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# PATIENT-THERAPIST DISSIMILARITY OF ROLE EXPECTATIONS RELATED TO PREMATURE TERMINATION OF PSYCHOTHERAPY WITH STUDENT-THERAPISTS

by

WARREN J. SANDLER

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Jan 21, 1975
date

Harold Wilensky
Chairman of Examining Committee

Jan 23 1975
date

Florence L. Denmark
Executive Officer

Professor Harold Wilensky

Professor Morton Bard

Professor Joseph Zacker
Supervisory Committee

The City University of New York

## Abstract

PATIENT-THERAPIST DISSIMILARITY OF ROLE EXPECTATIONS RELATED TO PREMATURE TERMINATION OF PSYCHOTHERAPY WITH STUDENT-THERAPISTS

by

Warren J. Sandler

Advisor: Professor Harold Wilensky

A recurring problem in the practice of psychotherapy is the premature termination of treatment by the patient. The inefficient use of professional time and manpower when a patient discontinues treatment is of special concern to public mental health clinics where psychological services are in short supply.

Prior research has pointed to the relationship of dropping out to several variables, including the client's educational level, socioeconomic status, race, personality traits, presenting complaints, preferences and expectations about therapy. Mutuality of patient-therapist expectations has been suggested by many investigators to play an important role in premature termination.

The present study investigated the effects of patient-therapist dissimilarity of role expectations in the dropping out process. It was hypothesized that long-term commitment is facilitated when

expectations are congruent. Secondarily, other factors related to dropping out, such as prognostic expectations, preferences, ethnicity, socioeconomic status, prior therapy, and source of referral, were explored.

Ninety-seven patients applying for psychotherapy at two university psychological centers were included in the sample. Before the intake, measures tapping patient initial role expectations and other variables, were administered. Therapist general role expectations were measured twice over a five month period. Both patient and therapist completed role expectation measures following the third and twelfth sessions. In addition, therapists rated patient intra-therapy behavior after the first interview, by completing the Behavioral Correlates (BC) Scale. Patient role expectations were measured by the Psychotherapy Expectancy Inventory-Revised (PEI-R); therapist role expectations were measured by the Therapist Psychotherapy Expectancy Inventory (T-PEI). Terminators were distinguished from Remainers according to number of sessions and therapist judgment. Measures of dissimilarity were calculated for each dyad via patient-therapist differences on all items of the PEI-R and T-PEI at each stage of therapy (Initial, Early and Late).

The results provided support for the hypotheses that Terminators manifested higher Initial Dissimilarity of role expectations than Remainers, and that dyads demonstrated reduced dissimilarity of role expectations as therapy continued. Although non-significant, the results further suggested that Terminators showed higher Early Dissimilarity than Remainers, and despite a decrease in dissimilarity

for both groups, a greater decrease was noted for Remainers.

Factor analyses on the PEI-R, T-PEI and BC scales replicated findings by Berzins (1971a, 1971b) that four meaningful subscales emerged. Congruence of the PEI-R and BC Scale was less than adequate. Patient expectancies changed on two PEI-R subscales (Advice and Audience-seeking) during 12 sessions of therapy. Therapist expectancies changed on two T-PEI subscales (Audience and Relationship-seeking) during 5 months of training.

Duration Expectation and its degree of congruence with that of therapists covaried modestly with actual duration, as did socio-economic status. Duration Expectation also tended to differentiate Terminators from Remainers.

The findings suggest that actively inducing accurate and congruent expectations in their patients, or matching patients and therapists in order to produce dyads compatible in role expectations may reduce premature termination. The PEI-R and T-PEI provide a basis for matching therapy pairs.

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# CHAPTER 1 HISTORY

## Introduction

A recurring problem in the practice of psychotherapy is the "premature termination" of treatment by the patient. In the face of the demand for and short supply of psychotherapeutic services, it is a waste of professional time and manpower when a patient drops out of treatment after extensive intake procedures. This is of special concern to public mental health clinics when high dropout rates are reported (Frank, Gliedman, Imber, Nash, & Stone, 1957; Heine & Trosman, 1960; Hiler, 1958; Meyer, Spiro, Slaughter, Pollack, Weingartner, & Novey, 1967; Rosenthal & Frank, 1958; Strupp, 1971; White, Fichtenbaum, & Dollard, 1964b). The inefficient use of services available from such outpatient clinics demands further research directed at understanding the various factors contributing to the early termination of treatment by the patient, and developing means of counteracting the influence of these antitherapeutic forces.

The phenomenon of premature termination has already generated a sizable amount of research in view of a widespread belief and some indirect evidence pointing to the positive relationship between length of treatment and therapeutic gain (Frank et al., 1957; Lorr, McNair, Michaux, & Raskin, 1962; Lorr & McNair, 1964; Luborsky, Auerbach, Chandler, Cohen, & Bachrach, 1971; Myers & Auld, 1955; Rosenthal & Frank, 1958; Stieper & Wiener, 1965). Furthermore, its implications for the selection of patients for psychotherapy and the assignment of therapists has been a prominent concern in the literature

(Begley & Lieberman, 1970; Hiler, 1958; Lorr, Katz, & Rubinstein, 1958; Marcus, 1968; Stieper & Wiener, 1965; White et al., 1964b). The systematic study of patient and therapist characteristics and their relationship to dropping out has been and continues to be a fruitful direction for psychotherapy research. The testing of screening instruments and techniques as valid predictors of dropping out is a necessary activity for current clinic practice.

It is with this in mind that this research project was developed. It is a study of several patient and therapist variables. More specifically, patient and therapist variables and their relationship to premature termination were systematically investigated: (a) patient-therapist dissimilarity of role expectations, (b) change in dissimilarity of role expectations during the course of therapy, (c) patient and therapist prognostic expectations, (d) patient preferences for therapist, (e) patient demographic factors.

## Literature Review

### Premature Termination

#### Background variables related to premature termination.

Previous research has pointed to the relationship between dropping out and a number of different factors. Strickland and Crowne (1963) conclude that patients with high need for approval tend to drop out of treatment early in order to defend a vulnerable self image. Marcus (1968) found remainers to be more suggestible, dependent and anxious. Females tended to remain, while males tended to terminate. Baum, Felzer, D'Zmura, and Shumaker (1966) believe that the experience level of the therapist is crucial. Those therapists with more experience have fewer patients who drop out. Hiler (1959) found that terminators complained of more purely organic symptoms, as well as of paranoid

and schizoid feelings. Meyer et al. (1967) reports that 64% of patients with psychological complaints finished contractual psychotherapy, whereas only 49% with physical complaints did so. Also, education, religion and source of referral were variables that differentiate those completing a therapeutic program. Furthermore, there is a greater tendency for those having lost a parent of the same sex as themselves to drop out.

A number of studies have found social class position to differentiate terminators from remainers. Rubinstein and Lorr (1956) found remainers to have higher socioeconomic status and more education. Studies by Schaffer and Myers (1954) and Rosenthal and Frank (1958) support the relationship between social class and continuation in psychotherapy. The latter found that more whites and more males stay in therapy. Yamamoto, James, Bloombaum, and Hattem (1967) showed that in a clinic staffed by white professionals, blacks have higher attrition rates than white clients. Also, a positive relationship was found to exist between therapist ethnocentricity and black attrition rates. Overall and Aronson's (1963) study also supports the view that lower class patients are less likely to return to treatment. White, Fichtenbaum, and Dollard (1964a) report a significant interaction between silence, social class and dropping out of therapy. They found that the percentage of silence during an initial interview was greater for dropouts and for patients of lower social status. Also, dropping out of therapy increased as the social position of the patient decreased. Frank et al. (1957) relate that suggestibility, education, and social class position may be associated with remaining in treatment. Furthermore, Riessman, Cohen, and Pearl (1964) state that the greatest number of unplanned terminations in psychiatric clinics are consistently found

to be among the low income groups.

Background variables unrelated to premature termination. Yet, the findings are less than consistent. Gliedman, Stone, Frank, Nash, and Imber (1957) found that patients with congruent incentives for therapy and those with noncongruent incentives remained approximately the same number of sessions. Brandt (1965), in reviewing studies of premature termination, reports that of 29 variables examined, only sex, age, and marital status consistently did not differentiate between remainers and dropouts. Strickland and Crowne (1963) found that social class, psychiatric diagnosis, and birth order are not related to length of stay in treatment. Meyer et al. (1967) report that dropouts and remainers are not differentiated according to age, sex, race or social class, marital status, psychiatric diagnosis, and duration of symptoms. They question the pessimistic view relating social class position and early dropping out, maintaining that members of lower classes can be motivated to complete a traditional therapy program. Heine and Trosman (1960) found that type of presenting complaint, somatic or emotional, was unrelated to continuation.

Reconciling some discrepancies. Thus, the findings of a number of representative studies are contradictory and equivocal, even with regard to the frequently observed relationship of social class and early termination. Reliable or clear generalizations are difficult to make as a result of variations in sample composition, dropout criteria, methods of evaluation, and parameters of psychotherapy. Nevertheless, in the present study, data on the patients' socioeconomic status and race were classified and tested in terms of dropping out. Still, it is believed, in accord with the suggestion by Meltzoff and Kornreich (1970), that it is the culturally based attitudes,

expectations, goals, roles and learned behaviors differentially associated with a patient's social position that are more important in the psychotherapeutic situation than a gross measure of socioeconomic level. It should be noted that Hollingshead and Redlich (1958) have identified a discernible set of psychotherapy expectations held by lower class patients. These include an expectation of pills and needles, sympathy and warmth, a demand for an authoritarian attitude on the part of the psychiatrist, an inability to understand that their troubles are not physical illnesses, and disappointment at not getting sufficient practical advice and direction. Also, Jones and Kahn (1964) found that "good" mental health attitudes are directly related to social class position. It is with this in mind that we turn to the primary area of investigation for the present study, i.e., the cognitive factor of expectation, which mediates between the psychotherapy interaction and several variables discussed above.

Expectations about Psychotherapy

Expectations have been shown to be a "powerful and far-reaching determinant of human behavior" (Goldstein, 1966). This has been demonstrated in many areas of interest, including perceptual hypothesis theory, personality theories, experimenter bias, hypnosis, placebo effect, and the self-fulfilling prophecy (Goldstein, 1962; Goldstein, 1966; Ullmann & Krasner, 1969). Overall, the literature shows that pretherapy expectancies can affect the psychotherapy relationship and be important in determining the outcome of therapy (Goldstein, 1962).

Patient expectations and premature termination. The effects of patient expectations on premature termination of therapy have been of interest to a number of investigators. For example, Marcus (1968)

found that patients who remain in therapy tend to believe more in the value of psychotherapy and expect it to last longer. Goin, Yamamoto and Silverman (1965) found that, on the average, patients stayed in therapy as long as they anticipated. Apfelbaum (1958) reports that patients who expect their therapist to be a model were less likely to drop out than those expecting the therapist to assume the role of critic or nurturer. Furthermore, Heine and Trosman (1960) found that patients who expected to adopt the role of active collaborator tended to continue while those anticipating a passive, cooperative role tended to terminate early.

Expectancy discrepancy and premature termination. In examining premature termination and the psychotherapy process, several studies have pointed to the importance of the patient's expectations in relation to the reality of the therapeutic process and/or the expectations of the therapist. Marcus (1968) found that male terminators showed a higher level of discrepancy between their expectations of therapy and their perception of the therapeutic experience. Goldstein (1962), reviewing a considerable number of studies, concludes that both therapist expectancy and an index representing the combined patient and therapist prognostic expectancies significantly covary with continuation in therapy. The findings of Overall and Aronson (1963) indicate a tendency not to return following the initial interview if expectations are not fulfilled. Those patients with the most inaccurate expectations of therapy were significantly less likely to return. Although no supporting data is presented, Heine and Trosman (1960) conclude that mutuality of expectations between patient and therapist is a crucial variable for continuation in psychotherapy. Clemes and D'Andrea (1965), in testing the effect of initial interview compatibility on patient anxiety, conclude that in order

for therapy to progress without premature termination and dissatisfaction on the part of the patient, the role expectations of both participants must be to some degree compatible. Lennard and Bernstein (1960) found that the lack of similarity between patient and therapist expectations was associated with increased "strain" during therapy. Chance (1959) suggests that mutuality of expectations may be one of the prerequisites to therapy. Cartwright (1968) relates that the more consensus there is between the participants about the expected behavior of each, then the more likely it is for the therapy situation to work.

Some researchers have made the assumption that therapists are homogeneous in terms of their expectations of psychotherapy and that it is the patients who have varying expectations. This may not be a valid assumption since therapists may also differ in their expectations (Strupp, 1971). Nevertheless, the impression that incompatible expectations is associated with premature termination has some empirical support, although no study, as far as is known, has directly tested this hypothesis.

Toward greater similarity of expectations: A "socialization" process during therapy. In general, a patient comes to therapy, not only with his conflicts, symptoms and needs, but also with a set of expectations regarding the goals and duration of therapy, and notions about the appropriate roles of the participants. In much the same way, the therapist also holds certain expectations regarding his role, his patient's role, the objectives and methods of his treatment, and so on. As Rickers-Ovsiankina, Berzins, Geller, and Rogers (1971) point out, "before patient meets therapist, each has some idea how their interaction should or probably will proceed, i.e., expectancies regarding

their roles (rights, obligations and 'appropriate' behaviors)."

