.34*		
Pre Depression(133)	.22*			
Pre Anxiety(133)		.40*		-.22*
Post Ego Strength(36)		.75**		
Post Depression (36)			.73**	.41*

** p of <.01

* p of <.05

TABLE 11

Comparisons between Locale: Teachers' College and City College, Ethnicity: White and Non-White, and Sex: Male and Female, and other dependent variables.

Variable	<u>Ethnicity</u>						<u>t</u>
	White			Non-White			
	N	Mean	S.D.	N	Mean	S.D.	
Libo PTT	76	.55	.50	19	.26	.45	2.30*
Close Ones in Treatment	80	.35	.48	19	.68	.48	2.73**
Seeman Case Rating Scale	43	4.95	1.84	6	3.00	2.00	2.42*
Sessions Missed	42	1.43	1.67	5	3.40	2.19	2.42*
Pre-Post Depression	25	1.12	2.39	4	-2.0	1.83	2.49*

Variable	<u>Sex</u>						<u>t</u>
	Male			Female			
	N	Mean	S.D.	N	Mean	S.D.	
Pre Anxiety	66	11.27	4.03	65	13.05	3.53	2.68**

Variable	<u>Locale</u>						<u>t</u>
	City College			Teachers' Coll.			
	N	Mean	S.D.	N	Mean	S.D.	
Previous Treatment	96	.67	.47	32	.28	.46	4.02**
Expectation of Duration	81	3.10	1.67	32	3.94	1.32	2.54*
Start of Change	86	1.56	1.36	31	2.51	1.90	3.01**
Age	69	22.07	4.67	33	26.03	7.00	3.38**

** p of <.01

* p of <.05

Locale. Subjects who applied for treatment at City College were younger ($\underline{t}=3.38$), more likely to have had previous treatment ($\underline{t}=4.0$), expected therapy to be a shorter process ($\underline{t}=2.54$), and expected to start seeing results in treatment sooner ($\underline{t}=3.01$). (See Table 11 for the results of Locale).

CHAPTER 4 DISCUSSION

DESCRIPTION AND ANALYSIS OF THE SAMPLE

The first task is to recapitulate and interpret the characteristics of the current sample. The modal subject was middle class, white and about twenty-three years old, with a minimal belief in religion.

Socioeconomic Status. Social class did not relate to favorable expectations. Similarly, Brady et.al. (1959) found that favorable attitudes did not correspond with occupation or level of education.

Ethnicity. There was a prevalence of whites in the present sample. The few non-whites had less favorable expectations and a less successful outcome. This corroborates findings on "Non-Yavis" patients. (Gleidman et.al., 1957). The current sample of non-whites were more likely to have a close one in treatment which seemed to correspond with a favorable prognosis for this sample. Close ones may be a major source of referral for non-whites whereas whites may utilize more varied sources of referral. The nineteen non-white patients may be different from other non-whites in that they are in treatment at two predominantly white clinics and have close ones in treatment.

Sex. Although women reported more anxiety than men prior to treatment, there was no difference in outcome. This contradicted

Stone et.al, (1961), who found that women had better outcome than men.

Locale. Most of the sample was from the City College Psychological Center. Patients at City College were younger than those at Teachers' College. Neither age nor locale showed any relationships with the measures of expectations or measures of outcome.

Intensity of Religious Belief. This was not found to be related to pretherapy expectations within this sample. The hypothesis may not have been adequately tested because of the widespread lack of belief in religion demonstrated by the current sample. The amount of variability was minimal. An adequate test of the importance of religious belief would necessitate a more heterogeneous sample.

Measures of Expectation

The subjects exhibited relatively negative attitudes on all three measures of expectation. This reflects a surprising lack of enthusiasm, as patients must muster a great deal of energy and courage to apply for psychotherapy. It may be a result of a resistance to completing the questionnaires.

Another possible explanation of the overall, relatively negative expectations lies in the finding that patients with favorable expectations of psychotherapy on the Libo PIT had greater initial depression. Rather than glorifying the person of the therapist, their depression may have lent a negative cast to their expectations.

Why would a patient with unfavorable expectations come for treatment? An examination of two extreme cases may illuminate this

paradox. One patient expected his therapist to be extremely "cold". On the Libo PIT he wrote, "Harvey feels Seymore is observing him rather than listening" also, "Harvey wants Seymore to talk to him rather than make him feel as if something was crazy about him". The choice of the name Seymore, or "see more" may symbolize the therapist's omniscience. This may also, in part, be a reaction to disclosing personal material on a questionnaire. The patient reported a moderately successful experience in therapy with a near average rating. After twelve sessions he only moderately felt that the tone of his therapist's statements "tended to be rather cold". Thus, his extreme expectations seemed to have mellowed as a result of his experience in treatment. The therapist rated this patient somewhat below the mean in success of treatment giving a below average rating to such statements as "Degree to which you felt warmly toward the patient" and "Degree to which you think the patient feels warmly toward you."

In sum, a patient who had the expectation that the therapist would be extremely cold established a relationship in which both participants felt some coolness but were able to work together.

Another patient, with an extremely unfavorable score on the Expectations of Therapy Measure, felt that "It is difficult to understand how talking to a psychotherapist can help a person solve his problems" and "Psychotherapists often have more problems than their patients". His responses on the measures of expectation, however, were inconsistent in that he reported anticipating that his therapist would be extremely "warm", "kind", and "accepting". On the

Libo PIT he wrote "nothing much of anything constructive will happen". He had "no belief one way or the other "that the results he wanted from therapy would be achieved". This patient expected to start seeing results" less than one month" after starting treatment and expected therapy to be a "four month" process. This may reflect an impatience for fast results. In sum, his unfavorable expectations may have mainly focused on the process of therapy rather than on the person of the therapist.

This patient completed twelve sessions and gave the therapy a very negative rating. Upon closer examination his negative score on Strupp's Patient Questionnaire was due to his feeling that he was still very much in need of help, he had not yet improved as a result of therapy. His feelings toward the therapist tended to be moderate to positive. The therapist reported marked success with this patient.

In sum, this patient's pessimism about the process of therapy and his impatience for quick results seemed to lead to feelings of dissatisfaction with therapy. On the other hand, his more favorable and receptive expectations of his therapist may have facilitated a good rapport and an optimistic rating on the part of the therapist.

(1) Initial Distress

There was an indication that initial distress was somewhat related to patients' pretherapy expectations, in that patients, who experienced slightly greater depression before the start of treatment, anticipated being attracted to their therapist.

and the clinical setting he represented. Since only one out of six correlations attained significance it cannot be said that the hypothesis was supported, but the results suggest a need for more specific study.

Gleidman et.al. (1957) enhanced the theoretical understanding of expectations by explaining that people with greater distress felt a more urgent need to change. Although depression usually engenders a sense of hopelessness, the slightly higher level of depression may in this case have heightened a need for relief, disposing the patient to put faith in what is offered.

Frank (1959) further suggested that a patient's disclosure of distress indicates a willingness to expose his vulnerabilities. This bodes well for a receptive attitude toward the therapist.

(2) Pretherapy Experiences

Referral Source: On the whole referral sources were described as very encouraging. There was an indication that hopeful attitudes on the part of the referral sources corresponded slightly with favorable expectations of psychotherapy and with a favorable outcome, implying that positive referral sources may enhance the patients' anticipation and subsequent evaluation of treatment.

Why would a patient who received an extremely negative referral come to treatment? There were only three incidents of extremely negative referrals. In one protocol, chosen at random, a client reported that her friend said the Psychological Center would be "not at all helpful". This twenty-five year old had previously been in therapy and had a close one whom she considered to be very

much helped by therapy. Despite her unfavorable referral, she believed that "results would be achieved". She had moderately favorable expectations of her therapist and therapy. On the Libo PIT she reported a highly charged anticipation of therapy: "He had spent the interview asking symptom questions, never even looking at her, asking her questions she had answered three times before on numerous forms which he should have read. She would like to tell him accurately and calmly why she is angry but if she tried to she would start crying". The therapist rated the outcome as being more successful than average. The client did not return her outcome questionnaire, consistent with her resentment of the "numerous forms".

In sum, this patient focused her negative feelings on the Psychological Center rather than on the process of psychotherapy. Her report of an extremely negative referral may have been an aspect of her anger at having to complete the questionnaire.

Previous Treatment. There was an indication that people who have been in therapy before have somewhat more favorable expectations of therapy. Further, these experienced patients were somewhat more motivated for treatment and had a slightly better outcome.

That these people are reapplying for a process with which they are acquainted implies a hopeful attitude. Their enhanced outcome may be due both to their slightly more favorable expectations and their educated or congruent expectations.

Close Ones in Treatment: There was an indication that people who have close ones in treatment have somewhat more favorable expectations of psychotherapy. These friends or relatives may provide the applicant with a realistic and encouraging picture of therapy. This corresponds with Kadushin's (1969) description of referral sources as being "friends and supporters of psychotherapy". In sum, both direct and indirect experience with therapy may enhance favorable expectations.

People who have close ones in treatment feel that therapy has been fairly successful. Therapists seem to enjoy working with patients who have some acquaintance with psychotherapy. Thus, experience with therapy may also enhance outcome.

Close Ones Helped: Patients who feel that their close ones have been helped by psychotherapy exhibited somewhat favorable expectations of therapy. They were rated by their therapists as having somewhat more successful outcome and were more likely to continue in treatment than those who did not think their close ones were helped. These patients seemed to be encouraged by the successful experiences of people close to them.

Why would a person who felt that a close one had not been helped come to therapy? There were no extreme responses to this item. One client who remained in therapy for the twelve sessions reported, however, that a close one had been only "slightly" helped by psychotherapy.

This client had a very enthusiastic referral source, and had never been in therapy previously. She "strongly believed", however, that the results in therapy would not be achieved. The negative pretherapy experience and the pessimistic prognostic outlook were not consistent with her responses on the measures of expectation. She reported moderately favorable expectations of therapy and of her therapist. There were no extreme statements on the Libo PIT. Both the client and the therapist reported a moderate degree of success in treatment with near average ratings. In sum, it seems that the negative experience of a close one did not mar this client's venture in psychotherapy. Perhaps in this client's case, the positive referral source outweighed the report of a close one.

The two contradictory findings, that patients with favorable referral sources reported an increase in depression after twelve sessions and that patients with close ones who had been in treatment experienced greater anxiety after twelve sessions may be understood by using Frank's (1959) conceptions. Patients with these positive pretherapy experiences coupled with a good therapeutic rapport, may be more willing to disclose their distress.

In sum, there was some support for the hypothesis with five out of twelve possible correlations attaining significance, four at the .05 level and one at the .01 level of probability. Positive pretherapy experiences may enhance the likelihood of favorable expectations and of a more successful outcome.

(3) Prognostic Expectations

It was hypothesized that patients' realistic and optimistic prognostic expectations would be related to favorable expectations of psychotherapy. There is apparent similarity between the concepts of patients' expectations of psychotherapy and patients' personal estimates regarding their expectations of outcome. Prognostic expectations however, are clearly defined by two elements, realism and optimism, whereas favorable expectations are measured by a generalized attitude scale.

Expectations of Duration: Most patients tended to estimate the duration of therapy as being a four to six month process. There was some indication that the more favorable the patients' expectations of therapy, the longer his estimate of the duration of therapy with one out of three correlations attaining significance at the .05 level of probability. Thus, patients with favorable expectations of therapy expected to stay somewhat longer and had a slightly more realistic outlook for the two clinics sampled.

Start of Change: Most patients expect to notice some results almost two months after the beginning of treatment. While related to estimated duration of treatment, this was unrelated to expectations.

Optimism: Patients were, on the average, just barely optimistic in their hopes for results. This lack of enthusiasm echoes the relatively negative attitudes displayed on the three measures of expectation. Optimism showed a small relationship with favorable expectations with one out of three possible correlations attaining

significance at the .05 level of probability.

Why would a pessimistic patient come to therapy? One patient who strongly believed "the results of therapy will not be achieved", responded in a somewhat inconsistent fashion on the Expectations of Therapy Measure when she strongly agreed that "Psychotherapists successfully help people with their problems". On the whole, this patient scored close to average in favorable expectations and in success of outcome.

Another pessimistic patient wrote on the Libo PIT "Nothing will change". This patient had moderately unfavorable expectations of therapy. However, she reported very favorable expectations of her therapist but did not complete the outcome questionnaire. Her therapist gave her an average rating of outcome indicating a moderate degree of success.

In sum, extreme pessimism did not seem to correspond with a consistent pattern of unfavorable expectations or of poor outcome. The inconsistency may be due to the patient's ambivalence.

The hypothesis was weakly supported by a slight relationship between expectations of duration and optimism and favorable expectations of therapy.

The weak relationship between patients' expectations of outcome and patients' expectations of their therapist and therapy, two apparently similar concepts, may have been due to the different degrees of specificity. Prognostic expectations were clearly defined by two aspects, realism and optimism. Favorable expectations were measured

in a more global way.

THE EFFECT OF EXPECTATIONS ON OUTCOME

In general, therapists rated patients as having moderately successful outcome whereas patients experienced a somewhat greater degree of success. Outcome measures were administered after twelve sessions. By and large, the therapists at the two clinics anticipated a much longer duration of therapy, seeing the twelve session mark as a mere beginning. Their relative restraint in the judgement of outcome is probably a conservative estimate of their view upon actual termination.

Therapists considered remainers to have a more successful outcome than terminators. In contrast, patients who terminated prematurely did not exhibit any difference in their attitudes from patients who remained. When interviewed by telephone, terminators said that the clinic was a fine place, but they had decided that they did not need therapy, that their problem was not psychological. Therapists rate terminators as having a poor outcome whereas these same terminators feel neutral to favorable about their experience. Thus, therapists and patients view the therapy situation from different vantage points.

Both measures reflecting the therapists' view of the outcome of therapy and measures reflecting the patients' view of outcome were fairly consistent. The lack of correspondence between therapist and patient based scales, however, reflects the multidimensional nature of outcome to be discussed later in this paper.

(4) Expectations and Outcome

The major hypothesis of the study stated that patients'

expectations of therapy and of therapists were directly related to the outcome of psychotherapy. Patients' stories reflecting high anticipation of attraction toward the therapist were found to correspond with the therapists' feeling of attraction toward the patient and the therapists' overall rating of the success of treatment. Both yielded correlations at the .01 level of probability. This finding upholds the formulation that interpersonal attraction is an essential factor in the success of psychotherapy (Goldstein, 1971).

While no causality can be assumed, the data suggests that therapists sense the patients' favorable attitudes and respond in kind. This would corroborate the findings of Rosenthal (1966), Russell(1961); Goldstein et.al.(1966), and Goldstein et.al. (1966), who concluded that increased patient attraction to the therapist leads the therapist to have a more favorable view of the patient.

Patients with favorable expectations miss fewer sessions and report that they were satisfied with the outcome of treatment. In each instance one out of three possible correlations attained statistical significance.

In sum, there was support for the hypothesis from both therapist and patient based measures of outcome.

Implications of the Influence of Expectations on Outcome

In their review, Strupp and Bergin (1969) take a mild position on the phenomenon of expectations. They feel that although these influences are a necessary and real part of helping relationships, expectations are not the essence of therapy. Expectations facilitate the relationship and, they claim, affect superficial mood changes, for example, depression. The influence is so obvious and overt that expectations seem more significant than they really are.

This is, at best, a weak argument. In this study, expectations not only correlated with change in depression but were also related to the therapist's ratings of outcome which is not, after all, a superficial mood change. Obvious and overt influences are strong factors which must be confronted.

Frank (1966) takes a strong position on the role of faith and persuasion in non-medical healing. In light of the evidence of personality change effected by shaman and religious healers, it is difficult for a psychotherapist to assert that it is the technique of therapy, rather than faith in a cure, that produces change.

In addition, Frank (1961) continues, the shaman, revivalist, interrogator or psychotherapist must have a firm belief that the procedures are for the subject's welfare and that they will work. Frank tells the story of Quesalid, a tribesman who decided to sham the role of a shaman in order to expose its fraudulance. He successfully deposed powerful shamans and cured scores of people.

His skepticism was not able to withstand his own successes and the belief of his group in his powers.

An inexperienced therapist often feels, at first, that he does not know what he is doing or how it would work. Even an experienced therapist may at times doubt the efficacy of his personal and private conversations with patients. Supervisors, colleagues and patients all help to reassure therapist as to their effectiveness and authenticity.

In addition to the influence of expectations, therapists are also aided by the healing power of time and nature, and by the numerous resocializing propensities with which culture has endowed patients, that they may perhaps take undue credit when patients do well.

The clinician's and researchers' reluctance to acknowledge the possible importance of expectations can be understood by examining the controversy that surrounded Rosenthal (1966). The implication that the content of an experiment or, in this case, of psychotherapy, is simply an epiphenomena, a mere reflection of factors preceding the event, makes experiments and psychotherapy seem like futile exercises.

Further, the clinician's hesitation to lend credence to the possible effects of expectations perhaps challenges his feelings of omnipotence, adding to self doubts. That the patient's expectations may possibly outweigh a cleverly phrased interpretation or a well timed intervention may strip the therapist of a sense of control.

Let us now take a closer look at the implications of the effect of expectations on psychotherapy. Is the role of the therapist negligible? To say expectations partly account for outcome in psychotherapy does not mean that they are totally responsible for the outcome. The stronger the effects of expectation, however, the more the highly stylized process of psychotherapy is cast into the role of a placebo.

Expectations are a necessary but not sufficient determinant of outcome. A hypothetical analogy will be useful here. The expectations of surgery patients can influence their recuperative powers. This does not mean that recuperation is totally the result of expectations. Since psychotherapy is a subtle and subjective process, the patients' anticipations probably play a large role. This formulation does not entirely negate the effects of the therapist. For example, evidence on the experience of therapists, Meltzoff and Kornreich (1970), shows that more experienced therapists have fewer premature terminations.

Since, in the present study, outcome was measured after only twelve sessions, we can merely conclude that expectations influence the initial phase of treatment. Therapists who work toward long term personality change could dismiss expectations as being a preliminary and transient phenomenon.

Rather than discount the effects of expectations, it would be more productive for clinicians to incorporate them into the practice of psychotherapy. Goldstein, (1971), and Stone et.al. (1961) have

constructively attempted to influence patients' expectations in order to facilitate the therapeutic relationship. The results of this study suggest that referral sources and therapists might improve the therapeutic alliance by encouraging favorable expectations in the patient. This conclusion can be extended to intake workers and receptionists. By being honest and encouraging, within ethical bounds, therapeutic personnel may be able to enhance the outcome of therapy.

Likewise, rather than minimizing the implications of the effects of expectations, researchers should be alerted to one more source of uncontrolled variance. If expectations are not held constant, it is impossible to tell exactly which therapeutic ingredients, placebo or otherwise, are doing most of the work in creating change. This caution burdens the researcher with yet another paralyzing injunction in an area plagued with unmanageable variables.

LIMITATIONS OF THE STUDY

The relatively few significant correlations were low. The partial support should not be discounted, however, because of the complexity of the constructs involved, and the difficulty in controlling confounding variables.

DATA COLLECTION

Of an original sample of one hundred and thirty-three subjects, eighteen were not accepted for treatment, sixteen were placed on a waiting list and fifteen did not show for their first therapy

appointment. Seventeen subjects terminated prematurely, and sixteen patients and two therapists did not complete outcome measures. Only twenty-six patients completed twelve sessions and returned all questionnaires. Subjects who remained for twelve sessions, and those who terminated prematurely differed only in therapist ratings of outcome.

Many subjects did not complete all measures or all questions within a given questionnaire. This, in addition to the relatively negative attitudes portrayed in the three measures of expectation, may reflect a resistance to filling out forms. The small return may be partly due to the uneasy marriage between the clinician and the researcher. Whereas the activities of the clinician generate hypotheses, the researcher is able to confirm and scientifically substantiate these claims. The necessary interdependence is fraught with difficulties.