The average individual has little information about the nature of psychotherapy and, unfortunately, the notions he does have are frequently inaccurate and hazy (Garfield & Wolpin, 1963; Levitt, 1966; Riessman et al., 1964). It is believed by some investigators that the early hours of therapy are crucial for dealing with and correcting the cognitive inaccuracies about therapy that the patient brings to the session (Goldstein, 1962; Heine & Trosman, 1960; Krause, Fitzsimmons & Wolf, 1969; Lennard & Bernstein, 1960; Overall & Aronson, 1963; Rotter, 1954). Moreover, studies by Heilbrun (1972), Hoehn-Saric, Frank, Imber, Nash, Stone, and Battle (1964) and Truax and Carkhuff (1967) suggest that attempts at briefing and pretraining patients prior to treatment in preparation for their role in psychotherapy contributes to enhancing the therapy situation and its duration and outcome.

Thus, an initial divergence of expectations about therapy can be anticipated and may be temporarily tolerated by the interacting participants. However, according to Lennard and Bernstein (1960, 1969) and Spiegel (1957), orderly and harmonious social process requires some degree of complementarity of behavior and expectations. When the discrepancy is too great, the participants experience a state of tension, the interpersonal system is strained, and can collapse (Burdick & Burnes, 1958; Lennard & Bernstein, 1960; Spiegel, 1957). Sociologists have viewed social systems to possess a set of reciprocal expectations, and it is during the initial phase of therapy that the participants can reveal and deal with their incompatible expectations, and reach some level of reciprocity and agreement. This socialization process in therapy has been described by Lennard and Bernstein (1960, 1969).

Great significance is being attributed to the interpersonal relationship of patient and therapist in an attempt to clarify and understand those factors contributing to more effective and efficient psychotherapy (Boucher, 1972). Strupp (1971), in viewing relationship factors as prerequisites for therapeutic influence, emphasizes the contractual nature of the psychotherapy relationship which necessitates an explicit understanding of the roles of the participants. Some researchers have noted relationship-relevant changes and related change-producing efforts by therapists during the course of psychotherapy. In a psychotherapy analogue, change in subjects' expectations in the direction of the characteristics of a warm stimulus therapist has been reported by Kumler (1969). Appel (1960) concludes that clients' expectations would have to change to adapt to the situation. Callis, Polmantier and Roeber (1955) recommend structuring on the part of the counselor depending on how closely the client's concept of what is to be done approaches the counselor's concept of what he intends to do. Furthermore, Welkowitz, Cohen and Ortmeyer (1967) found patient-therapist value similarity to increase with length of contact.

In view of these observations and the accepted belief that neither patient nor therapist remain static during the psychotherapy process, it is not unreasonable to assume that the initial expectations each bring to the therapy context can undergo a substantial amount of modification. It is likely that this change occurs in the direction of greater harmony and rapport when the relationship does endure. Of course, any assessment of change would necessitate at least two administrations of measures. To date, change in dissimilarity of expectations over the course of therapy, particularly as it relates to remaining in

treatment, has not been systematically examined.

## Hypotheses

Premature termination was hypothesized to be related to dissimilarity of patient-therapist role expectations. More specifically, prematurely terminated relationships would demonstrate higher levels of dissimilarity than relationships not prematurely terminated. The following hypotheses were tested:

1. Prematurely terminated relationships manifest higher Initial Dissimilarity than relationships not prematurely terminated.

2. Prematurely terminated relationships manifest higher Early Dissimilarity than relationships not prematurely terminated.

Since measures on Initial Dissimilarity of patient-therapist role expectations were obtained prior to measures on Early Dissimilarity, a period of time in therapy was available between both measures for change in expectations to occur.

Finally, changes in dissimilarity of role expectations during the therapy process were hypothesized:

3. Remaining in therapy is associated with reduced dissimilarity of patient-therapist role expectations. More specifically, continued therapeutic relationships will demonstrate increased congruence of role expectations during the course of therapy.

Thus, the primary goal of the study was to examine premature termination as it was related to dissimilarity of patient-therapist role expectations with the belief that long-term commitment is facilitated when expectations are congruent.

Other factors, including prognostic expectations, preferences, ethnicity, socioeconomic position, prior therapeutic contact, and source of referral, were explored in relation to the criteria.

# CHAPTER 2 METHOD

## Subjects

The study sample consisted of 97 patients applying for psychotherapy at the City College Psychological Center and at the Teachers College Psychological Consultation Center during the first half of the 1972-1973 academic year. Patients were offered psychoanalytically oriented psychotherapy, generally for the length of the academic year. The major mode of treatment at the Psychological Center (PC) was individual psychoanalytically oriented psychotherapy. At the Psychological Consultation Center (PCC) patients referred for group therapy, behavior therapy, or vocational-educational counseling were not included in the sample. The cost to the patient for therapy was nominal. The demographic characteristics of the patients at the two centers are described in Table 1. Fewer measurements were obtained on Social Class because Ss did not consistently answer every questionnaire item. The same patients were used by Borin (1974) in another research study.

Age. The mean age of the total group was 23.1 years. Patients at PC were younger, with a mean age of 21.2 years, and more homogeneous in age, SD, 3.6, than those at PCC. (PCC mean age=25.5, SD=7.4.)

Social Class. Socioeconomic status (SES) was determined by the Hollingshead Two Factor Index of Social Position (1957). Education and occupation were differentially weighted and the subject was assigned

TABLE 1

Demographic Characteristics (Age, Social Class, Ethnicity, Sex) of the Samples at PC and PCC

| Variable | PC | PCC | Combined Sample |
|---|---|---|---|
| Age | | | |
| N | 55 | 42 | 97 |
| Mean[a] | 21.2 | 25.5 | 23.1 |
| SD | 3.6 | 7.4 | 5.9 |
| Range | 17-38 | 16-54 | 16-54 |
| Social Class | | | |
| N | 38 | 29 | 67 |
| Mean[b] | 3.60 | 2.76 | 3.24 |
| SD | 1.00 | 1.27 | 1.19 |
| Range | 1-5 | 1-5 | 1-5 |
| Ethnicity | | | |
| White | 41 (74%) | 33 (79%) | 74 (76%) |
| Non-White | 14 (26%) | 9 (21%) | 23 (24%) |
| Sex[c] | | | |
| Male | 29 (53%) | 11 (26%) | 40 (41%) |
| Female | 26 (47%) | 31 (74%) | 57 (59%) |

[a]For difference between the mean age at PC and PCC, $t=3.47$, $p<.01$.

[b]For difference between the mean social class at PC and PCC, $t=2.95$, $p<.01$.

[c]PC and PCC differed in sex of patients. Chi square=6.92, $p<.01$.

to one of five social classes (one being the highest class). Patients were asked to describe both their own and their parents' education and occupation. Usually, SES was based on the subject's education and occupation, but if the subject was a student and had no occupation, his SES was based on his father's education and occupation.

The patients at PC were of a lower SES than those at PCC. The average SES for the total group was 3.24. This represents a partial college education and occupations such as store managers, small business owners, technicians, and semi-professionals.

Ethnicity. Seventy-six percent of the sample was white. No difference was found between the two centers in the ethnic composition of their patients.

Sex. Of the total sample, 59% were female and 41% were male. Males and females at PC were 53% and 47% respectively, with a greater percentage of females at PCC (74%).

Therapists. The 11 therapists at PC with a mean age of 26.2 years and the 18 therapists at PCC with a mean age of 27.0 years were advanced graduate students in Clinical and Counseling Psychology, participating in a 9 month psychotherapy practicum. The overall mean age of the therapists was 26.7 years. There were four female and seven male therapists at PC; ten females and eight males at PCC. All therapists were under the supervision of experienced therapists.

Of the 29 therapists who agreed to cooperate with the study, two PCC male therapists withdrew their participation during the course of the study. From the outset, four therapists--one PC female, one PCC female, two PCC males--refused to participate in the research.

Intake interviewers. Seventeen intake interviewers at PC, with a mean age of 26.5 years, were beginning graduate students in Clinical Psychology. There were nine females and eight males. No formal intake procedure was followed at PCC.

## Materials

Patient's Psychotherapy Expectancy Inventory. The revised Psychotherapy Expectancy Inventory (PEI-R) is a patient role expectancy measure, originally developed at the University of Connecticut in a group research project directed by M. A. Rickers-Ovsiankina, and has been theoretically and empirically described in Berzins (1968) and Rickers-Ovsiankina et al. (1971). It has been recently revised primarily by Berzins (1971b) in the context of a research project concerned with patient-therapist matching. The revised form contains 30 items (24 keyed items and 6 fillers) with each rated on a seven point scale, and can be scored for four patient role expectancy categories. Statistically, data on the PEI and PEI-R point to substantial internal consistency and temporal stability, and suggest that the four scales of the PEI-R related meaningfully, although modestly, to validational criteria examined. Subscale homogeneneity estimates for the PEI-R ranged from .75 to .87 (Berzins, 1971b). Test-retest coefficients obtained on the PEI from patients in therapy ranged from .54 to .68 with a one week interval (no therapy intervening) and from .56 to .76 with a four week interval (patient continuing in therapy during that period). Correlations of congruence between patient PEI expectations and patient intra-therapy behavior ranged from .13 to .41. When scores were ipsativized within patients, coefficients ranged from .24 to .43. Discriminant validity data showed PEI scores unrelated to

Rotter Locus of Control and Marlow-Crowne Social Desirability scale (Rickers-Ovsiankina et al., 1971). Convergent/discriminant validity data on the PEI-R indicated meaningful relationships of the subscales to several criteria including personality variables, symptomotology, therapists' clinical judgments, and therapy outcome (Berzins, 1971b).

A factor analysis of the PEI-R (Berzins, 1971b) resulted in the emergence of four anticipated factors, which were labelled and described as follows:

1. Approval-seeking refers to patient's concern with obtaining and maintaining the therapist's support and emotional guidance.

2. Advice-seeking refers to patient's expectation that the therapist provide guidance and evaluation.

3. Audience-seeking refers to patient's anticipation of engaging in verbal initiative during therapy.

4. Relationship-seeking refers to patient's expectation of spontaneous self-disclosure and emotional give and take in the context of a comfortable, egalitarian relationship with the therapist. (A copy of the PEI-R is included in Appendix A.)

Therapist's Psychotherapy Expectancy Inventory. A therapist version of the PEI-R (T-PEI) was designed for the present study in order to elicit the same role expectations from the therapist's perspective. (See Appendix B for T-PEI.) Minimal changes in wording of the PEI-R items were effected, and only the 24 keyed items of the PEI-R were used. Hence, therapists responded directly concerning therapist and patient role expectations from their frame of reference as therapists. Items on the T-PEI were also answered on a seven point rating scale.

Behavioral Correlates (BC) Scale. The BC scale, a therapist rating scale, was originally developed as a measure of patient role

behavior in psychotherapy, and has been employed in validating the PEI (Berzins, 1968; Rickers-Ovsiankina et al., 1971) and in other investigations (Berzins, Herron & Seidman, 1971; Rogers, 1969). It has been revised following a factor analysis of the item pool (Berzins, 1971a). The revised BC subscales were relabelled to be consistent with the PEI-R. Internal consistency coefficients of the BC subscales ranged from .75 to .84, and temporal stability over one month (patient continued therapy) ranged from .53 to .81.

The revised BC Scale, containing 34 items (24 keyed, 10 fillers), each rated on a seven point scale, was used to examine the congruence of the patients' initial response to the PEI-R with their subsequent intra-therapy behavior, i.e., to what extent do patients behave in therapy in accord with their prior expectations. (A copy of the revised BC Scale is included in Appendix C.)

Patient prognostic expectations and preferences. Questions directed at the applicants' prognostic expectations and preferences for therapists were included in a Pretherapy Questionnaire along with the patient's pretherapy PEI-R and questions pertaining to demographic information. (See Appendix A.) Prognostic expectations involved the applicant's expectancy about the duration of therapy, rate of progress, and his faith in therapy. Preferences about the age and sex of the therapist were also elicited, since these are frequently related to or determined by an individual's expectations (Boulware & Holmes, 1970). Five items (1, 2, 4, 5, 11) were used by Borin (1974) in another study with the same respondents.

Therapist prognostic expectations. Prior to beginning their psychotherapy practicum, therapists were asked about their general

expectancies for treatment duration and rate of progress. (See Appendix B.)

Criterion Measures

Premature termination occurred when the patient unilaterally decided to leave therapy against the advice and/or without the agreement of his therapist prior to six psychotherapy sessions. This cut-off point has been used by other investigators to define psychotherapy dropouts (Hiler, 1958; Rosenthal & Frank, 1958; Rubinstein & Lorr, 1956). Stieper and Wiener (1965) recommend using a single cut-off point to distinguish stayers from non-stayers, and based their point upon a significant drop between three and four sessions in dropout rate. In Garfield's review (1971), five to six interviews were found to be the median number of sessions for patients in several studies.

Sessions alone were not the sole criterion for identifying premature termination. Judgments by therapists, regardless of number of sessions, were also used.

Twenty-four percent of the 85 patients who began therapy, terminated within five sessions. The mean number of sessions held was 19.20, while the median was 17.00. ($SD$=15.31, Range=1-90.) There were no differences between the number of sessions held at PC and PCC, means of 16.73 and 21.85 respectively ($t$=1.54, $df$=83) although the distribution of total sessions was more variable at PCC. (PC $SD$=12.97 vs. PCC $SD$=17.25.)

In addition to the number of sessions criterion, therapist judgments of premature termination were also obtained. Therapists were asked if therapy relationships that had terminated were prematurely ended by their patients. Therapists were asked to consider this in light of whether therapeutic objectives were fulfilled. Eight patients who

completed more than five sessions were judged premature terminators by their therapists.

Criterion groups. Thus, number of sessions and therapist judgment provided two indices for premature termination. Utilizing these criteria, therapy relationships and patients were categorized as follows:

1. Prematurely Terminated Relationship-Terminator 1 (T1) included the relationships and patients judged prematurely terminated by the therapist that met for less than six sessions.

2. Prematurely Terminated Relationship-Terminator 2 (T2) included the relationships and patients judged prematurely terminated by the therapist that met for six or more sessions.

3. Prematurely Terminated Relationship-Terminator (T) included all T1 and T2 combined.

4. Non-Prematurely Terminated Relationship-Remainer (R) included all relationships and patients not judged prematurely terminated by the therapist that met for six or more sessions.

5. No-Shows (NS) included all patients who were offered treatment following application and/or intake, but subsequently refused to accept therapy or did not come for treatment.

The two therapy centers did not differ in the number of relationships classified as T and R (Chi square=.004, df=1). Approximately 30% were designated Terminators and 70% Remainers.

## Procedure

Upon application to the center, prospective patients were administered the PEI-R and Pretherapy Questionnaire prior to their intake interview, or at PCC, prior to their first therapy session. In order to tap pre-treatment expectations (initial expectations), this information

had to be collected before the applicant was interviewed since the intake represents the first major step in the treatment program. Those applicants who were accepted for treatment and began psychotherapy, were asked to complete the PEI-R again between their third and fourth therapy hours. For those patients terminating treatment prior to their third session, every attempt was made to readminister the PEI-R within two weeks after their termination. Thus, two administrations of the PEI-R were attempted for all patients seen for psychotherapy. For those patients continuing treatment up to or beyond the twelfth hour, a third administration of the PEI-R was performed at that time. Therapists were requested to familiarize themselves with the schedule of administrations so that they could inform their patients at the appropriate times to complete the necessary forms.

An almost parallel procedure was established for therapists, with two exceptions. In the first place, each therapist was asked to rate the behavior of each of his patients based on their initial meeting, by completing the BC Scale immediately following the first session. Secondly, all therapists were requested to respond to the T-PEI in two ways. The first required therapists (and intake interviewers) to complete the questionnaire under "typical therapy patient" set, that is, they answered in terms of conducting an hour of psychotherapy with their "typical therapy patient." This form of the T-PEI was administered to the therapy and intake staff early in the academic year and again five months later. In this manner, data was generated on the clinician's general role expectations for psychotherapy.

The second approach involved obtaining the therapists' role expectations with regard to specific patients. Therapists completed the T-PEI for each of their respective patients between the third and fourth

hour of therapy. A third therapist expectancy measure was obtained after the twelfth hour for those patient-therapist pairs continuing treatment up to or beyond that point.

The summary of the administration of measures to patients and therapists is presented in Table 2.

Data Analysis

Dissimilarity measures were computed for each therapeutic dyad by calculating the difference between patient and therapist ratings on each PEI-R and T-PEI item. Total difference scores for patient-therapist dyads were used to test the separate hypotheses. In this fashion, three sets of dissimilarity measures were derived for some therapeutic pairs and two sets for others, depending on the number of sessions held. These were as follows:

1. Initial (or pre-treatment) Dissimilarity based on the patient's Pretherapy PEI-R and the therapist's "typical therapy patient" T-PEI.

2. Early Dissimilarity based on completion of the PEI-R by patient and T-PEI by therapist between the third and fourth therapy hour.

3. Late Dissimilarity based on completion of the PEI-R by patient and T-PEI by therapist following the twelfth therapy hour.

Demographic data, source of referral, and prior psychotherapeutic contacts were obtained. Source of referral was categorized into (a) self, (b) peer, (c) authority (non-mental health), (d) authority (mental health).

Finally, data on patient preferences and prognostic expectations were also examined. Preferences for age and sex of therapist were categorized according to whether these preferences were or were not satisfied, as well as according to the type of preference expressed.

TABLE 2

Summary of Administration of Measures to Patients and Therapists at Different Stages of Psychotherapy

| Stage | Patient | Therapist |
|---|---|---|
| Initial (before treatment) | Pretherapy PEI-R | T-PEI for "typical therapy patient" (before and after 5 months psychotherapy practicum) |
| Following 1st session | | BC Scale |
| Early (between 3rd and 4th session) | PEI-R | T-PEI for specific patient |
| Late (following 12th session) | PEI-R | T-PEI for specific patient |

Prognostic expectations were explored. Duration Expectation referred to how long the patient initially expected to remain in therapy. Rate Expectation referred to how long after therapy begins did the patient expect to start seeing results. Both Rate and Duration Expectation were further classified according to the degree of realism, determined by therapist mean Duration and Rate Expectation. Belief in the efficacy of psychotherapy according to direction and according to strength of belief or disbelief (five point scale) was measured.

# CHAPTER 3 RESULTS

The hypotheses relating patient-therapist dissimilarity of role expectations to Terminators (T) and Remainers (R) were investigated with analysis of variance techniques. Hypotheses and analyses involving change over time employed a repeated measures design. Validation studies involved factor analytic and canonical correlation procedures.

Because some subjects, particularly those involved in Prematurely Terminated Relationships (T), did not complete a full battery of questionnaires, the number of subjects varied among the different analyses and comparison groups.

## Dissimilarity of Role Expectations

### Initial Dissimilarity of Role Expectations

To test Hypothesis 1, T were systematically compared to R on the basis of their Initial Dissimilarity of role expectations. Seventy-eight percent of the therapy dyads completed a set of Initial PEI-R.

The ANOVA for the comparison between all T and R yielded an F of 6.00 ($df=1/62$, $p<.05$).[1] (See Table 3 for means and SDs.)

The comparison between subgroups T1, T2, and R produced a nonsignificant F of 2.30 ($df=2/61$). (See Table 3 for means and SDs.)

### Early Dissimilarity of Role Expectations

Of those pairs terminating therapy prior to six sessions (T1),

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[1]Where difference scores were analyzed, squared difference scores were analyzed in an attempt to maximize differences. In all cases they yielded identical results and were not reported.

TABLE 3

Initial Dissimilarity (Means and Standard Deviations) of Role Expectations and Criterion Groups (T, T1, T2, R)

| Criterion Group | N | Mean | SD |
|---|---|---|---|
| T | 19 | 55.47 | 10.08 |
| T1 | 13 | 54.38 | 8.87 |
| T2 | 6 | 57.83 | 12.92 |
| R | 45 | 48.47 | 10.60 |

only 31% (4 dyads) completed the second PEI-R if they completed the first. The return rate was comparable for R. If the Initial PEI-R was completed, 36% (16 dyads) completed the second. A lower return rate occurred for T2, where only 17% (1 dyad) that completed the Initial PEI-R, submitted a second. One T1 dyad completed only a second PEI-R, bringing the total to five T1 dyads for which a second PEI-R was available. Altogether, six sets of Early PEI-R questionnaires were available for T (T1 and T2 combined), but one dyad did not complete the Initial questionnaire.

Early Dissimilarity. Hypothesis 2 states that T would manifest higher Early Dissimilarity of role expectations than would R. R (N=19) demonstrated Early Dissimilarity similar to T1 (N=5). (See Table 4 for means and SDs.) The variability of the two groups was not different ($F=2.36$, $df=18/4$). The SD and the mean for R were influenced by an extreme score of 86. Excluding this pair, the SD and mean for R were 10.62 and 43.98 respectively. When T1 and T2 were combined (N=6), they demonstrated as a group a mean Early Dissimilarity of 48.50. The variability of the combined T group changed little (SD of 9.14). (See Table 4 for means and SDs).

Repeated Measures--Initial and Early Dissimilarity. T (T1 and T2 combined) were compared to R on Initial and Early Dissimilarity through a repeated measures design. Five T and 16 R who completed both Initial and Early PEI-R were used for the analysis.

The analysis failed to demonstrate any significant interaction or main effects. (See Table 5 for ANOVA Summary.)

The data for the repeated measures design were in part different from the data for comparisons on Early Dissimilarity alone, since the repeated measures design required that both sets of PEI-R

TABLE 4

Early Dissimilarity of Role Expectations (Means, Standard Deviations, and Ranges) and Criterion Groups (T, T1, R)

| Criterion Group | N | Mean | SD | Range |
|---|---|---|---|---|
| T | 6 | 48.50 | 9.14 | 34-57 |
| T1 | 5 | 46.80 | 9.11 | 34-57 |
| R | 19 | 46.10 | 13.99 | 30-86 |

TABLE 5

Summary of Repeated Measures Analysis of Variance for Initial and Early Dissimilarity of Role Expectations and Criterion Groups (T & R)

| Source | df | MS | F |
|---|---|---|---|
| Criterion Group (A) | 1 | 270.86 | 1.58 |
| S's (A) | 19 | 172.02 | |
| Trials | 1 | 185.74 | 3.37 |
| A x T | 1 | 28.60 | .52 |
| S's (A) x T | 19 | 55.15 | |

(Initial and Early) be available. (See Table 6 for means and SDs.) Hypothesis 2, referring to Early Dissimilarity differences between T and R, was not supported.

Change in Dissimilarity of Role Expectations During Therapy

It was hypothesized that remaining in therapy is associated with decreased dissimilarity of role expectations. To examine this, a repeated measures ANOVA was performed on 13 therapy dyads for whom a complete set of PEI-R were obtained at three successive points in time.

An F of 5.07 ($p < .05$) was derived for Trials. (See Table 7 for Summary of ANOVA.) Therapy dyads demonstrated an Initial Dissimilarity mean score of 50.00, with lower mean scores as therapy continued (means of 42.08 and 43.46 for Early and Late respectively). (See Table 8 for means and SDs.) A Scheffé test for means yielded significant contrasts between Initial and Early ($t=2.98$, $p < .05$) and Initial and Late ($t=2.46$, $p < .05$), but non-significance for Early vs. Late ($t=-.52$). The drop in dissimilarity of role expectations occurred early in therapy and there appeared to be little change afterwards during the first few months of therapy.

## Instrument Validation

Prior to the testing of hypotheses, certain psychometric properties of the measuring instruments were explored.

Factor Analyses

Factor analyses of the Patient PEI-R, BC Scale, and Therapist PEI-R (T-PEI) were performed on this population in order first to determine the appropriateness of the four categories of role expectations and role behaviors found by Berzins (1971a, 1971b), and secondly,

TABLE 6

Initial and Early Dissimilarity of Role Expectations (Means and Standard Deviations) and Criterion Groups (T & R)

| Trial | N | Mean | SD |
|---|---|---|---|
| Initial | | | |
| T | 5 | 53.40 | 9.07 |
| R | 16 | 49.38 | 11.46 |
| Early | | | |
| T | 5 | 50.40 | 9.91 |
| R | 16 | 42.50 | 10.40 |

TABLE 7

Summary of Repeated Measures Analysis of Variance for Initial, Early and Late Dissimilarity of Role Expectations for Therapy Dyads

| Source | df | MS | F |
|---|---|---|---|
| Trials | 2 | 232.78 | 5.07* |
| Subjects | 12 | 290.36 | |
| S's x T | 24 | 45.91 | |

*$p < .05$

TABLE 8

Initial, Early and Late Dissimilarity of Role Expectations (Means and Standard Deviations) for Therapy Dyads

| Trial | N | Mean | SD |
|---|---|---|---|
| Initial | 13 | 50.00 | 12.03 |
| Early | 13 | 42.08 | 10.40 |
| Late | 13 | 43.46 | 11.36 |

to identify the factors of the T-PEI which was constructed for this study.

The factor analyses were performed via the method of principal components and factors were rotated orthogonally via Kaiser's normalized varimax procedure. In order to replicate Berzins' (1971a, 1971b) analyses, unities were placed in the diagonol for the PEI-R and T-PEI, while for the BC Scale, communalities were estimated from the squared multiple correlation coefficient for each item. The analyses were terminated after five factors were extracted. All applicants completing an Initial PEI-R ($N=82$), all patients rated on the BC Scale by their therapist ($N=52$), and all therapists and intake interviewers completing a "typical therapy patient" T-PEI ($N=44$) were employed for the respective analyses.

Although the sample sizes for the current factor analyses were appreciably smaller than those studied by Berzins (1971a, 1971b), the results not only corroborated the four categories on each scale, but were also highly consistent with and similar to the original findings. (See Appendix D for factor loadings on the above scales.)

Congruence of PEI-R and BC Scale

The four factors of the Patient PEI-R were canonically correlated with the four factors of the BC Scale to examine the congruence of the two scales. Forty-three patients completing the Initial PEI-R for whom a BC Scale was obtained were used. The congruence of the two scales was of borderline significance. A maximum canonical correlation of .56 was found which yielded a Chi square of 25.5 for 16 df ($p > .05 < .10$). The intercorrelation matrix of the eight factors is presented in Table 9. The only cross scale relationship that reached statistical significance was between PEI-R and BC Relationship-seeking

TABLE 9

Intercorrelations (Decimals omitted) of PEI-R and BC Scale Factors

| Factor | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|
| PEI-R | | | | | | | |
| 1. Approval-Seeking | 32a | -12 | -03 | 08 | 06 | 12 | 20 |
| 2. Advice-Seeking | | 18 | 09 | 04 | 10 | -22 | 30 |
| 3. Audience-Seeking | | | 62b | 07 | 10 | 24 | 17 |
| 4. Relationship-Seeking | | | | 15 | 21 | 25 | 35a |
| BC Scale | | | | | | | |
| 5. Approval-Seeking | | | | | 68b | 12 | 11 |
| 6. Advice-Seeking | | | | | | 01 | -07 |
| 7. Audience-Seeking | | | | | | | 31a |
| 8. Relationship-Seeking | | | | | | | |

a $p < .05$
b $p < .01$

with an $r$ of .35 ($p < .05$). Significant relationships were found within each scale. For the PEI-R, significant correlations were found between Approval-seeking and Advice-seeking ($r = .32$, $p < .05$), Audience-seeking and Relationship-seeking ($r = .62$, $p < .01$). Under the BC Scale, significant relationships were found between Approval-seeking and Advice-seeking ($r = .68$, $p < .01$), Audience-seeking and Relationship-seeking ($r = .31$, $p < .05$). These relationships tend to support Berzins' (1971b) statement that the first two factors relate to a "dependency upon others" role orientation, while the latter two refer to a "turning toward others and self" role orientation.