Some of the usual friction between the researcher and the clinician surfaced during the course of this study. Ten therapists involved in the current study expressed a resistance to participating in psychotherapy research. Some felt it would alter the treatment, raising untimely questions in the patients' minds. These therapists were unfamiliar with Lennard and Bernstein's (1960) finding that an early and active discussion of expectations facilitates therapy. The other therapists, however, felt patient responses would be "grist for the mill".

Although therapists were generous with their time and energy, few were enthusiastic. Most therapists had to be reminded to return

questionnaires. Some refused to personally hand their patients questionnaires because they wanted to disassociate themselves from what they considered the mechanical and cold exploitation of their patients. Therapists felt that research disrupted the confidential and intimate atmosphere established in therapy. They did not want this privileged and private relationship violated.

The directors of the two clinics involved in the study were aware of the problem. In one case, a director was surprised that any student therapists agreed to cooperate with the research. Supervisors, generally, did not obstruct the research but also did not encourage student therapists to participate.

Eight patients who were interviewed did not express the same sentiments as their therapists. Two patients complained about the bother of completing questionnaires, about the time and energy involved, but the other six took it for granted since it was presented as a routine procedure of the clinic. The patients were being interviewed by an authority figure, a researcher, and may have been anxious to please and have understated their feelings. It is the sense of this investigator, however, that therapists exaggerate the impact of a research study. This points to the need for greater collaboration between the researcher and the clinician.

PROBLEMS IN MEASUREMENT

Problems in measurement were yet another factor which contributed to the paucity of significant correlations.

Measures of Expectation

The Libo PIT proved to be a valuable measure of expectations in that it correlated with MMPI measures, outcome measures and questions which measured previous acquaintance with therapy and ethnicity. Its open ended level of measurement may have enabled subjects to disclose unconscious or repressed material which would not be available on the more structured measures which called for conscious thoughts.

The results provided a test of the validity of the measures. Libo (1957) originally designed the PIT to predict whether or not a patient would return after his first therapy interview. The finding that patients who miss more sessions demonstrate negative expectations on the Libo PIT lend support to the validity of the instrument. On the other hand, subjects who had favorable attitudes on the Libo PIT did not attend a significantly greater number of sessions.

Similarly, the correlations between the Expectations of Therapy Measure and other therapy related variables such as prognostic expectations, previous experience, and Strupp's Patient Questionnaire, lent some support to the validity of this scale as a measure of expectations of psychotherapy. The Expectations of Therapist Semantic Differential, however, correlated only with Post Ego Strength. The Semantic Differential may not have been a useful measure due to the lack of variability in the responses.

Although the Libo PIT was the most valuable measure of expectation, it did have shortcomings. The Libo PIT is a dichotomous measure

composed of two aspects, degree of involvement with the therapist and intensity of attraction toward the therapist. Results indicated that the final Libo PIT score mainly reflected intensity of attraction. Although these two aspects are related, it is not clear that they are similar enough to combine into one score. The combination of these two separate aspects confuses the interpretation of the single final score and, furthermore, makes the interval data of the two aspects inaccessible. The final nominal data score of the Libo PIT wastes a great deal of information embodied by its two interval components.

The three measures of expectation did not correlate with each other. This could be due, firstly, to measurement error. There were some indications, however, that the instruments were adequate. All three questionnaires are moderately reliable (see Method Section). The tendency of the results to support the hypotheses and the correlations with other therapy related variables lent support to the validity of the Libo PIT and the Expectations of Therapy Measure.

The lack of correlation among the three measures of expectation may be due to the difference in the level of measurement, both open ended and structured tests were used. Results of an unconscious level may not correspond with results of a conscious level in that subjects can distort and repress consciously reported data. This possible explanation calls for further study.

Furthermore, the lack of correlation may point to a multi-dimensional nature of expectations with expectations of therapy being

a different construct from expectations of therapist. For example, a person may have apprehensive anticipations of therapy but sense it will be good for him, no matter how much it hurts. On the other hand, the same person may foresee only negative feelings about his therapist. The lack of correspondence among the measures of expectation points to an area in need of further study. There is a paucity of instruments which adequately examine the affective nature of expectations of psychotherapy.

Measures of Outcome

Strupp's Patient Questionnaire: The major difficulty with Strupp's Patient Questionnaire was the heterogeneity of the items. Firstly, four out of the twenty-eight items had six and seven point scales rather than five point scales. All items were simply added to arrive at total score. The four items with longer scales were not directly comparable to the twenty-four five point scales. Strupp, however, did not publish a method of weighting the longer items.

Secondly, not all items in the questionnaire allowed the patient to evaluate the therapist and therapy. Six items dealt basically with the patients' past or present level of adjustment and need for treatment. This heterogeneity reduced the level of reliability*.

*Because of the low corrected split half reliability coefficient of .63, an item analysis was performed. Twenty-two items correlated at least .32 ($p=.05$) with total score. Items 1,5,17,22,23, and 27 yielded non-significant correlations. If the above six items are omitted, the corrected split half reliability coefficient is .93.

The MMPI as a Measure of Outcome

The Ego Strength and Depression scales seemed to be mildly subject to the pull of regression toward the mean on retest. If Ego Strength is a useful measure of change in psychotherapy, it would tend to increase as a result of therapy. Ego Strength scores were divided into three equal groups: low, medium and high. Although high Pre Ego Strength scores decreased sharply upon retest, the bulk of low and medium Pre Ego Strength scores increased. This provided some support for the use of the Ego Strength scale as a measure of change in psychotherapy. Results for the Depression scale were inconclusive.

Evidence based on . . . correlations with the measures of expectation, and partial correlations with the measures of expectation suggested that regression toward the mean was not an important factor. Ego Strength scores increased after psychotherapy. Again, results for the Depression scale were inconclusive.

The paucity of correlations between the measures of expectation and the change scores of the Ego Strength and Depression scales along with the tendency for subjects with favorable expectations to experience a decrease in Ego Strength did not support the hypothesis.

This relatively objective measure of outcome, furthermore, was not consistent with the more subjective measures of patient and therapist views of outcome. This underlines the multidimensional nature of outcome which will be discussed further.

PROBLEMS IN RESEARCH DESIGN

Psychotherapy research was stimulated by Eysenck's (1952) challenge that psychotherapy is ineffective. Bergin, (1971) in his reply to Eysenck claims that the question "is psychotherapy effective" is no longer fruitful.

" Does psychotherapy work is like asking what are the effects of medicine? and then proceeding to collect a group of doctors practicing on patients to test for changes in "health", whatever that is".

Bergin (1971) has reworded the question to read,

" What specific therapeutic interventions produce specific changes in specific patients under specific conditions?"

This reformulation of the question highlights some of the complexities involved in psychotherapy research. As the hurdles in research design are reviewed, the reader will begin to understand why there is a paucity of research in this area.

Outcome Criteria

Just as there are numerous theories of personality and techniques of psychotherapy, there is much disagreement on the concept of personality change. Strupp (1971) decries this lack of accord. Whereas behaviorists accept only overt behavior change as a criteria, other psychologists accept self report. The reliability and validity of projective techniques has been open to question while reports of friends and relatives may be self serving.

Change has been found to be multidimensional. In large factor analytic studies, Nichols and Beck (1960) and Cartwright and Roth

(1957) discovered that each person's rating of change comprised a different factor. The most typical factors are: a) client self-evaluation b) therapist evaluation, c) TAT or other fantasy evaluation, d) indices of concrete overt behaviors.

The lack of correspondence between patient based and therapist based measures of outcome was demonstrated in the current study. Rather than take one participant's word over the other, each can be considered in its own right. Multiple measures of outcome are desirable, but increase the complexity of the evaluation of change.

Bergin (1971) advocated the development of specific rather than global indices of improvement. Thus, if a person seeks help for depression, change in depression could be the criteria of outcome rather than global psychological status. This would necessitate small sample research. Similarly, Kiesler (1966); Bergin et.al 1971 applauded the growing tendency to employ specific techniques to suit different problems.

Lack of Control Groups

If a patient has changed over the time span in which psychotherapy has occurred, can these changes be attributed to psychotherapy? In order to test this, an experimental and a control group is needed. The experimental group is tested prior to therapy and upon termination. They may also be followed up after their therapy.

There have been various approaches to control groups. A control group must include patients who are applying for psychotherapy. These patients must have an experience similar to the experimental group.

Receiving no treatment or being rejected for immediate treatment and placed on a waiting list are not adequately similar to the experiences of the experimental group. The best solution is to accept the patient into a series of discussions known as an attention placebo control. This, it may be argued, is not clearly different from psychotherapy.

In the present study, it is questionable whether improvement on the post test of the MMPI can be attributed to psychotherapy as no adequate control group was available.

Past attempts to utilize control groups with the MMPI have failed. Levis and Carrera(1967) and Barron and Leary (1955), using populations similar to that of the current study (outpatients in their twenties with some college education) used waiting list controls to investigate the MMPI as a measure of outcome in psychotherapy. Both found no difference between subjects who had undergone psychotherapy and subjects who had been placed on a waiting list. Cartwright (1956) reanalyzed Barron and Leary's (1955) data and found that the experimental and control groups were not comparable. Thus, although the MMPI is thought to be an adequate measure of change in psychotherapy (Strupp and Bergin, 1969) there continues to be a problem in locating adequate control groups.

Effects of Pretesting

Goldstein, Heller and Sechrest (1966) underlined the possible sensitizing effects of pretesting. The variables under experimental scrutiny are brought to the patient's awareness and may enhance the possibility of subsequent change, on the specific instrument used.

They feel this necessitates a control group of non-pretested but treated subjects.

These considerations are especially strong in the current study. Expectations are subtle, complex and easily influenced (Frank et.al., 1957). The mere administration of a questionnaire tapping expectations may either alter the patients' expectations or alert them to special aspects of the therapy process, contaminating future measures. Orne (1962) further suggested that simply being in an experiment is enough to evoke a special response.

The Therapist as an Uncontrolled Variable

The plethora of theories and techniques of psychotherapy creates a confusion as to the definition of the process. In the present study, psychotherapy is defined as the transactions between the therapist and the patient in psychoanalytically oriented treatment. It is, however, by no means certain that all the therapists agree on the definition of psychoanalytically oriented therapy. It is probable that they did not behave in the same manner. This lack of homogeneity contributes uncontrolled variance.