## Post Hoc Analyses

In order to better comprehend the many factors that are associated with patient and therapist expectations and the phenomenon of premature termination of therapy, aside from patient-therapist dissimilarity of role expectations, additional analyses were performed on patients and therapists separately.

## Patient Variables

### Patient Status Related to Role Expectations

Terminators and Remainers were compared on initial role expectations.

The results of the ANOVA demonstrated no significant interaction between patient status (Criterion Group) and role expectation (Factors). This was true in comparing T1, T2 and R, and in comparing all T(1 and 2 combined) to R. (See Tables 10 & 11 for ANOVA Summaries.) However, significant differences were found among role expectations across all patient groups ($F = 14.29$, $p < .01$, and $F = 15.67$, $p < .01$ respectively.)

## TABLE 10

Summary of Repeated Measures Analysis of Variance for Role Expectation Factors and Criterion Groups (T1, T2, R)

| Source | df | MS | F |
|---|---|---|---|
| Criterion Group (A) | 2 | .57 | .21 |
| S's (A) | 66 | 2.72 | |
| Factors (b) | 3 | 17.36 | 14.29** |
| A x B | 6 | 2.24 | 1.85 |
| S's (A) x B | 198 | 1.22 | |

**$p < .01$

TABLE 11

Summary of Repeated Measures Analysis of Variance for Role Expectation Factors and Criterion Groups (T & R)

| Source | df | MS | F |
|---|---|---|---|
| Criterion Group (A) | 1 | 1.56 | .58 |
| S's (A) | 67 | 2.68 | |
| Factors (B) | 3 | 19.24 | 15.67** |
| A x B | 3 | 1.45 | 1.18 |
| S's (A) x B | 201 | 1.23 | |

**$p < .01$

Inspection of the means in Table 12 suggested that patients on the whole may have stronger initial expectations for receiving advice and sharing an egalitarian relationship with their therapist than they have for receiving approval and taking the initiative in therapy.

Premature termination of therapy did not appear to be related to the different types of role expectations that patients initially hold.

Change in Patient Role Expectations

To investigate changes in expectations patients hold, a repeated measures ANOVA was performed on all patients for whom three successive PEI-R measures were obtained ($N=15$). (See Table 13 for means and SDs.) This analysis offered the opportunity to observe how patients' role expectations change during the course of psychotherapy.

The ANOVA yielded a significant interaction between Stage in Therapy and Factors ($F=4.43$, $p < .01$). (See Table 14 for ANOVA Summary.) This relationship is illustrated in Figure 1. Approval-seeking and Advice-seeking role expectations decreased during 12 sessions of therapy, while Audience-seeking role expectations appeared to have increased. Reducing the interaction term to simple main-effects indicated that Advice-seeking ($F=7.88$, $p < .01$) and Audience-seeking ($F=4.22$, $p < .05$) role expectations changed significantly over the course of 12 sessions.

Patient Status Related to Other Variables

Comparisons ($t$ and Chi square) were made among patient groups in order to explore the presence of other variables contributing to premature termination of therapy. The number of subjects for any particular patient group varied among the comparisons because patients failed to consistently answer every Pretherapy Questionnaire item.

TABLE 12

Role Expectation Factors (Means and Standard Deviations) and Criterion Groups (T, T1, T2, R)

| Role Expectation Factors | Criterion Groups T | T1 | T2 | R |
|---|---|---|---|---|
| N | 20 | 14 | 6 | 49 |
| Approval-seeking Mean | 3.57 | 3.63 | 3.42 | 3.97 |
| SD | 1.23 | 1.33 | 1.08 | 1.30 |
| Advice-seeking Mean | 4.21 | 4.32 | 3.94 | 4.53 |
| SD | 1.43 | 1.37 | 1.65 | 1.20 |
| Audience-seeking Mean | 3.72 | 3.70 | 3.75 | 3.96 |
| SD | 1.16 | 1.31 | .81 | 1.14 |
| Relationship-seeking Mean | 5.18 | 4.82 | 6.00 | 4.87 |
| SD | 1.46 | 1.60 | .59 | 1.30 |

TABLE 13

Patient Role Expectation Factors (Means and Standard Deviations) at Three Stages of Psychotherapy (N=15)

| Role Expectation Factor | Initial Stage Mean | SD | Early Stage Mean | SD | Late Stage Mean | SD |
|---|---|---|---|---|---|---|
| Approval-seeking | 4.27 | 1.35 | 3.72 | 1.08 | 3.62 | 1.08 |
| Advice-seeking | 5.03 | .76 | 4.31 | 1.10 | 3.82 | 1.32 |
| Audience-seeking | 3.79 | 1.41 | 4.46 | 1.45 | 4.63 | 1.61 |
| Relationship-seeking | 4.84 | 1.51 | 4.92 | 1.25 | 4.63 | 1.49 |

TABLE 14

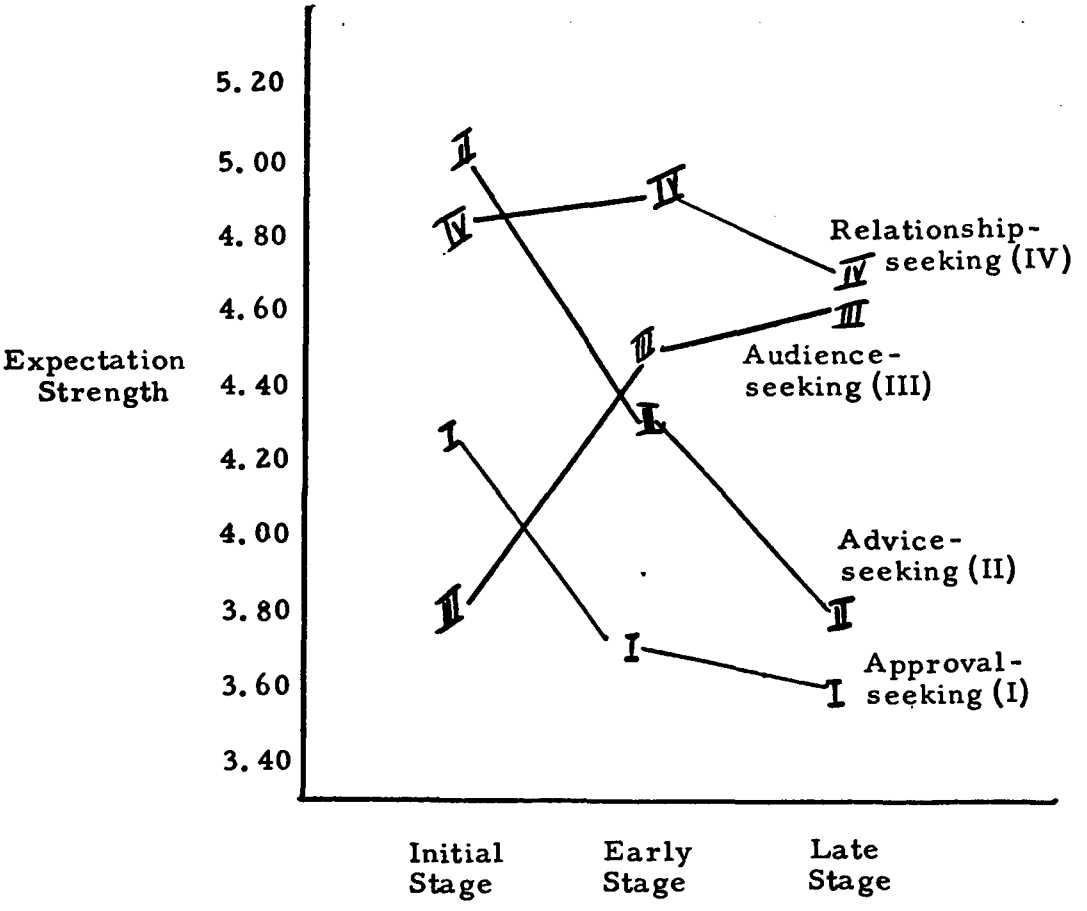
Summary of Repeated Measures Analysis of Variance for Change in Patient Role Expectation Factors over Three Stages of Psychotherapy

| Source | df | MS | F |
|---|---|---|---|
| Subjects | 14 | 5.20 | |
| Factors (A) | 3 | 6.55 | 2.22 |
| A x S's w. groups (error a) | 42 | 2.96 | |
| Stage of Therapy (B) | 2 | 1.41 | 1.31 |
| A x B | 6 | 3.10 | 4.43** |
| B x S's w. groups (error b) | 28 | 1.07 | |
| AB x S's w. groups (error ab) | 84 | .70 | |

**$p < .01$

FIGURE 1

Change in Patient Role Expectation Factors over Three Stages of Psychotherapy



Demographic variables. Age, social class, and educational level failed to differentiate R and T. (See Table 15 for t-tests.) Likewise, ethnicity, sex, and religion failed to distinguish among the NS, R, and T groups. (See Table 16 for Chi square.)

Duration Expectation. The difference between R and T for patient's initial expectation of how long therapy will last approached significance ($t = 1.87$, $df = 61$, $p > .05 < .07$). T expected therapy to be of shorter duration than did R. (See Table 17 for means, SDs, ranges, and t-test.) With regard to the estimated amount of time these groups expected to remain in therapy, T appraised their stay to last 4 months, while R expected it to be about 6 months.

Rate Expectation. In general, patients expected to begin seeing results after 1 or 2 months of therapy. A patient's initial expectation of how long it will take until he notices results failed to distinguish T and R. (See Table 17 for means, SDs, ranges, and t-test.)

Belief. All groups held positive beliefs that results would be achieved. No significant differences were demonstrated between T and R on the basis of their initial belief in the efficacy of psychotherapy. (See Table 17 for means, SDs, ranges, and t-test.)

Age Preference. Patients preferred their therapists to be in the 25 to 34 age range. T and R did not differ in their initial preferences for age of their prospective therapist. (See Table 17 for means, SDs, ranges, and t-test.)

Sex Preference. Sixty-six percent of the patient population preferred to have a male therapist. Initial preference for sex of therapist did not differentiate R from NS+T, nor R from T. (See Table 18 for percentages and Chi square.)

TABLE 15

Patient Therapy Status and Means, Standard Deviations, Ranges, and p-levels* for Age, Social Class, and Educational Level

| Variable | NS | R | T1 | T2 | T | p-level |
|---|---|---|---|---|---|---|
| Age | | | | | | |
| N | 12 | 55 | 17 | 8 | 25 | |
| Mean | 21.6 | 23.6 | 23.0 | 23.0 | 23.0 | n.s. |
| SD | 4.5 | 6.2 | 7.6 | 3.2 | 6.5 | |
| Range | 18-35 | 16-54 | 17-49 | 18-28 | 17-49 | |
| Social Class | | | | | | |
| N | 3 | 44 | 14 | 6 | 19 | |
| Mean | 4.67 | 3.07 | 3.46 | 3.00 | 3.32 | n.s. |
| SD | .58 | 1.11 | 1.27 | 1.41 | 1.29 | |
| Range | 4-5 | 1-5 | 1-5 | 1-5 | 1-5 | |
| Educational Level | | | | | | |
| N | 6 | 47 | 14 | 7 | 21 | |
| Mean | 3.50 | 2.74 | 2.93 | 2.57 | 2.81 | n.s. |
| SD | .84 | .68 | .62 | .98 | .75 | |
| Range | 3-5 | 1-5 | 2-4 | 1-4 | 1-4 | |

*t-test performed between R and T.

TABLE 16

Patient Therapy Status and Frequencies, Percentages, and p-levels* for Ethnicity, Sex, and Religion

| Variable | NS | R | T1 | T2 | T | p-level |
|---|---|---|---|---|---|---|
| Ethnicity | | | | | | |
| White | 9 (75%) | 41 (74%) | 11 (65%) | 8 (100%) | 19 (76%) | |
| Non-White | 3 (25%) | 14 (26%) | 6 (35%) | 0 (0%) | 6 (24%) | n. s. |
| Sex | | | | | | |
| Male | 6 (50%) | 25 (46%) | 5 (29%) | 2 (25%) | 7 (28%) | |
| Female | 6 (50%) | 30 (54%) | 12 (71%) | 6 (75%) | 18 (72%) | n. s. |
| Religion | | | | | | |
| Jewish | 1 (33%) | 19 (53%) | 4 (50%) | 4 (80%) | 8 (62%) | |
| Catholic | 2 (67%) | 11 (31%) | 1 (12%) | 1 (20%) | 2 (15%) | |
| Protestant | 0 (0%) | 6 (17%) | 2 (25%) | 0 (0%) | 2 (15%) | |
| Other | 0 (0%) | 0 (0%) | 1 (12%) | 0 (0%) | 1 (8%) | n. s. |

*p-level for Chi square comparisons. Cells were collapsed to compare R vs. T vs. NS and/or R vs. T + NS.

TABLE 17

Patient Therapy Status and Means, Standard Deviations, Ranges, and p-levels* for Duration Expectation, Rate Expectation, Belief, and Age Preference

| Variable | NS | R | T1 | T2 | T | p-level |
|---|---|---|---|---|---|---|
| Duration Expectation | | | | | | |
| N | 8 | 45 | 12 | 6 | 18 | |
| Mean | 3.88 | 4.89 | 3.67 | 4.83 | 4.06 | $>.05<.07$ |
| SD | 1.81 | 1.42 | 1.72 | 1.33 | 1.66 | |
| Range | 2-6 | 1-6 | 1-6 | 3-6 | 1-6 | |
| Rate Expectation | | | | | | |
| N | 8 | 46 | 12 | 6 | 18 | |
| Mean | 2.25 | 2.98 | 3.33 | 2.83 | 3.17 | n.s. |
| SD | 1.04 | 1.47 | 1.83 | 2.14 | 1.89 | |
| Range | 1-4 | 1-7 | 1-7 | 1-7 | 1-7 | |
| Belief | | | | | | |
| N | 6 | 45 | 13 | 6 | 19 | |
| Mean | 4.17 | 3.82 | 3.77 | 3.83 | 3.79 | n.s. |
| SD | .98 | .78 | .72 | 1.17 | .86 | |
| Range | 3-5 | 2-5 | 3-5 | 2-5 | 2-5 | |
| Age Preference | | | | | | |
| N | 8 | 45 | 14 | 5 | 19 | |
| Mean | 2.75 | 2.93 | 2.50 | 2.60 | 2.53 | n.s. |
| SD | 1.16 | 1.21 | 1.09 | .55 | .96 | |
| Range | 1-5 | 1-6 | 1-4 | 2-3 | 1-4 | |

*t-test performed between R and T.

TABLE 18

Patient Therapy Status and Frequencies, Percentages, and p-levels* for Sex Preference, Prior Therapy, and Source of Referral

| Variable | NS | R | T1 | T2 | T | p-level |
|---|---|---|---|---|---|---|
| Sex Preference | | | | | | |
| Male | 4 (50%) | 27 (75%) | 7 (58%) | 3 (50%) | 10 (56%) | |
| Female | 4 (50%) | 9 (25%) | 5 (42%) | 3 (50%) | 8 (44%) | n. s. |
| Prior Therapy | | | | | | |
| Yes | 5 (56%) | 29 (54%) | 8 (47%) | 4 (57%) | 12 (50%) | |
| No | 4 (44%) | 25 (46%) | 9 (53%) | 3 (43%) | 12 (50%) | n. s. |
| Source of Referral | | | | | | |
| Self | 3 (30%) | 26 (50%) | 4 (24%) | 6 (74%) | 10 (40%) | |
| Peer | 4 (40%) | 12 (23%) | 7 (41%) | 1 (12%) | 8 (32%) | |
| Authority (Non-Mental Health) | 1 (10%) | 5 (10%) | 2 (12%) | 0 (0%) | 2 (8%) | |
| Authority (Mental Health) | 2 (20%) | 9 (17%) | 4 (24%) | 1 (12%) | 5 (20%) | n. s. |

*p-level for Chi square comparisons. Cells were collapsed to compare R vs. T vs. NS and/or R vs. T+NS.

Prior Therapy. As shown in Table 18, approximately half of the patient population (53%) had some prior therapeutic experience. Whether or not a patient had previous therapy did not differentiate R vs. NS+T. (See Table 18 for percentages and Chi square.)

Source of Referral. A considerable percentage of the patient population (45%) were self-referred, while 27% were referred by peers and another 27% by authority figures (mental health and non-mental health). The particular type of referral source through which the patient learned about the services at the two centers did not differ significantly among NS, R, and T. (See Table 18 for percentages and Chi square.)

Intercorrelation of Patient Variables

In order to explore the relationship between patient variables and duration of therapy, all relevant variables were intercorrelated for all patients in therapy (NS omitted from analysis). The intercorrelation matrix is presented in Appendix E. The number of subjects again varied because some did not respond to all questionnaire items.

Duration of therapy was measured by the number of therapy sessions (No. of Sess.). Although the correlation was small, continuing in therapy was found to be directly related to the patient's initial expectation of how long therapy would last (Duration Expectation). The longer a patient expected to be in therapy, the greater the number of sessions held ($r = .25$, $p < .05$). Likewise, the more realistic his expectation for duration of therapy (Realistic Dur. Expect.), the longer he remained in therapy ($r = .25$, $p < .05$).

Also, SES was modestly correlated with the number of therapy sessions. The higher a patient's SES, the greater the number of sessions held ($r = .26$, $p < .05$).

## Therapist Variables

### Change in Therapist General Role Expectations

The set of general role expectations held by therapists was tapped by two "typical therapy patient" T-PEI measures separated by a five month period. The first assessed general role expectations prior to the initiation of that year's practicum in psychotherapy. The second T-PEI was obtained after five months exposure to conducting psychotherapy. Only those therapists completing both General T-PEI measures could be included in the analysis ($N=23$). (See Table 19 for means and SDs.)

A repeated measures ANOVA yielded a significant interaction between Time and Factors ($F=5.66$, $p<.01$). (See Table 20 for ANOVA Summary.) A decrease in Approval-seeking role expectations accompanied by an increase in Audience-seeking and Relationship-seeking role expectations is illustrated in Figure 2. Further analysis of the interaction into simple main-effects demonstrated that Audience-seeking ($F=10.58$, $p<.01$) and Relationship-seeking ($F=10.56$, $p<.01$) did change significantly over the five month period.

Hence, these types of therapist attitudes were susceptible to the influence of learning and exposure, and changed from a position of expecting a dependency orientation from their patients to a position of expecting patients to assume greater autonomous intra-therapy behavior.

### Therapist Type and General Role Expectations

Classification of therapists according to the dropout status of their patients was limited by the population size. Only one therapist in the sample had solely T, but this therapist had not completed a T-PEI.

Therapists were grouped into three subgroups, and although

TABLE 19

Therapist General Role Expectation Factors (Means and Standard Deviations) Before and After Five Months Psychotherapy Practicum (N=23)

| Role Expectation Factor | Time | | | |
|---|---|---|---|---|
| | Before | | After | |
| | Mean | SD | Mean | SD |
| Approval-seeking | 4.75 | .79 | 4.48 | .77 |
| Advice-seeking | 3.02 | .84 | 2.95 | .66 |
| Audience-seeking | 4.32 | 1.26 | 5.00 | .86 |
| Relationship-seeking | 3.63 | 1.27 | 4.32 | 1.21 |

TABLE 20

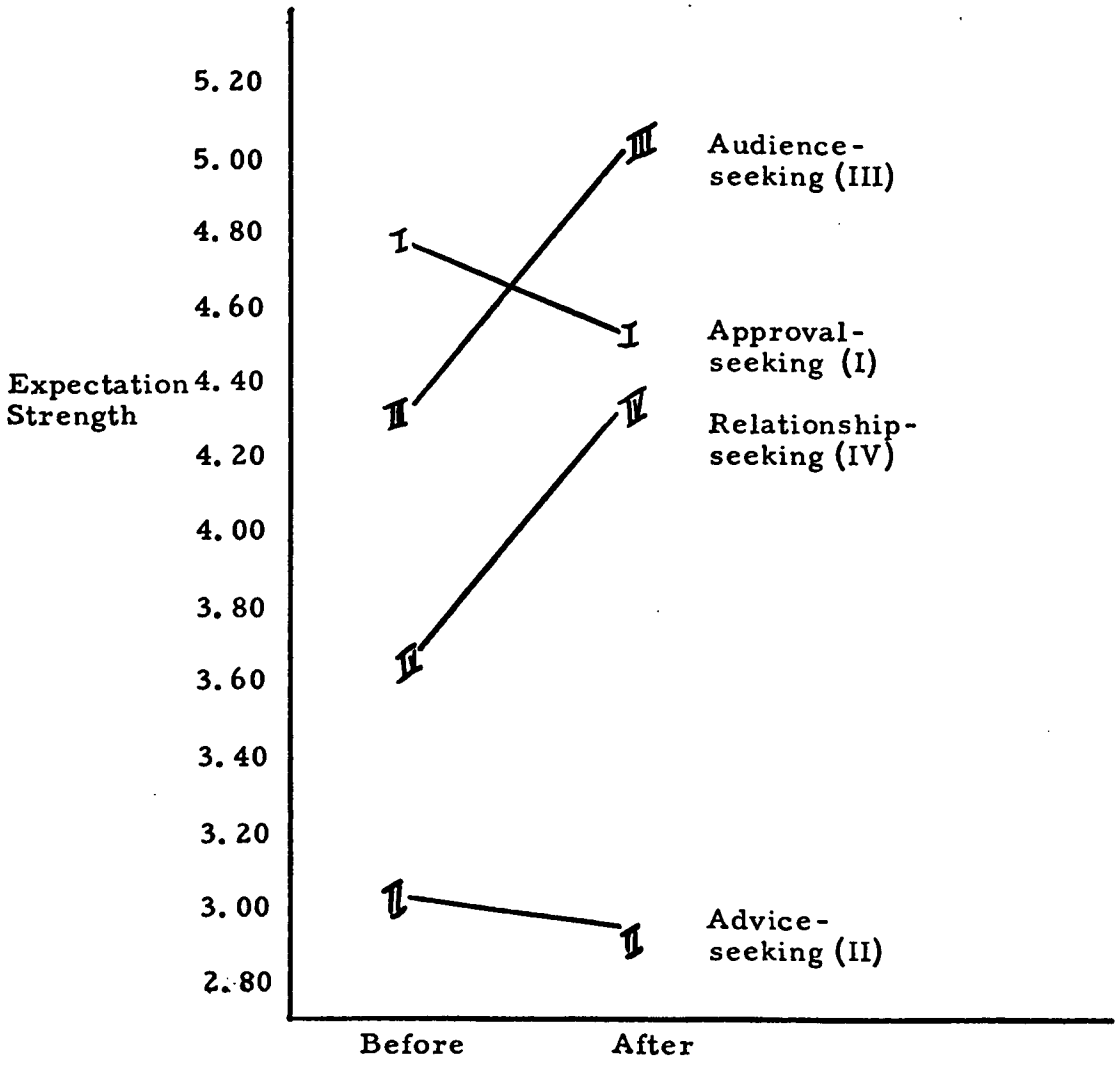
Summary of Repeated Measures Analysis of Variance for Change in Therapist General Role Expectation Factors over Five Months Psychotherapy Practicum

| Source | df | MS | F |
|---|---|---|---|
| Subjects | 22 | 1.66 | |
| Factors (A) | 3 | 28.00 | 20.39** |
| A x S's w. groups (error a) | 66 | 1.37 | |
| Time (B) | 1 | 3.05 | 5.96* |
| A x B | 3 | 2.83 | 5.66** |
| B x S's w. groups (error b) | 22 | .51 | |
| AB x S's w. groups (error ab) | 66 | .50 | |

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

FIGURE 2

Change in Therapist General Role Expectation Factors Before and After Five Months Psychotherapy Practicum



statistical tests were precluded due to sample size, observation of the means for general role expectations was suggestive of trends.

As presented in Table 21, comparisons involved the two therapists with more T than R (T > R), the nine therapists with more R than T but with at least one T (R > $T_1$), and the three therapists with only R (R-alone). All therapists had three or more patients.

Initially the T > R therapists more strongly expected to offer advice and less strongly expected their patients to take the verbal initiative and share an egalitarian relationship with their therapist than did R > $T_1$ and R-alone. Of all three types, R-alone least expected to give advice.

During a five month period of conducting psychotherapy all therapists changed and became increasingly similar. Overall, all therapists became similar in Advice-seeking scores, T > R showed higher Audience-seeking approximating that of other therapists, and R > $T_1$ and R-alone became almost identical. The difference between T > R and other therapist types after 5 months was that they expected more Approval-seeking and there was still no overlap in Relationship-seeking expectations. (See Table 21 for respective means.)

Therapist Prognostic Expectations

Duration Expectation. Therapists at PC and PCC expected therapy to last more than 6 months. The mean rating for both groups was almost identical as was the range of ratings. Not one therapist expected therapy to last less than 2 months. (See Table 22 for means and ranges.) It was evident that, on the average, patients' expectation for duration of therapy (4-6 months) was below that of their therapists.