Therapists cannot be regarded as interchangeable units. Depending on training, experience and personality, therapists exert different effects under different conditions. In the current study, the level of experience and type of training was controlled. This, however, by no means makes the influence of the therapists uniform.

The Patient as an Uncontrolled Variable

If we measure change in the patient with the use of pre and

post therapy personality indices, there is no assurance that the change is due to psychotherapy.

Maturation is a naturally occurring phenomenon, a part of growing up. Eysenck (1952) challenged that psychotherapy adds nothing to the natural process of spontaneous recovery. Thus, the simple observation of a change in personality or behavior over time cannot be necessarily attributed to the effects of therapy.

A pre and post measure of the MMPI was utilized in the current study. The phenomenon of regression toward the mean may be due to a natural change in the subject over time. Thus, it is difficult to conclude that psychotherapy has caused the change.

Furthermore, change may be a result of situational factors, such as a lucky new job. Since the patient is out in the world most of the time, it is difficult to control their extratherapy experiences. Any findings which demonstrate the effectiveness of psychotherapy must outweigh these confounding influences. Thus, even minimal evidence of the efficacy of psychotherapy can be considered valuable support.

In sum, the many uncontrolled elements in psychotherapy research and in the current study, have been outlined. This does not negate the value of this research. Much can be learned from studies even if they do not fully meet the most rigorous cannons of science.

IMPLICATIONS FOR FURTHER RESEARCH

The divisiveness in the field of psychotherapy research echoes schisms that occur between the different schools of psychology. Strupp (1973) urged researchers to study variables which are common

to all forms of psychotherapy. Bergin (1971) decried the dependence on doctrinaire allegiances and urged a non school approach.

One future tack could be to employ extensive and exhaustive studies of the process of psychotherapy. At a conference in Chicago in 1966, NIMH agents together with many top psychotherapy researchers, explored the feasibility of initiating large scale collaborative studies. Strupp (1973) explained that the ideas were vetoed because the complexities involved in psychotherapy research are too difficult to isolate and because the researchers involved were unwilling to invest their efforts in this direction.

An opposite tack is favored by Kiesler (1966); Bergin et.al. 1971 a proponent of the use of single case studies. This recalls the idiographic vs. nomothetic controversy, (Allport, 1962). Although the intensive study of the single case is a valuable source of hypotheses, it does not confirm laws applying to individuals generally. Kiesler (1966); Bergin et.al. 1971 goes on, however, to review some single case studies which begin to delineate methods of approach.

A review of Bergin's (1971) reformulation of the "problem" of psychotherapy research is in order.

" What specific therapeutic interventions produce specific changes in specific patients under specific conditions?"

An acceptance of this point of view naturally leads to the use of single case studies. It would be impossible to explicate all of the above specifications with an n of more than one.

Colby (1962) supported the single case study approach by emphasizing the importance of repeated observations by independent observers. He felt that it is hopeless to generalize about "all" patients as no "all" exists about anything in the psychotherapeutic process.

Another approach to psychotherapy research would be to abandon specific procedure and to study change as it occurs naturally. Strupp (1971) creatively advocated the documentation of conditions under which a person changes, a focus on the phenomenon of personality change in and of itself. These new insights could then be applied to psychotherapy.

Similarly, Frank (1961) helps us to shift our glance elsewhere, toward a host of procedures not formally designated as psychotherapy but having a great deal in common with it. He explicated those commonalities central to healing in primitive societies, religious revivalism, miracle cures, Communist thought reform, placebo effects in medical practice and contemporary psychotherapy. Thus, variables fostering personality or behavioral change are not unique to psychotherapy.

CONCLUSION: ART vs. SCIENCE

Due to the schism between the clinician and the researcher, research investigations have had little impact on clinical practice. This may be due to some extent, to a difference in temperament and language. Whereas the clinician makes theoretical or practical statements, the researcher couches his findings in terms of the .05 level of statistical confidence.

The field of psychotherapy is beset with numerous fads, doctrinaire opinions and schools of thought. Clinicians often make exaggerated and unfounded claims. There is a lack of strong relationship between theory and clinical practice. The theoretical formulations invoked by the therapist to explain the effects of his work are often impossible to test, and grossly lacking in parsimony and evidence. At times, theoretical formulations become dogmatic dictums adding to the conceptual unclarity and obstructing dispassionate scientific investigation.

Despite all of this, one therapist refused to cooperate in the study because he felt that psychotherapy research was a waste of time. It is true that the results of most investigations have not had substantial practical significance. To some extent clinical penetration and scientific rigor have varied inversely.

Because of the extreme complexity of the phenomena under study, individual researchers have, by necessity been forced to restrict their efforts to relatively minor aspects of the larger problem. Furthermore, researchers are not always able to address themselves to the areas of greatest concern and immediacy in clinical practice.

Abstract

PATIENTS' PRETHERAPY EXPECTATIONS AND THEIR RELATION TO EARLY
EXPERIENCE ON TREATMENT BY BEGINNING PSYCHOTHERAPISTS

by

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An individual's expectations have a strong effect on his future behavior. Prior research has shown that both patient and therapist expectations play a major role in the outcome of therapy. Although the content of expectations has been delineated, the affective aspect of expectations has been relatively unexamined. The present study dealt specifically with favorable and unfavorable expectations. It suggested that whether or not a patient was positively oriented, expected to like his therapist and expected to benefit from therapy, would influence the quality of his relationship with the therapist and would affect the success of therapy. Additional correlates of favorable expectations were explored.

One hundred thirty-three clients successively applying for psychotherapy at two University Psychological Centers were included in the sample. Before the intake interview, measures tapping expectations and attitudes related to expectations were administered. After twelve sessions, all clients and therapists were asked to complete outcome

measures. Twenty six clients completed all measures.

Expectations were measured by the Libo Picture Impressions Test, Expectations of Therapists Semantic Differential and on the Expectations of Therapy Measure. Anxiety, Depression and Ego Strength scales of the MMPI and a brief pretherapy questionnaire were also administered. Outcome was measured by Strupp's Patient and Therapist Questionnaire, Seeman's Case Rating Scale, attendance and pre and post measures of the Ego Strength and Depression scales of the MMPI.

The results revealed partial support for the hypotheses that patients' initial level of distress, pretherapy experiences and realistic and moderately optimistic expectancies were directly related to favorable expectations of psychotherapy and that these favorable expectations were related to outcome.

Experience and training of therapists and type of treatment were controlled to the extent that that therapists were relatively similar in age and experience. The study was limited in the lack of a control group and difficulties in defining outcome criteria.

The results suggest that outcome for this type of therapeutic situation to at least a minimal extent can be predicted before the patient ever meets the therapist. If expectations were totally predictive of outcome, psychotherapy would be considered a highly stylized placebo. The degree to which expectations are associated with therapy can, however, be harnessed into more effective treatment techniques.

The findings alert clinicians to the important influence of expectations. Referral sources and therapist may contribute to effective treatment by encouraging positive attitudes. Clinicians should be aware that previous experience with therapy, high initial distress and realistic and moderately optimistic prognostic expectancies all bode well for the therapeutic alliance.

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APPENDIX

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APPLICANT'S PRE INTAKE QUESTIONNAIRE

Name _____ Date _____

All person who apply to the Center for psychological assistance are asked to answer questions about why they came and what they expect from the Center. The questions deal with personal history, personality and expectations. This will help us understand your problem and eventually provide the best treatment possible for you. All materials are confidential. Be sure to answer all questions as completely and honestly as possible, and in the order presented.

PERSONALITY INVENTIORY (MMPI)

The next pages have numbered questions. Read each one quickly. Circle every statement True or False as the statement applies to you. Remember to give your own opinion of yourself. Do not skip any statements.

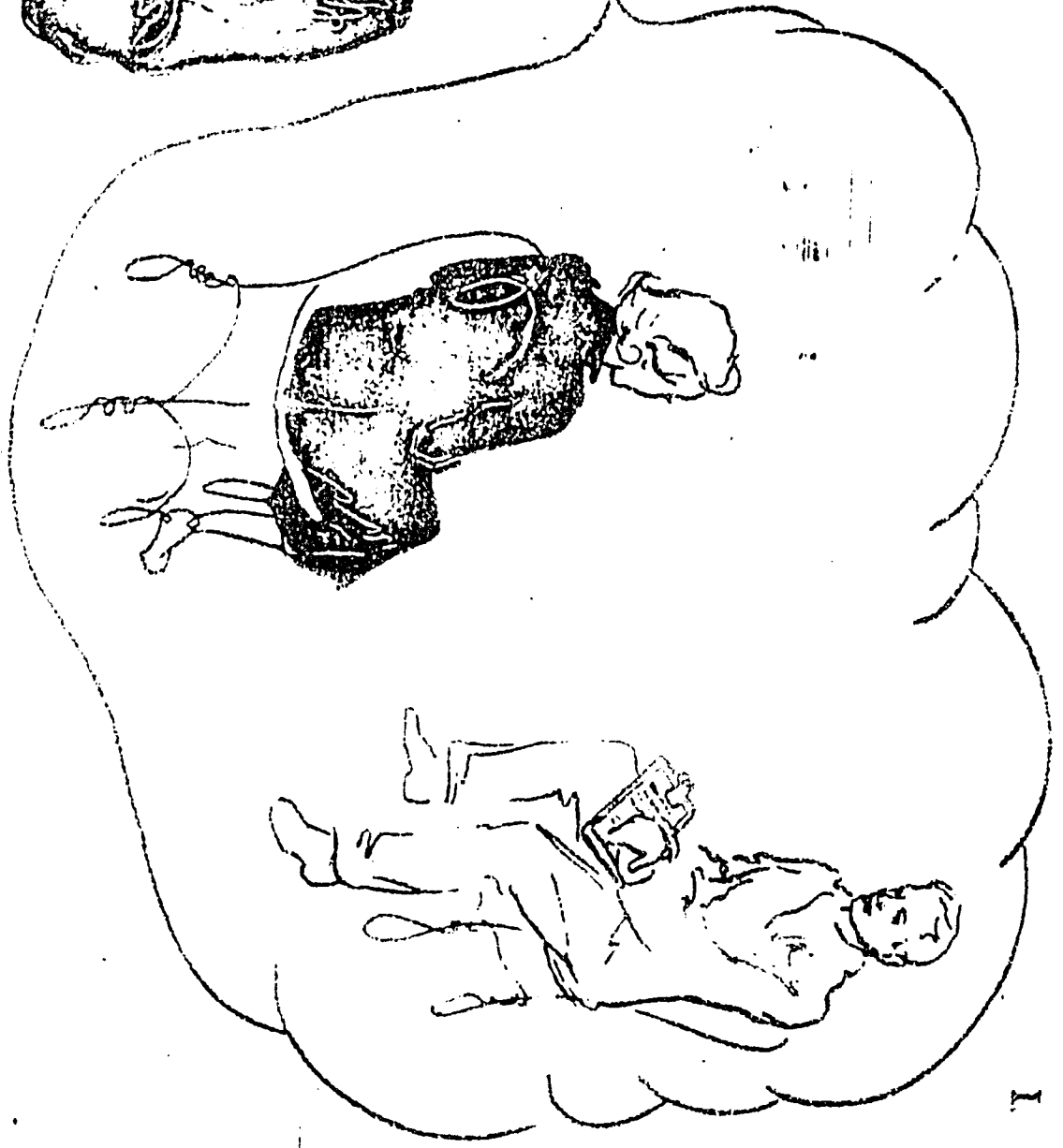
- True False 1. I have a good appetite.
- True False 2. I am easily awakened by noise.
- True False 3. I work under a great deal of tension.
- True False 4. I have diarrhea once a month or more.
- True False 5. At times I have fits of laughing and crying that I cannot control.
- True False 6. I find it hard to keep my mind on a task or job.
- True False 7. I have had very peculiar and strange experiences.
- True False 8. I have a cough most of the time.
- True False 9. I seldom worry about my health.
- True False 10. At times I feel like smashing things.
- True False 11. My sleep is fitful and disturbed.
- True False 12. My judgment is better than it ever was.
- True False 13. When I am with people I am bothered by hearing very queer things.
- True False 14. I am a good mixer.
- True False 15. Everything is turning out just like the prophets of the Bible said it would.
- True False 16. Parts of my body often have feelings like burning, tingling, crawling, or like "going to sleep".