TABLE 21

Therapist General Role Expectation Factors and Therapist Type Before and After Five Months Psychotherapy Practicum

| Therapist Type | N | Approval-seeking Mean | Advice-seeking Mean | Audience-seeking Mean | Relationship-seeking Mean |
|---|---|---|---|---|---|
| T>R | | | | | |
| Before | 2 | 4.65 | 4.00 | 3.35 | 2.15 |
| After | 2 | 5.25 | 2.90 | 4.85 | 3.00 |
| R>T1 | | | | | |
| Before | 9 | 4.97 | 3.18 | 5.02 | 4.03 |
| After | 9 | 4.42 | 2.88 | 5.26 | 4.64 |
| R-alone | | | | | |
| Before | 3 | 4.30 | 2.43 | 5.00 | 3.80 |
| After | 2 | 4.45 | 2.80 | 5.00 | 4.70 |

TABLE 22

Therapist Prognostic Expectations (Means and Ranges) at PC and PCC

| Prognostic Expectation | PC | PCC | Combined Sample |
|---|---|---|---|
| Duration Expectation | | | |
| N | 11 | 16 | 27 |
| Mean | 5.73 | 5.75 | 5.74 |
| Range | 4-6 | 3-6 | 3-6 |
| Rate Expectation | | | |
| N | 11 | 16 | 27 |
| Mean | 3.64 | 3.12 | 3.33 |
| Range | 1-5 | 1-5 | 1-5 |

Rate Expectation. Therapists at PC expected their patients to begin seeing results after a period of 2 to 4 months, while those at PCC expected results to be noticed after 2 months of therapy. The range of ratings for both groups was identical and in no instance did any therapist expect it would take more than 6 months before results would be noticed. (See Table 22 for means and ranges.) Thus, it appeared that patients may have expected results a bit sooner (1-2 months).

## Summary of Results

Hypothesis 1 was supported in that Prematurely terminated relationships (T) demonstrated higher Initial Dissimilarity of role expectations than those not prematurely terminated (R). Dissimilarity of role expectations decreased during the course of 12 therapy sessions, with a significant drop demonstrated prior to 4 sessions (Hypothesis 3). Hypothesis 2, referring to Early Dissimilarity differences between T and R, was not supported.

In the analyses of other variables, patient role expectations changed significantly over 12 sessions of therapy. Advice-seeking role expectations decreased, while Audience-seeking increased. Significant changes were found in therapist general role expectations over a 5 month period of psychotherapy practicum. Audience-seeking and Relationship-seeking role expectations increased significantly. Duration Expectation and SES were directly, though modestly, correlated with duration of therapy.

Several non-significant trends were worthy of note. Patients in general, regardless of status, had stronger initial expectations for receiving advice and sharing an egalitarian relationship, than for

receiving approval and taking the verbal initiative. Differences between T and R approached significance on Duration Expectation. Role expectations distinguished those therapists with higher and lower success rate of retaining patients in therapy. The latter initially expected to offer more advice and expected less verbal initiative from their patients. After a 5 month practicum experience they expected less advice-seeking and greater patient verbal initiative. Those with a better retention rate were less disposed to give advice. Patients anticipated a briefer stay in therapy than did their therapists, and they expected results sooner.

Factor analyses of the PEI-R, BC Scale, and T-PEI yielded meaningful subscales very similar to those originally found by Berzins (1971a, 1971b). Congruence of role expectations and subsequent behavior, assessed by canonical correlation procedures, approached significance. However, individual intercorrelations between PEI-R and BC subscales were low, with one significant, but modest, relationship.

# CHAPTER 4 DISCUSSION

## Implications of the Study

The primary focus of the study was the patient-therapist dyad, a dynamic interactive system. Within this framework, changes in one element of the system can effect a change in the entire system. Although somewhat artificial, but for the purpose of simplification, the elements of the interactive system will be discussed separately. The patient-therapist interaction will be focused on first, followed by a consideration of patients and therapists individually.

### Patient-Therapist Dissimilarity of Role Expectations

Incompatibility of patient-therapist role expectations was found to be inversely related to continuation of the psychotherapy relationship. This was clearly supported by two analyses. Terminators demonstrated higher Initial Dissimilarity of role expectations than Remainers, and dissimilarity of role expectations decreased during the early stage of therapy.

The conclusion was not supported by two other analyses, which was probably the result of an inadequate sample size. It is the nature of clinical data that a small sample size may be generated and statistical significance may not be demonstrated. Although the data did not always reach acceptable levels of significance, certain trends are noteworthy and encouraging for future research. The trend of the means for Terminators and Remainers on Initial and Early Dissimilarity (repeated measures design) was in the predicted direction. Terminators

not only demonstrated higher Initial Dissimilarity, but also, higher Early Dissimilarity than Remainers. Despite a decrease in dissimilarity for both groups over the first few sessions, a greater decrease was noted for Remainers. Accordingly, Hypothesis 2 warrants further investigation with larger samples before conclusive statements can be made. Finally, Terminators who remain for more than 5 sessions but are judged by their therapists to have terminated prematurely, tended to demonstrate higher Initial Dissimilarity of role expectations than Remainers and those Terminators who leave within 5 sessions.

Lennard and Bernstein's (1960) finding of a major relationship between the degree of dissimilarity of participant expectation and the degree of "strain" and disequilibrium that occurs within the psychotherapy dyad can help our understanding of the basis for continuation of therapy. Successful participation in a social situation requires complementarity of expectations and behaviors. Lennard and Bernstein (1960) predict that if expectations are too dissimilar, the social system disintegrates unless the differences can be reconciled. In essence, it is the therapist's task to socialize his patient by teaching him a new set of reciprocal role relationships pertinent to the psychotherapy context. Efforts toward "socialization" can restore the equilibrium of the interactive system and help it to endure. Premature termination of therapy is viewed as resulting from a failure to reach a sufficient level of mutuality and agreement about roles and goals of therapy. Festinger's (1957) theory of cognitive dissonance sheds some light on this process. When dissonance is present, in addition to trying to reduce it, the person will actively avoid the situation that would probably further increase the dissonance.

Mutual expectations and congruence of patient expectancies with their perception of what occurs in therapy can facilitate process and outcome (Clemes & D'Andrea, 1965; Heine & Trosman, 1960; Levitt, 1966; Marcus, 1968; Overall & Aronson, 1963). It is crucial to focus on and modify patient expectations toward congruence early in treatment, sometimes even before treatment begins (Goldstein, 1962; Greenberg, 1969; Heilbrun, 1972; Heitler, 1973; Hoehn-Saric et al., 1964; Rotter, 1954; Yalom, Houts, Newell & Rand, 1967). Such recommendations appear justified in order to maintain patients in therapy, considering the relationship between dissimilarity of role expectations and dropping out.

It is necessary to innovate or devise approaches to reduce dissimilarity, particularly where it is already known to exist as in the case of lower class patients (Bergin, 1966; Heitler, 1973; Levitt, 1966; Lorian, 1974). Gould (1967) reports successful therapy with blue-collar workers by modifying his approach. His techniques involved being more informal, flexible about length of sessions, physically active, and concrete. He used role-playing and met clients in settings other than the office, including parks and bars. These modifications seemed to help his lower class clients accept the doctor-patient relationship.

Change in Role Expectations

That role expectations do change during the therapy process was evident by a number of findings in the study. Patient-therapist dissimilarity of role expectations decreased as therapy continued, with the drop occurring in the early stage of therapy. Although the results do not delineate whether it was the patient, therapist, or both

who changed, it is clear that, overall, the change in expectations was in the direction of greater harmony and congruence.

Also suggestive was the trend of the means for dissimilarity of Terminators and Remainers. Both groups could still be distinguished at the "early" stage of therapy (after 3 sessions), and differential change in the direction of greater congruence took place for each group. That dissimilarity appeared to decrease less for Terminators than for Remainers could mean that therapists were less active in structuring the relationship with the former toward greater mutuality of expectations.

Therapists can differ in the degree to which they attempt to structure the therapy situation for their patients, including their providing guidlines about what patients can expect within and from psychotherapy. Similarly, patients may differ in their flexibility and capacity to learn new roles, their compliance and submission to an authority figure, and their prior conceptions about psychotherapy. While a patient may have a particular set of expectations prior to therapy, others can be induced. Meltzoff and Kornreich (1970) point out that expectations are fluid and subject to change. Distinguishing between those expectations held at the begining of therapy and those held at some later point is necessary.

The assumption that each member of the therapy dyad may alter his role expectations seems justified. Indirect support is offered by the analyses examining change in role expectation factors for patients and for therapists. The categories of role expectations initially held by patients, undergo change during the first 12 sessions of therapy. Therapists too, in the course of their initial training, demonstrated changes in their role expectations.

## Psychotherapy Expectations of Patients and Therapists

A composite description of the typical patient and therapist expectations about therapy can clarify potential sources of difficulty in developing a therapeutic relationship within these settings.

Patient expectations. At the beginning of therapy, patients hold relatively strong expectations for receiving advice (Advice-seeking) from and sharing an egalitarian relationship (Relationship-seeking) with their therapist. Patients have relatively weak expectations of initiating discussions in therapy (Audience-seeking) and looking for approval (Approval-seeking) from their therapist. This is consistent with results reported by Berzins (1971b). In part, this is in agreement with the findings of others. While analyzing patient expectations of therapy and therapist, Begley and Lieberman (1970) found that patients tend to expect direction from their therapist and anticipate getting along on a natural easy-going basis with him. Garfield and Wolpin (1963) state that most patients expect the therapist to give some advice early in therapy.

When a patient applies for therapy, he typically expects it to last between 4 and 6 months, with noticeable changes taking place after 1 to 2 months of therapy. He has positive expectations that results will be achieved.

As therapy continues, patients gain stronger expectations for initiating verbal interaction and anticipate less advice-giving and advice-seeking. Essentially, they expect to behave in a more autonomous fashion as they experience what therapy is.

Therapist expectations. When they begin their training, therapists hold relatively high expectations that patients will be seeking approval and initiating verbal interaction. They expect less in

advice-seeking and relationship-seeking behavior. Consistent with their analytic framework, they maintain relatively weak Advice-seeking expectations throughout their early training (5 months), in spite of their patients' initial insistance on receiving advice. As they gain experience, therapists increasingly expect an egalitarian relationship and even greater patient initiative in therapy. Therapists who have more Terminators than Remainers, however, did not appear to appreciably raise their Relationship-seeking expectations, and, somewhat different from their more successful colleagues, they began their training with comparatively high Advice-seeking expectancies.

As with most analytic therapies, these therapists expect therapy to last for more than 6 months. Not one therapist expected it to last less than 2 months. However, they view it reasonable to expect some positive results after 2 to 4 months.

Similarities and differences. Initially, patients and therapists differ considerably at first contact. Patients hold greater expectancies for advice than do their therapists, and have lower expectations of initiating discussions than their therapists anticipate. Therapists expect patients to seek approval and an authoritarian relationship with them. Patients change their role expectations during therapy. They approach their therapist by expecting to initiate discussions and not seek advice. Furthermore, therapists tend to approximate their patient's expectations for an egalitarian relationship later in their training.

Patients and therapists differ in their initial expectancies for duration and rate of progress. Patients tend to be more optimistic in both respects.

It is likely that patients come to understand in time that advice will not be forthcoming and learn to expect this less. At the same time they learn the value placed on their own verbal initiative in therapy and develop a greater expectancy of performing this way.

Beginning therapists may become more comfortable functioning within the context of an egalitarian relationship as they gain experience and security in their therapist role. Neophyte therapists may be highly threatened by patients who expect to share an equal give-and-take. This may explain the high Initial Dissimilarity of Terminators who remain for more than 5 sessions but are judged by their therapists to have terminated prematurely. These patients hold relatively high Relationship-seeking expectancies, which may overwhelm inexperienced therapists to the extent that the relationship does not reach an acceptable level of stability and harmony.

Subsequent studies could focus on the process within sessions through which patient-therapist differences and similarities on specific prognostic and role expectations make or break the therapy relationship. Unanswered important questions include understanding the process through which expectations change in therapy, and the factors operating that facilitate or impede such change.

Implications for Clinical Practice

It is crucial that therapists make every effort to elicit, clarify and correct their patients' inaccurate role expectations during the initial phase of therapy to achieve a greater degree of consensus and mutuality. Both parties should have a clear understanding of their roles and responsibilities in therapy, and what they contract should be mutually acceptable and without ambiguity. This intervention can greatly reduce

the disruptive force of incompatible role expectations (Lennard & Bernstein, 1960).

In assigning patients to therapists, matching patient and therapist according to their individual sets of role expectations can facilitate compatibility even further. This would enhance efforts toward selecting the therapist most suited for each patient. Use of the PEI-R and T-PEI as instruments for quickly assessing role expectations seems promising.

Furthermore, it may be necessary for the therapist to adjust his role expectations, even temporarily, so as to meet his client on sufficient common ground. In this way mutuality can also be served.

Disruptive Effects of Therapist Expectations

While the problem of premature termination has been thus far concerned with the patient's inaccurate expectations, the therapist's failure to alter these expectancies, and the lack of mutuality, the picture is incomplete. The potentially disruptive effects of therapists' expectations must be considered.

The frequent finding that social class covaries with duration provides an example. Lower class patients have expectations of therapy that approximate a medical model (Overall & Aronson, 1963; Hollingshead & Redlich, 1958), whereby the patient expects an authoritarian and advice-giving solution offering symptomatic relief. When the lower class patient is confronted with traditional psychotherapy which demands a verbal give-and-take, introspection, and talking about feelings, he is dissatisfied and does not return.

Also, the lower class patient dropping out may be a sign of health if his environment will not accept the changes therapy implements.

As Lorian (1973) points out, healthy middle class solutions may not be healthy for problems of the poor.

On the other hand, the therapist too has expectations and preferences for the type of patient he will find gratifying to work with. If the therapist's expectations and needs are fulfilled, he will likely consider the situation rewarding and respond to the patient positively. Like his patient, he may be disappointed if his expectations are not fulfilled. The reason middle class therapists do poorly with lower class patients may be largely a result of therapist preference for patients of higher socioeconomic status and a negative bias for lower class patients (Rosenthal & Frank, 1958). Middle class therapists may feel uneasy with lower class patients, having difficulty empathizing with them and a lack of understanding for their subcultural values, standards and way of life. Therapists can gain preconceptions about such patients and anticipate failure before therapy even begins. As a consequence of his disappointment and expectations, he can differentially mete out rewards (Ullmann & Krasner, 1969), resulting in some patients staying and some leaving. Whether awareness of their expectations for any given client can lead to continuation, remains to be demonstrated.