- True False 17. I sometimes keep on at a thing until others lose their patience with me.
- True False 18. I sometimes tease animals.
- True False 19. I am easily downed in an argument.
- True False 20. I am certainly lacking in self-confidence.
- True False 21. I usually feel that life is worthwhile.
- True False 22. I do many things which I regret afterwards (I regret things more or more often than others seem to).
- True False 23. I go to church almost every week.
- True False 24. I believe in the second coming of Christ.
- True False 25. I have met problems so full of possibilities that I have been unable to make up my mind about them.
- True False 26. I am happy most of the time.
- True False 27. Some people are so bossy that I feel like doing the opposite of what they request, even though I know they are right.
- True False 28. I have never vomited blood or coughed up blood.
- True False 29. I do not worry about catching diseases.
- True False 30. I like collecting flowers or growing house plants.
- True False 31. I like to cook.
- True False 32. I certainly feel useless at times.
- True False 33. At times I feel like picking a fist fight with someone.
- True False 34. During the past few years I have been well most of the time.
- True False 35. I have never had a fit or convulsion.
- True False 36. I have never had a fainting spell.
- True False 37. When I get bored I like to stir up some excitement.
- True False 38. My hands have not become clumsy or awkward.
- True False 39. I feel weak all over much of the time.
- True False 40. Sometimes, when embarrassed, I break out in a sweat which annoys me greatly.

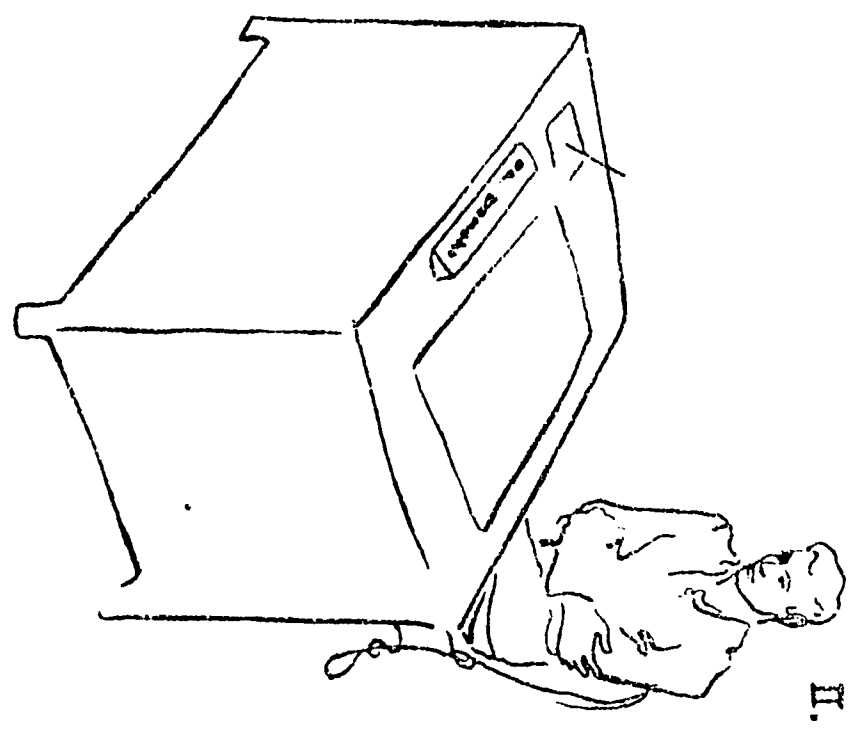
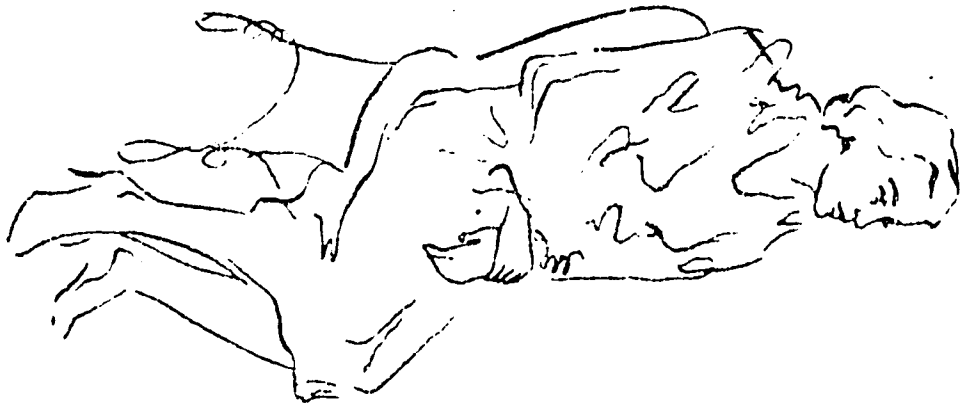
- True False 41. I have had no difficulty in keeping my balance in walking.
- True False 42. I do not have spells of hay fever or asthma.
- True False 43. I enjoy many different kinds of play and recreation.
- True False 44. I like to flirt.
- True False 45. I believe my sins are unpardonable.
- True False 46. I frequently find myself worrying about something.
- True False 47. I like science.
- True False 48. I like to talk about sex.
- True False 49. I have at times stood in the way of people who were trying to do something, not because it amounted to much but because of the principle of the thing.
- True False 50. I get mad easily and then get over it soon.
- True False 51. I brood a great deal.
- True False 52. I have periods of such great restlessness that I cannot sit long in a chair.
- True False 53. I dream frequently about things that are best kept to myself.
- True False 54. I believe I am no more nervous than most others.
- True False 55. My way of doing things is apt to be misunderstood by others.
- True False 56. I have had blank spells in which my activities were interrupted and I did not know what was going on around me.
- True False 57. I can be friendly with people who do things which I consider wrong.
- True False 58. If I were an artist I would like to draw flowers.
- True False 59. I sweat very easily even on cool days.
- True False 60. When I leave home I do not worry about whether the door is locked and the windows closed.

- 105
- True False 61. I do not blame a person for taking advantage of someone who lays himself open to it.
- True False 62. At times I am full of energy.
- True False 63. Once in a while I laugh at a dirty joke.
- True False 64. Life is a strain for me much of the time.
- True False 65. I am more sensitive than most other people.
- True False 66. I cannot keep my mind on one thing.
- True False 67. I feel anxiety about something or someone almost all the time.
- True False 68. At times I hear so well it bothers me.
- True False 69. Often I cross the street in order not to meet someone I see.
- True False 70. I have strange and peculiar thoughts.
- True False 71. Sometimes I enjoy hurting persons I love.
- True False 72. Sometimes some unimportant thought will run through my mind and bother me for days.
- True False 73. I am inclined to take things hard.
- True False 74. I am not afraid of fire.
- True False 75. I am not usually self-conscious.
- True False 76. I do not like to see women smoke.
- True False 77. When someone says silly or ignorant things about something I know about, I try to set him right.
- True False 78. I feel unable to tell anyone all about myself.
- True False 79. My plans have frequently seemed so full of difficulties that I have had to give them up.
- True False 80. I have sometimes felt that difficulties were piling up so high that I could not overcome them.
- True False 81. I am usually calm and not easily upset.
- True False 82. I would certainly enjoy beating a crook at his own game.
- True False 83. At times I think I am no good at all.
- True False 84. I have had some very unusual religious experiences.