Social Class

The finding in this study that socioeconomic status correlated modestly with duration of therapy may be interpreted in the above manner. The lower correlation compared to other studies (Rosenthal & Frank, 1958; Rubinstein & Lorr, 1956; Schaffer & Meyers, 1954; White et al., 1964a) is readily understandable. Whether SES rating truly reflected the patient is questionable since the SES of the patient's

family of origin was used if the patient was a student. Furthermore, the variability on this factor was somewhat restricted by nature of the sample used.

Social class was the only demographic variable found to covary with actual duration that differentiated patients at PC and PCC. Yet, the two psychotherapy centers did not differ in their mean number of sessions, nor did they differ with regard to the number of Terminators and Remainers. Accordingly, both samples were combined for analyses in order to utilize as large a sample as possible.

Duration Expectation

Duration Expectation was found to be related to actual duration of treatment and approached significance in differentiating Terminators from Remainers. This is consistent with the findings of Marcus (1968) and Goin et al. (1965). Lorian (1974) suggests that correlations between patient expectations about length of therapy and actual duration can imply that "rather than simply dropping out in the middle, patients leave treatment at phenomenologically defined end points."

The degree to which expected duration was realistic also correlated with actual duration. Realism was based on the consensus of the therapist population. Thus, it may not be the expected duration singly that relates to length of stay, but the combined patient-therapist prognostic expectation that covaries with duration of treatment. Garfield and Wolpin (1963), in their survey of psychotherapy expectations, emphasize that patients and therapists differ in their expectations about length of treatment, with therapists expecting it to last longer.

Here too, active efforts by therapists to enhance congruence so that both share a common notion about length of contact seems advisable.

Patient Role Expectations

Patient role expectation factors were not related to premature termination within the limits of the sample size. This did not replicate findings by Clemes and D'Andrea (1965) and Heine and Trosman (1960) who found participant and collaborative expectations of patients related to continuation, and passive guidance expectations related to termination. Although it should be recognized that the populations differed, the difference in findings may be largely the result of different measuring instruments.

Other Patient Variables

The absence of significant findings on several variables that have been demonstrated in other studies to differentiate Terminators and Remainers is relatively unremarkable. Contradictory findings on such variables as age, sex, social class, race and source of referral, are plentiful in the literature. In his review, Brandt (1965) indicates that only sex, age and marital status consistently failed to distinguish remainers from dropouts.

The sample size of the present study was comparatively small. Therefore, the contribution of these variables to early termination cannot be ruled out.

Therapist Type and Role Expectations

Classification of thereapists according to their success rate of maintaining patients in therapy suggested certain trends. Therapists with more Terminators than Remainers were found to be more advice oriented and less prone to view their patients on a level of psychological equality when compared to therapists with only Remainers or more Remainers than Terminators.

Beginning therapists may differ in their role expectations which in turn determines whether they are more or less successful in keeping their patients in therapy. Hiler (1958) points out that few studies have dealt with characteristics of therapists which may be responsible in part for patients discontinuing therapy. Future studies should examine the contribution therapist expectancies make to premature termination.

A Quasi-Developmental Sequence of Role Expectations

Berzins (1971b) and Rickers-Ovsiankina et al. (1971) proposed that role expectations emerged in therapy within a quasi-developmental framework. According to this concept, patients progress from a helpless, nurturance-seeking position or advice and structure-seeking one, through a period of autonomous self exploration, to a fourth peer-like position with the therapist. They suggest the sequence can be analogous to the developmental sequence undergone by children in the course of maturation or the "interpersonal games" proposed by Szasz (coercion, self-help and cooperation).

The analysis of change in patient role expectations offers some support for their model. In 12 sessions, Advice-seeking decreased while Audience-seeking increased. Relationship-seeking was relatively high to begin with and hardly changed, but change on this factor may well require a greater length of time in therapy. Approval-seeking means decreased, although not significantly.

In addition, beginning therapists seem to go through their own developmental sequence in terms of role expectations. In the course of their early training, they tended to more strongly expect increasingly greater degrees of autonomy from their patients as well as enhanced psychological equality.

Overall, these findings offer some insight into and confirmation of beliefs about what happens to the patient during therapy and what transpires for therapists during the course of their training. Other process studies on relevant variables may help clarify further the complex nature of psychotherapy. It is recommended that researchers seriously consider repeated measures designs in attempting to evaluate the effects of psychotherapy.

## Exceptional Cases

Initial Dissimilarity of role expectations was found to differentiate Terminators from Remainers. There were individual cases that ran contrary to the predictions made. Examination of these cases may generate fruitful hypotheses.

### Remainers with High Initial Dissimilarity

Firstly, certain dyads with high Initial Dissimilarity of role expectations continued in therapy. Two such cases can be illustrated.

Miss J. D., a 17 year-old "working class", white college student who remained in therapy 42 sessions, had an extremely high Initial Dissimilarity with subsequent reduction in dissimilarity. Her Duration Expectation was more than 6 months, but she expected results in 2 months. She held positive beliefs that results would be achieved. She had no previous therapy, and her presenting complaint was depression, crying spells, and feeling alone and strange.

Her expectation of duration may have offered sufficient congruence to facilitate her remaining in therapy until she and her therapist attained greater harmony of role expectations.

Miss M. S., a 27 year-old Spanish-speaking college graduate who remained in therapy 50 sessions, had a very high Initial Dissimilarity

followed by a reduction in dissimilarity. She expected therapy to last more than 6 months, but expected results before 1 month passed. She strongly believed results would be achieved and she had been in therapy before. Her presenting problem involved crying and worrying.

Again, the most parsimonious explanation is that sharing mutual expectations with her therapist about length of contact took precedence over other considerations until role expectations became more congruent. Also, being of higher SES and having been in therapy before may have had facilitative effects.

These two cases suggest that positive signs on other variables, particularly those found to covary with actual duration may maintain the relationship until dissimilarity is reduced. Realistic expectations for duration of both Remainers appears to have contributed to these patients continuing in therapy when they otherwise might not have remained.

Terminators with Low Initial Dissimilarity

Other dyads with low Initial Dissimilarity of role expectations failed to survive. Two such cases can be illustrated.

Mr. A. G., a 19 year-old "working class", white college student who terminated therapy after 5 sessions, had a low Initial Dissimilarity with subsequent increased dissimilarity. The patient did not offer a Duration Expectation, but expected results to be noticed before 1 month of therapy. He had no prior therapy and believed results would be achieved. His presenting complaint was that nothing was enjoyable, school was meaningless, and his parents were manipulative. He was assigned to a therapist who had more Remainers than Terminators.

It seems likely that not finding results forthcoming so quickly

and experiencing more dissimilarity in role expectations, he left therapy. Also, his presenting problem suggests he experienced his difficulties to lie external to himself which would not bode well for self-change. Being assigned to a therapist who had a fairly good success rate of keeping patients in therapy did not help.

Mr. T. C., a 19 year-old white college student of relatively low SES who terminated therapy after 5 sessions, had a very low Initial Dissimilarity. He had no prior therapy, did not offer a Duration or Rate Expectation, and had no belief either way about whether therapy would be helpful. His presenting problem involved difficulty remembering things and interpersonal passivity. He was diagnosed Passive-Aggressive Personality Disorder.

It is reasonable to assume that his passive-aggressive manner was revealed both by his omitting responses to questionnaire items and his leaving therapy. Furthermore, it is interesting to note that in both cases, Duration Expectation was not offered. This may hold some significance for premature termination and should be explored further in subsequent research.

Remaining in Therapy without Decreased Dissimilarity

One additional case can be presented of a therapy dyad that continued meeting for 36 sessions in spite of a constant fairly high level of dissimilarity throughout. The patient was a 19 year-old Cuban female college student. The patient believed results would be achieved and both Duration and Rate Expectation were more than 6 months. She had previous therapy and was assigned to a therapist who had only Remainers. Her presenting problem involved guilt feelings about her parents knowing of her homosexuality, depression and anxiety.

In spite of no reduction in disimilarity, a considerable degree of self-discomfort and realistic expectations about length of treatment suggested a good prognosis for continuing.

Implications

Duration Expectation emerged as a very important variable. Its stabilizing effects on relationships that might otherwise be expected to terminate cannot be ignored. Further refinements of the broad clues uncovered in this study through multivariate analyses may increase our understanding of the interrelatedness of relevant variables.

## Limitations of the Study and Recommendations for Future Research

Naturalistic vs. Manipulative Studies

This study followed the naturalistic research model. Many variables could be investigated simultaneously in a comprehensive fashion. The main drawback, however, was that statements about causality or directionality could not be made.

The finding of covariation between dissimilarity of role expectations and premature termination does not mean that the former produced the latter. Although the theory upon which this study was based implies causality, this was not directly tested. The study attempted to test a prediction that followed from and indirectly supported the theoretical formulation. To establish the cause and effect relationship of dissimilarity to dropping out would require controlling dissimilarity of role expectations by preselection. Each therapist could be assigned patients who are similar and dissimilar to him in role expectations. The PEI-R and T-PEI could be used to assess dissimilarity and provide the basis for assignment of patients, such that each therapist has both

similar and dissimilar patients. Identifying dissimilarity of role expectations as a variable related to premature termination is the first step in this direction. In face of the study's relatively small sample size, support for hypotheses of dissimilarity suggest that it may prove to be a practical and theoretically valuable variable for future research.

Manipulative studies on premature termination have utilized a preparatory interview or induced expectancies as the independent variable (Krause et al., 1969). As Wilkins (1973) points out, these types of studies present a methodological problem. Whether the desired expectancy state was actually induced could be determined only in a circular fashion since expectancy state was identified by the outcome it was said to produce. The PEI-R could be used as an independent measure to determine whether change in expectancy state occurs as a result of induction procedures. This would involve the administration of the PEI-R before and after the intake interview to patient groups receiving and not receiving a role induction interview.

Generalizability of Results

One of the major difficulties in evaluating psychotherapy research entails the definition of the criterion measure. The criterion for dropping out varies among studies, which makes generalizations difficult. Stieper and Wiener (1965) state that much of the inconsistency among studies of Terminators and Remainers could be the result of the variation in cutting points for these groups.

Secondly, since therapy was conducted by beginning psychotherapists, patient dropping out may reflect good judgment on their part. They may have been unwilling to risk placing themselves in the

hands of novices. Hence, dropping out may be influenced by the patients' reaction to the experience level of the therapists.

Not only does the experience level of the therapists limit generalizations, but so does their psychoanalytic orientation. Whether similar findings can be demonstrated within other systems of psychotherapy remains to be investigated.

Furthermore, the patient population at the two psychotherapy centers may differ considerably from the population at many other public clinics. The median number of treatment sessions was greater than at clinics reported by Garfield (1971), and the number of Terminators was relatively small compared to what is found at other clinics. This may be partly a consequence of the relatively nominal fee and the emphasis on longer-term therapy than what may be stressed at other public clinics.

The results of the present study must be considered in this light. Generalizations about the results are restricted by the criterion, clinic setting, and patient and therapist sample utilized.

Problems in Data Collection

Gathering data on the Terminators who were available was problematical, especially once a patient left therapy. While in treatment, a patient may have sufficient incentive to complete the required forms. Once he leaves, particularly if dissatisfied, he divorces himself from the situation.

Telephone contacts with Terminators. Thirteen patients who left therapy early without completing the second PEI-R were contacted by the researcher. In addition to soliciting again their cooperation in completing the forms sent to them, they were asked about their experience in therapy.

Most expressed dissatisfaction with therapy and/or the therapist. Their reasons for leaving varied and included financial difficulties, paradoxically disliking the time-limited nature of the treatment, therapist passivity and inexperience, feeling they no longer needed treatment, things not "clicking" between themselves and the therapist, lack of faith in therapy, and the unnatural and impersonal nature of the relationship. Six of those followed-up expected more advice and guidance from their therapist. Yet, five expressed little discrepancy between their original expectation and their subsequent understanding of how much they were required to help themselves in therapy.

Obviously, self-reports by Terminators involve their own rationalizations and justifications for leaving, and can be contaminated by their offering socially desirable responses to the researcher's questions. Although conclusions are difficult to make about the total group's reported experience of treatment, many left because of dissatisfaction with the nature of treatment and the relationship with their therapist.

Difference Scores

Using total difference scores to tap change in patients and therapists did result in a loss of information. Both members of the dyad could have changed in parallel ways without any change in difference scores being registered. This was a limitation in the analyses of the data. Using the PEI-R and T-PEI to measure dissimilarity of role expectations was a novel approach with these instruments. However, direction of change could not be measured. In future studies, factor score totals could be calculated; then both direction of change

and magnitude of differences between patient and therapist could be determined.

Control Groups

In evaluating change on any variable during psychotherapy, the absence of a control group leaves questions unanswered. Simply because change was shown to have occurred, does not rule out that it occurs merely with time or as a result of patient response bias. Meltzoff and Kornreich (1970) warn that patients may pick up the investigator's bias and give socially desirable responses that are intended to please. Since subjects can become sensitized to measures that are repeated (Goldstein, Heller & Sechrest, 1966), this may require a control group not given repeated measures. Literature on the "social psychology of the psychological experiment" (Orne, 1962) points to the presence of powerful sources of bias due to the demand characteristics of the situation.