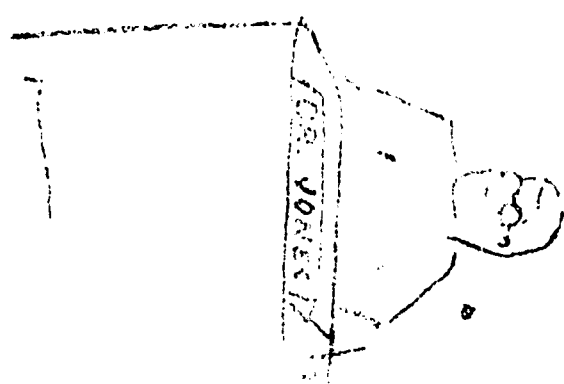
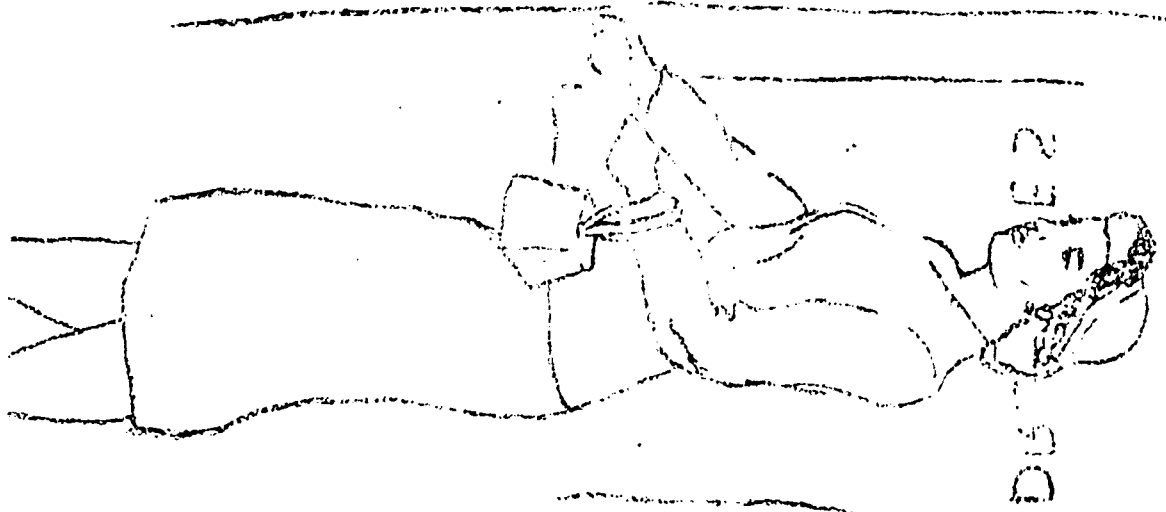
- True False 85. One or more members of my family is very nervous.
- True False 86. I am attracted by members of the opposite sex.
- True False 87. The man who had most to do with me when I was a child (such as my father, stepfather, etc.) was very strict with me.
- True False 88. Christ performed miracles such as changing water into wine.
- True False 89. I pray several times every week.
- True False 90. I feel sympathetic towards people who tend to hang on to their griefs and troubles.
- True False 91. I am afraid of finding myself in a closet or small closed place.
- True False 92. I am a high-strung person.
- True False 93. Dirt frightens or disgusts me.
- True False 94. I think Lincoln was greater than Washington.
- True False 95. In my home we have always had the ordinary necessities (such as enough food, clothing etc.)
- True False 96. I am made nervous by certain animals.
- True False 97. My skin seems to be unusually sensitive to touch.
- True False 98. I feel tired a good deal of the time.
- True False 99. I never attend a sexy show if I can avoid it.
- True False 100. I shrink from facing a crisis or difficulty.
- True False 101. If I were an artist I would like to draw children.
- True False 102. I sometimes feel that I am about to go to pieces.
- True False 103. I have often been frightened in the middle of the night.
- True False 104. I very much like horseback riding.



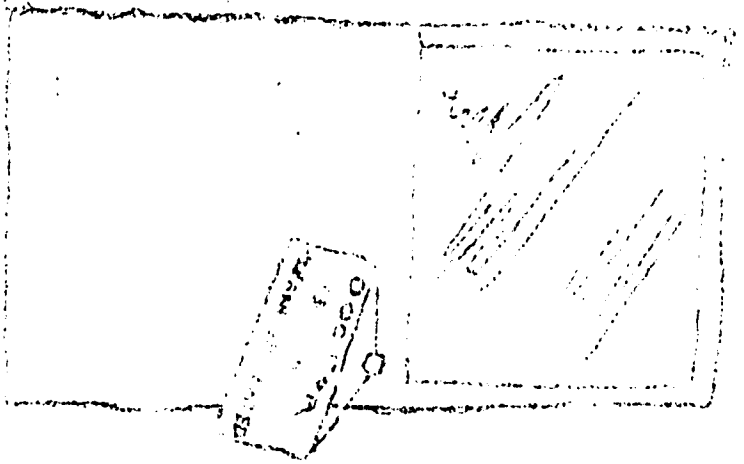
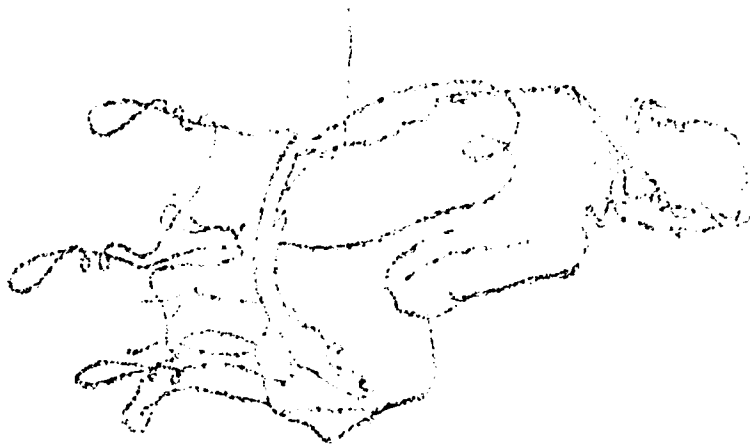
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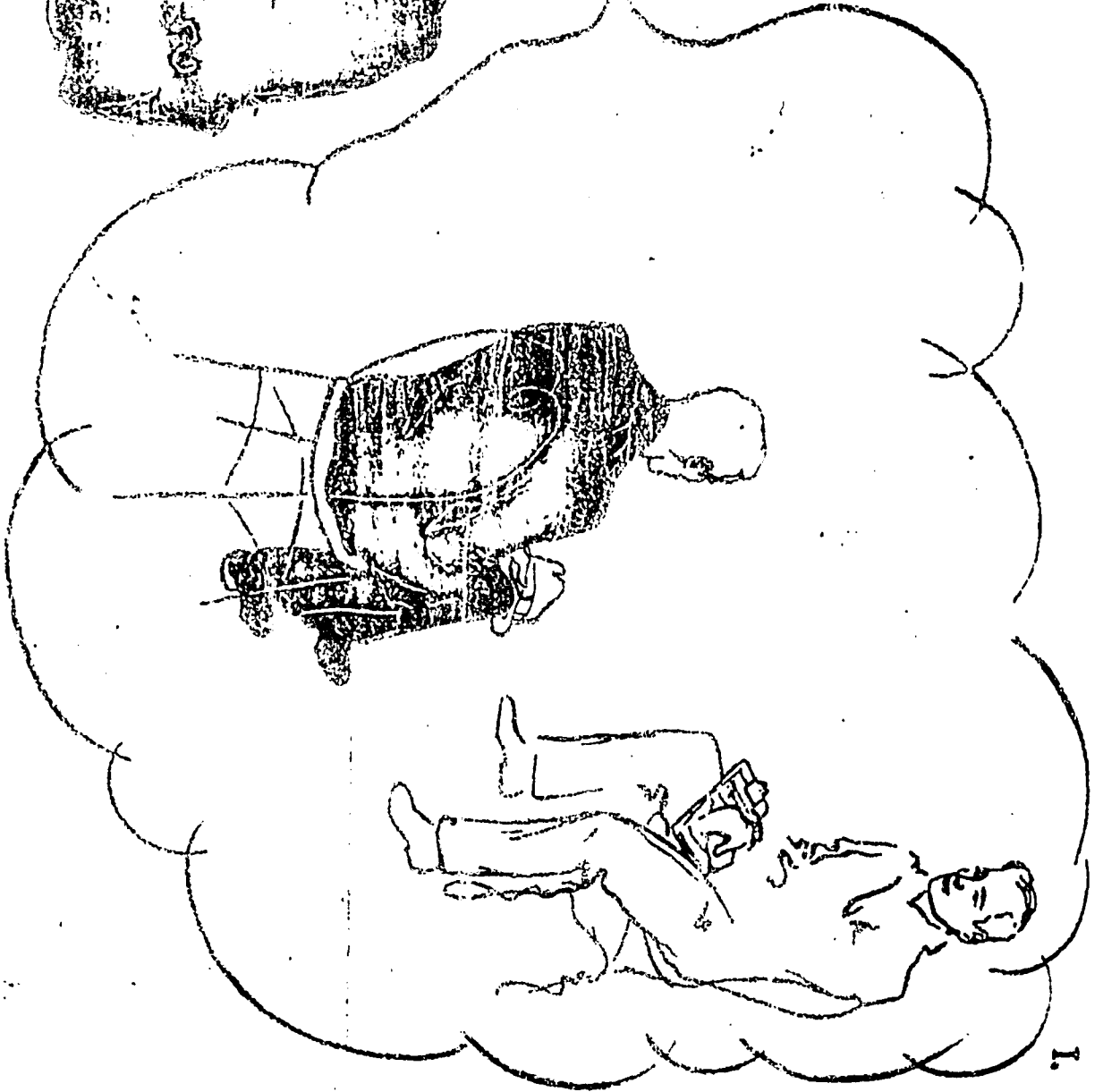
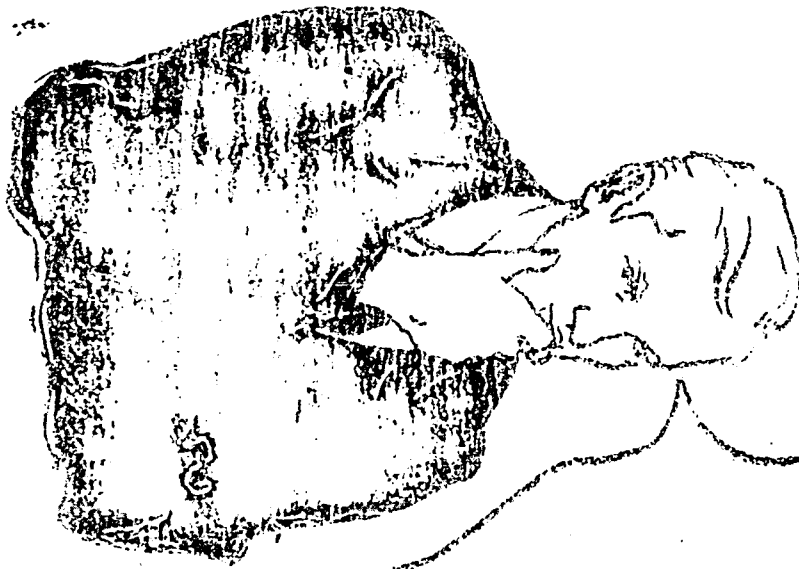


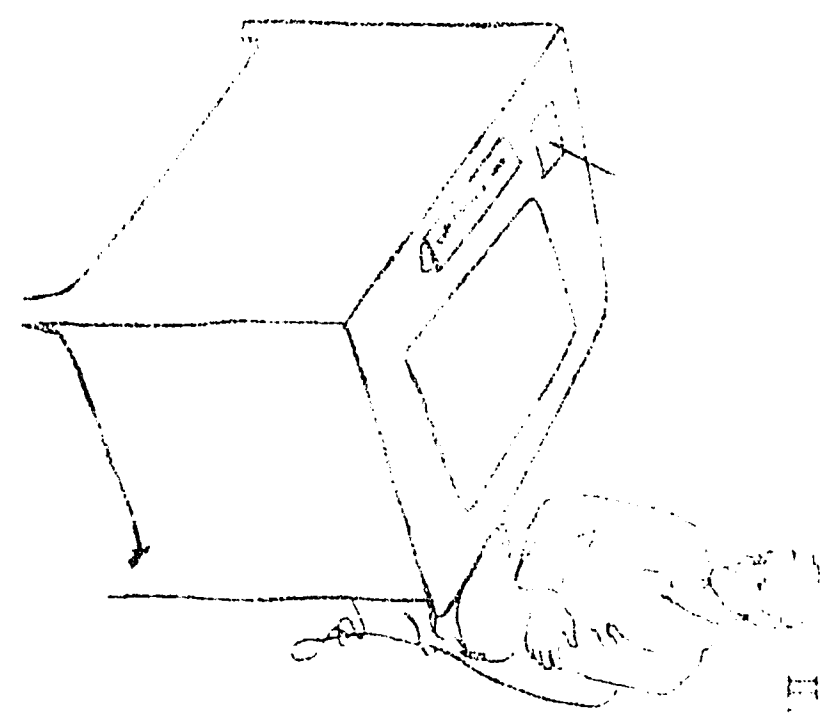
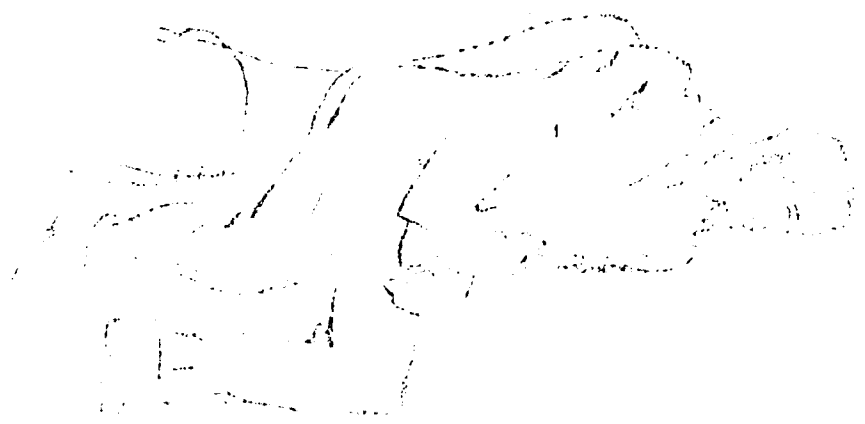
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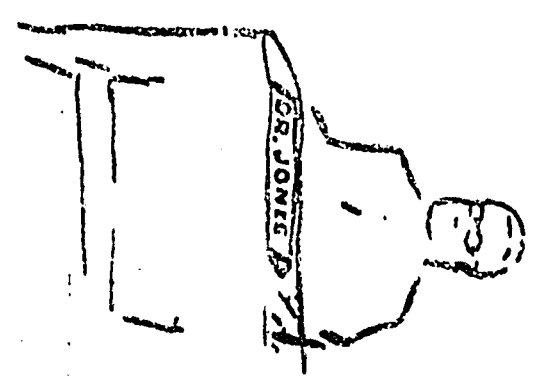
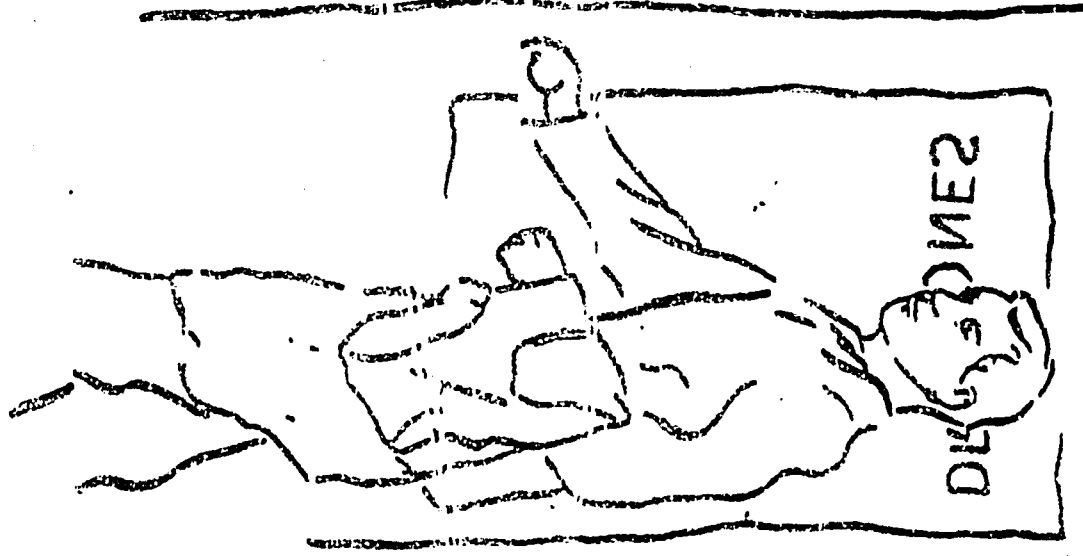


III.

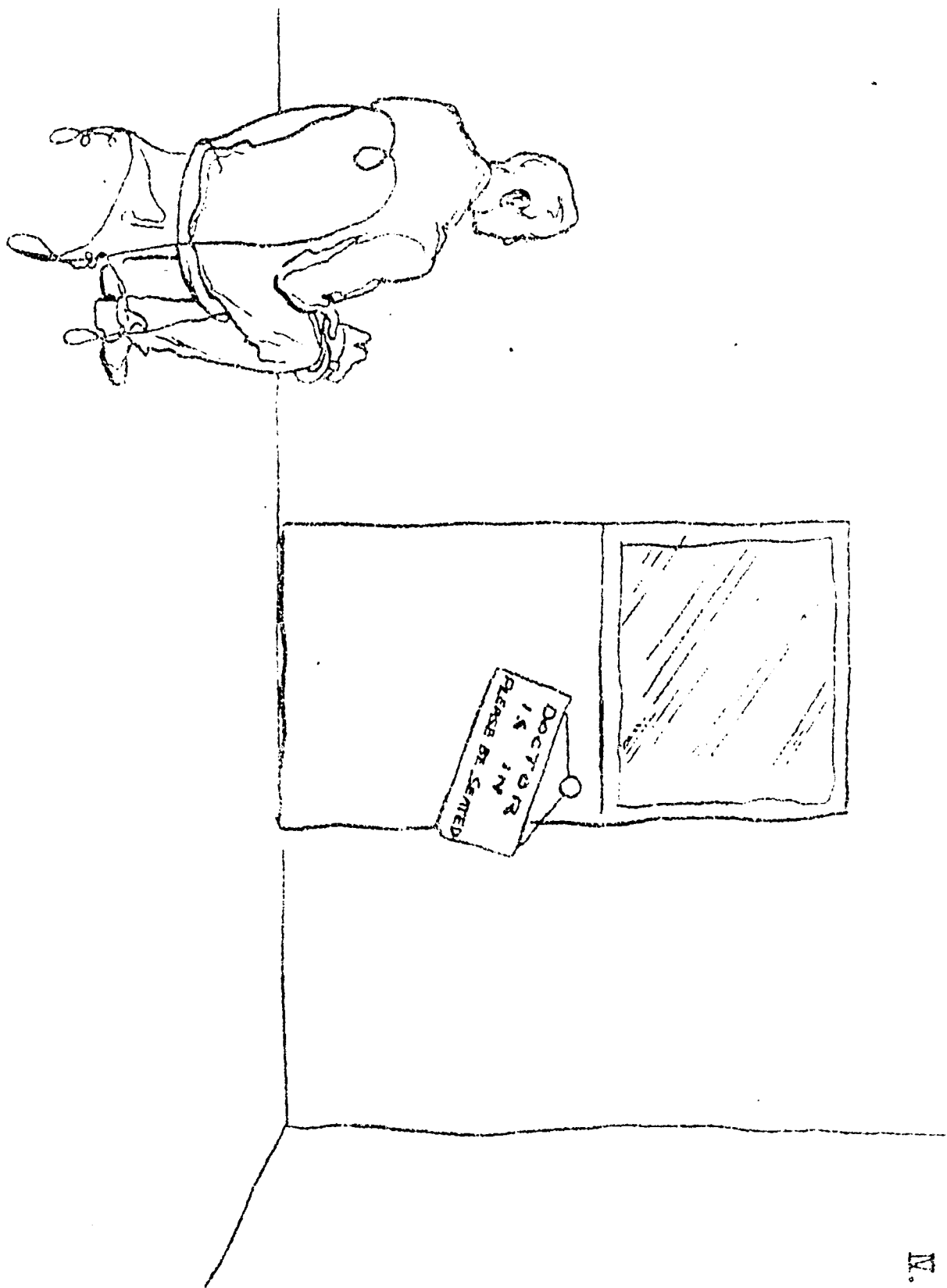








III.



PRETHERAPY QUESTIONNAIRE

1. Who told you about this psychological center? (a friend, teacher)
- _____
2. What was their opinion of the center as a place for you?
5. very helpful 4. moderately helpful 3. somewhat helpful 2. slightly helpful 1. not at all helpful (circle one)
3. Have you ever been in therapy? 1. yes 0. no (circle one)
4. Has anyone very close to you ever sought psychological help?
1. yes 0. no (circle one)
5. How much do you think they were helped?
5. very much 4. moderately 3. somewhat 2. slightly 1. not at all (circle one)
6. About how long do you expect to be in therapy?
- (check one)
1. _____ less than 1 month 2. _____ 1 month 3. _____ 2 months 4. _____ 4 months 5. _____ 6 months 6. _____ more than 6 months
7. About how long after you begin therapy do you expect to notice some results?
1. _____ less than 1 month 2. _____ 1 month 3. _____ 2 months 4. _____ 4 months 5. _____ 6 months 6. _____ more than 6 months 7. _____ after therapy has terminated (check one)
8. What is your present belief that results you want from therapy will be achieved?
1. _____ strongly believe results won't be achieved 2. _____ believe results won't be achieved 3. _____ no belief or the other 4. _____ believe results will be achieved 5. _____ strongly believe results will be achieved (Please check mark on scale)
9. I believe in my religion.
5. very strongly 4. strongly 3. moderately 2. slightly 1. not at all (circle one)

PERSONAL INFORMATION

Age _____

Religion _____

Race _____

Years of school completed _____

Occupation _____

Years of school completed by father _____ mother _____

Father's Occupation _____ mother _____

Expectations of Therapy

This is a test about your attitudes and feelings about therapy. Each one of the questions has one of five possible answers. Write the appropriate number next to each statement.

Answer as following for each question:

- | | |
|----------------------|----------------------------|
| 1. strongly agree | 5) |
| 2. agree | 4) |
| 3. uncertain | (Note: Rating scale was 3) |
| 4. disagree | 2) |
| 5. strongly disagree | 1) |

For Example:

2. It is helpful to talk to friends about personal problems.

In this example, the person agrees with the statement.

1. Psychotherapists successfully help people with their problems.
2. A friend with emotional problems should be encouraged to consult a psychotherapist.
3. Talking about your problems to a psychotherapist is mostly a waste of time. (Note: reverse coding)
4. It is difficult to understand how talking to a psychotherapist can help a person solve his problems. (Note: reverse coding)
5. Psychotherapists often have more problems than their patients. (Note: reverse coding)
6. Psychotherapists are well trained to help people with emotional problems.
7. People with psychological problems would be better off going to their family doctor rather than to a psychotherapist. (Note: reverse coding)
8. Psychotherapists don't really know much about what they are doing. (Note: reverse coding)
9. People who understand themselves are better able to deal with problems that may arise.
10. There are very few people who wouldn't benefit from psychotherapy.
11. If more people were in psychotherapy, there would be fewer conflicts.
12. Most people who are in psychotherapy have serious sexual problems.
13. People should only consider psychotherapy as a last resort. (Note: reverse coding)
14. People who have benefited from psychotherapy probably would have gotten better anyway in the same amount of time. (Note: reverse coding)

THERAPIST'S VIEW OF THERAPY

Therapist _____ Patient _____
 _____ number of sessions attended _____
 Date _____ number of sessions missed _____

This is part of a research study designed to relate patients' expectations of therapy with the success of therapy. You are receiving this questionnaire after 12 sessions, nevertheless, the questions are geared to tap your view of the outcome of therapy. Please answer as completely and as truthfully as possible. This questionnaire is strictly confidential. Thank you for your cooperation in this study.

STRUPP THERAPIST QUESTIONNAIRE

Please rate each of the following items, comparing the patient with other patients whom you see in psychotherapy.

		(1)	(2)	(3)	(4)	(5)
		very little	some	mod- erately	fairly great	very great
1. Personal liking for patient.	before	_____	_____	_____	_____	_____
	after	_____	_____	_____	_____	_____
2. Improvement expected (prognosis)	before	_____	_____	_____	_____	_____
3. Degree to which counter-transference was/is a problem in therapy (Note: reverse coding)		_____	_____	_____	_____	_____
4. Degree to which you usually enjoy working with this kind of patient in psychotherapy		_____	_____	_____	_____	_____
5. Degree to which you felt/feel warmly toward the patient		_____	_____	_____	_____	_____
6. How much of an "emotional investment" did/do you have in this patient?		_____	_____	_____	_____	_____
7. Degree to which you think the patient felt/feels warmly toward you		_____	_____	_____	_____	_____
8. How would you characterize your working relationship with this patient?						
(Note: coding	1.	2.	3.	4.	5.	
	Extremely poor	Fairly poor	Neither good nor poor	good	fairly good	extremely good

SEEMAN'S CASE RATING SCALE

9. Please circle the appropriate number: What is your rating of the outcome of therapy? (or of the success of therapy up to now)

Complete 1 2 3 4 5 6 7 8 9 Marked Success

STRUPP PATIENT QUESTIONNAIRE

The questions that follow deal with your feelings about therapy and your therapist. These questions assume that your therapy is completed. If, in fact, you are not yet finished with therapy, answer according to how you feel now.

Circle the appropriate answer

1. How much in need of further therapy do you feel now?

(5)	(4)	(3)	(2)	(1)
a great deal	a fair amount	could use more	considerable need	very great need

2. How much have you benefited from your therapy?

(5)	(4)	(3)	(2)	(1)
a great deal	a fair amount	to some extent	very little	not at all

3. Everything considered, how satisfied are you with the results of your psychotherapy experience?

_____ 1. Extremely dissatisfied	_____ 4. Fairly satisfied
_____ 2. Moderately dissatisfied	_____ 5. Moderately satisfied
_____ 3. Fairly dissatisfied	_____ 6. Highly satisfied
	_____ 7. Extremely satisfied

4. What impression do you have of your therapist's level of experience?

_____ 1. Extremely inexperienced
_____ 2. Rather inexperienced
_____ 3. Somewhat inexperienced
_____ 4. Fairly experienced
_____ 5. Highly experienced
_____ 6. Exceptionally experienced

Please indicate to what extent each of the following statements describes your therapy experience. Disregard that at one point or another in therapy you may have felt differently. Use the following code and circle your answer.

- | | |
|-----------|--|
| 5 4 3 2 1 | 5. I feel the therapist was rather active most of the time. |
| 5 4 3 2 1 | 6. I am convinced that the therapist respected me as a person. |
| 5 4 3 2 1 | 7. I feel the therapist was genuinely interested in helping me. |
| 5 4 3 2 1 | 8. I often felt I was "just another patient" (Note: reverse coding) |
| 5 4 3 2 1 | 9. The therapist is always keenly attentive to what I had to say. |
| 5 4 3 2 1 | 10. The therapist tended to be rather stiff and formal. (Note: reverse coding) |
| 5 4 3 2 1 | 11. The therapist's manner was quite natural and unstudied. |

- 5 4 3 2 1 12. I feel that he often didn't understand my feelings.
(Note: reverse coding)
- 5 4 3 2 1 13. His general attitude was rather cold and distant.
(Note: reverse coding)
- 5 4 3 2 1 14. I was never sure whether the therapist thought
I was a worthwhile person.
- 5 4 3 2 1 15. I had a feeling of absolute trust in the therapist's
integrity as a person.
- 5 4 3 2 1 16. I felt there usually was a good deal of warmth in the
way he talked to me.
- 5 4 3 2 1 17. The tone of his statements tended to be rather cold.
(Note: reverse coding)
- 5 4 3 2 1 18. I usually felt I was fully accepted by the therapist.
- 5 4 3 2 1 19. I never had the slightest doubt about the therapist's
interest in helping me.
- 5 4 3 2 1 20. The therapist's manner of speaking seemed rather
formal. (Note: reverse coding)
- 5 4 3 2 1 21. My therapist stressed intellectual understanding as much
as emotional experiencing.

22. How severely disturbed did you consider yourself at the beginning of your
therapy?

5.	4.	3.	2.	1.
Extremely disturbed	very much disturbed	Moderately disturbed	somewhat disturbed	very slightly disturbed

23. How much anxiety did you feel at the time you started therapy?

5.	4.	3.	2.	1.
a tremendous amount	a great deal	a fair amount	very little	none at all

24. How much do you feel you have changed as a result of psychotherapy?

5.	4.	3.	2.	1.
a great deal	a fair amount	somewhat	very little	not at all

25. How much of this change do you feel has been apparent to others?
(a) People closest to you (husband, wife, etc.)

5.	4.	3.	2.	1.
a great deal	a fair amount	somewhat	very little	Not at all

(b) Close friends

5.	4.	3.	2.	1.
a great deal	a fair amount	somewhat	very little	not at all

(c) Co-workers, acquaintances, etc.

5.	4.	3.	2.	1.
a great deal	a fair amount	somewhat	very little	not at all

26. On the whole how well do you feel you are getting along now?

_____ 7. Extremely well
_____ 6. Very well
_____ 5. Fairly well
_____ 4. Neither well nor poorly
_____ 3. Fairly poorly
_____ 2. Very poorly
_____ 1. Extremely poorly

27. How adequately do you feel you are dealing with any present problems?

5.	4.	3.	2.	1.
Very adequately	fairly adequately	neither adequately nor inadequately	somewhat inadequately	very inadequately

28. To what extent have your complaints or symptoms that brought you to therapy changed as a result of treatment?

_____ 6. Completely disappeared
_____ 5. Very greatly improved
_____ 4. Considerably improved
_____ 3. Somewhat improved
_____ 2. Not at all improved
_____ 1. Got worse

29. How soon after entering therapy did you feel any marked change?

_____ months and/or _____ hours of therapy (approximately)