Different control groups could be employed in the future, including patients who receive only Early or only Late measures, and subjects who are not in therapy but are matched with patients along relevant dimensions. Establishing appropriate control groups would require a large sample size.

Resistance to Research

Substantial reluctance to participate in this research was evidenced on all levels. Patients and therapists were "forgetful" about completing the necessary forms and had to be continually reminded. From the beginning, therapists viewed the research as an invasion of privacy. They expressed worry about how the study might interfere with the therapy. Several voiced the apprehension that the initial

questionnaire would stimulate untimely issues in therapy about expectations. These student-therapists were anxious about any perceived attempts by an outsider to evaluate their clinical work. They refused initially to take any responsibility for reminding their clients to complete the forms, and would not personally hand the forms to their clients. Eventually, some therapists did give their clients gentle reminders at the request of the researcher.

Four therapists refused to cooperate from the beginning, and two withdrew their participation during the course of the study. Two, who refused to cooperate, stated that they did not believe in the value of psychotherapy research. Another mentioned she could not complete the initial questionnaire because she did not have any general set of expectations for therapy.

Eight patients who were interviewed following an exploratory phase of the study were less bothered by the research than were the therapists. Two did complain about the time and energy involved in completing questionnaires; the rest accepted it as a normal procedure at the center.

It appears that therapists experienced the research to be more intrusive than did their patients. The resistance to research by the therapists is somewhat surprising since the scientist-professional model operates at their universities. How committed they are to this model seems questionable. When they are in their professional role, the scientist role seems alien.

In reaction to the therapists' low tolerance for research, they were treated differently than their patients insofar as less background data was requested from them. Their cooperation and responsiveness

was important to maintain, especially in view of the number of questionnaires they were asked to complete. Researchers should be alert to this potential entrapment in future naturalistic studies.

Furthermore, the question can be raised whether the study itself had an effect on precipitating early termination of therapy. It could not be determined, however, from a comparison of the data to previous years, whether the study had such an influence.

Congruence of Role Expectations and Subsequent Behavior

The lack of congruence observed between the PEI-R and BC subscales suggests a number of possibilities. Firstly, patients may not behave in therapy as they say they expect they will. Initially, they have something at stake, i.e., getting accepted for treatment, and this could determine their response to the PEI-R. On the other hand, what one thinks and what one does can be two different things. By and large, patients come to therapy not understanding the determinants of their behavior, especially when their behavior is contrary to what they expect of themselves. How well conscious and "rational" expectations relate to unconscious and "irrational" ones needs to be explored.

Secondly, relatively inexperienced therapists were asked to rate their patients' behavior after the first interview. This can often be a stressful session for the beginning therapist. He has a number of issues to attend to, as well as anticipating discussing the session with his supervisor. He may not be a very effective rater of this patients' role behavior based on his initial contact, and he may not have sufficient data to rate. Nevertheless, this rating had to be performed before too much exposure to therapy had occurred in order to

assess the similarity between patient expectation and behavior. Perhaps inexperienced therapists should not be used in research, since they are not representative samples of the population of therapists. Yet, much psychotherapy research is based on them because they are the most readily accessible.

An alternative explanation would point to the lack of criterion validity for the measurement instruments. The factor analyses, however, suggest that there is at least construct validity.

## Conclusions

The finding that Terminators can be differentiated from Remainers on certain variables supports the concept that Terminators may be potentially identified in terms of independent predictor variables. Identification of patient-therapist dissimilarity may be useful information in either selection of the therapist best suited for each patient, or informing the therapist about the magnitude of the dissimilarity between himself and his patient. The PEI-R and T-PEI are rather simple, stable instruments that can be administered quickly. They can be useful for future psychotherapy research.

If a suitable match of patient and therapist cannot be effected, the suggestion was that therapists actively structure the relationship in the direction of greater mutuality by focusing on and inducing realistic expectations for therapy. While matching and maniuplating expectations may depart from usual clinic practice, we cannot leave any stone unturned.

Continued investigations of the interaction between therapist and patient on relevant variables may clarify the forces that lead to stable therapy relationships. The problem of continuation in therapy may be secondary to the matter of therapeutic effectiveness. Staying

in therapy, however, may be a necessary, although not sufficient condition for a patient to improve from therapy. Lastly, increased emphasis on repeated measures and process studies is advised if our goal is to better understand the nature of change and what changes during psychotherapy.

One last word of caution. As Schofield (1964) warns, studies aimed at identifying from the outset which patients will remain and which will discontinue may be abused if the goal is only to select "good" patients for therapy. This would only reduce further the number of people offered psychotherapy, beyond the already recognized YAVIS syndrome. This was not the goal of the present study. The expressed aim of the research was to underscore the need to implement greater efforts toward reducing dissonance within the dyad so that treatment could continue.

# APPENDIX A

## PEI-R

## PSYCHOTHERAPY EXPECTANCY INVENTORY-Revised

In order to help us provide you with the best possible treatment, it is necessary for you to fill out this questionnaire as sincerely as possible. The questionnaire consists of 30 questions about the kinds of things you personally would expect to happen if you were to have an hour of psychotherapy tomorrow.

For those who have never had any psychotherapy, it may be difficult to pretend that one is in psychotherapy--and yet it's important to do just that. It helps to imagine that you have already known your therapist for a few hours, so that it isn't a completely strange situation to you.

For those who have had some psychotherapy in the past, we'd like you to pretend that you're answering these questions while you still were in therapy.

EACH QUESTION ON THE FOLLOWING PAGES REFERS TO A "NEXT" HOUR OF PSYCHOTHERAPY AND WE'D LIKE YOU TO KEEP THIS IN MIND WHILE YOU ANSWER. PUT ALL ANSWERS ON THE SPECIAL ANSWER SHEET WHICH HAS BEEN PROVIDED IMMEDIATELY FOLLOWING THE QUESTIONNAIRE. MAKE NO MARKS IN THE BOOKLET ITSELF.

The numbers of the questions in the questionnaire are the same as the numbers on the answer sheet. Note that each number on the answer sheet is followed by numbers ranging from 1 to 7. For each question, then, you have seven choices for expressing your ideas about what will take place during your imaginary or real next psychotherapy hour.

EXAMPLE: How strongly do you expect to talk about your feelings with your therapist?

Your task is to estimate the extent to which you anticipate doing so. Then circle the number on the answer sheet for that question which best expresses your estimate, bearing in mind that

1 represents - - - - NOT AT ALL
4 represents - - - - MODERATELY
7 represents - - - - VERY STRONGLY

Don't hesitate to use numbers other than 1, 4, and 7; try to be as exact as you can. Please answer every question. If a question is not quite clear to you, put a little check mark beside it on the ANSWER SHEET, but answer it anyway. Also, if some questions seem to repeat themselves, don't go back to see how you answered before.

DO NOT WRITE ON THIS PAGE

DURING YOUR NEXT HOUR OF PSYCHOTHERAPY - - - -

1. How strongly do you expect your therapist to be reassuring?
2. How strongly do you expect to say whatever comes into your mind?
3. How strongly do you expect to watch your therapist to get ideas on how you should act during the hour?
4. How strongly do you expect to act as freely as you would with your best friend?
5. How strongly do you expect to feel "free" and "open"?
6. How strongly do you expect to watch your therapist's behavior for "helpful hints" as to the desirable behavior during the hour?
7. How strongly do you expect to feel like opening up without any help from your therapist?
8. How strongly do you expect your therapist to be gentle in phrasing his opinions about an important topic?
9. How strongly do you expect to behave in a spontaneous manner?
10. How strongly do you expect to be concerned with the impression you make on your therapist?
11. How strongly do you expect to please your therapist?
12. How strongly do you expect to be comfortable in expressing your feelings toward your therapist?
13. How strongly do you expect to feel as though you were "in charge" of the hour?
14. How strongly do you expect to get definite advice from your therapist?
15. How strongly do you expect your therapist to discover what's responsible for your current problems?

DO NOT WRITE ON THIS PAGE

DURING YOUR NEXT HOUR OF PSYCHOTHERAPY - - - -

16. How strongly do you expect your therapist to suggest what you should do about your problem?

17. How strongly do you expect your therapist to speak frankly?

18. How strongly do you expect to be the one who begins the talking?

19. How strongly do you expect your therapist to clearly announce his value judgments about your behavior?

20. How strongly do you expect to be concerned with how you appear to your therapist?

21. How strongly do you expect to "carry the ball" conversationally?

22. How strongly do you expect your therapist to tell you that things will work out all right?

23. How strongly do you expect to discuss whatever comes to mind without "pulling punches"?

24. How strongly do you expect to seek "answers" from your therapist?

25. How strongly do you expect to find yourself examining your past?

26. How strongly do you expect to initiate the conversation?

27. How strongly do you expect to lead the way in bringing up topics to talk about?

28. How strongly do you expect your therapist to pick ideas apart and criticize them?

29. How strongly do you expect your therapist to level with you?

30. How strongly do you expect to prepare some material for the next hour?

PSYCHOTHERAPY EXPECTANCY INVENTORY-Revised

ANSWER SHEET

Name:_____Today's Date:_____

PLEASE REMEMBER THAT

1 = NOT AT ALL; 4 = MODERATELY; 7 = VERY STRONGLY

---

| | | | |
|---|---|---|---|
| 1. | 1 2 3 4 5 6 7 | 16. | 1 2 3 4 5 6 7 |
| 2. | 1 2 3 4 5 6 7 | 17. | 1 2 3 4 5 6 7 |
| 3. | 1 2 3 4 5 6 7 | 18. | 1 2 3 4 5 6 7 |
| 4. | 1 2 3 4 5 6 7 | 19. | 1 2 3 4 5 6 7 |
| 5. | 1 2 3 4 5 6 7 | 20. | 1 2 3 4 5 6 7 |
| 6. | 1 2 3 4 5 6 7 | 21. | 1 2 3 4 5 6 7 |
| 7. | 1 2 3 4 5 6 7 | 22. | 1 2 3 4 5 6 7 |
| 8. | 1 2 3 4 5 6 7 | 23. | 1 2 3 4 5 6 7 |
| 9. | 1 2 3 4 5 6 7 | 24. | 1 2 3 4 5 6 7 |
| 10. | 1 2 3 4 5 6 7 | 25. | 1 2 3 4 5 6 7 |
| 11. | 1 2 3 4 5 6 7 | 26. | 1 2 3 4 5 6 7 |
| 12. | 1 2 3 4 5 6 7 | 27. | 1 2 3 4 5 6 7 |
| 13. | 1 2 3 4 5 6 7 | 28. | 1 2 3 4 5 6 7 |
| 14. | 1 2 3 4 5 6 7 | 29. | 1 2 3 4 5 6 7 |
| 15. | 1 2 3 4 5 6 7 | 30. | 1 2 3 4 5 6 7 |

1. Who told you about this psychological center? (a friend, teacher)

   _____

2. What was their opinion of the center as a place for you? (circle one)

   a. very helpful  b. moderately helpful  c. somewhat helpful  d. slightly helpful  e. not at all helpful

3. Have you ever been in therapy? yes no (circle one)

4. Has anyone very close to you ever sought psychological help?

   yes no (circle one)

5. How much do you think they were helped? (circle one)

   a. very much  b. moderately  c. somewhat  d. slightly  e. not at all

6. About how long do you expect to be in therapy? (check one)

| (1) | (2) | (3) | (4) | (5) | (6) |
|---|---|---|---|---|---|
| less than 1 month | 1 month | 2 months | 4 months | 6 months | more than 6 months |

7. About how long after you begin therapy do you expect to notice some results? (check one)

| (1) | (2) | (3) | (4) | (5) | (6) | (7) |
|---|---|---|---|---|---|---|
| less than 1 month | 1 month | 2 months | 4 months | 6 months | more than 6 months | after therapy has terminated |

8. What is your present belief that the results you want from therapy will be achieved?

| (1) | (2) | (3) | (4) | (5) | |
|---|---|---|---|---|---|
| Strongly believe results won't be achieved | Believe results won't be achieved | No belief one way or the other | Believe results will be achieved | Strongly believe results will be achieved | (Place check mark on scale) |

9. About how old would you prefer your therapist to be?

| (1) | (2) | (3) | (4) | (5) | (6) | |
|---|---|---|---|---|---|---|
| 20-24 | 25-29 | 30-34 | 35-39 | 40-49 | over 50 | (check one) |

10. Would you prefer your therapist to be male or female? (circle one)

11. I believe in my religion

    a. very strongly  b. strongly  c. moderately  d. slightly  e. 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 _____

## APPENDIX B

### T -PEI

### THERAPIST PSYCHOTHERAPY EXPECTANCY INVENTORY

This questionnaire is part of a research project investigating patient and therapist expectations of psychotherapy. The questionnaire consists of 24 questions about the kinds of things you personally would expect to happen if you were to conduct an hour of psychotherapy tomorrow with this patient.

EACH QUESTION ON THE FOLLOWING PAGES REFERS TO A "NEXT" HOUR OF PSYCHOTHERAPY AND WE'D LIKE YOU TO KEEP THIS IN MIND WHILE YOU ANSWER. PUT ALL ANSWERS ON THE SPECIAL ANSWER SHEET WHICH HAS BEEN PROVIDED IMMEDIATELY FOLLOWING THE QUESTIONNAIRE. MAKE NO MARKS IN THE BOOKLET ITSELF.

The numbers of the questions in the questionnaire are the same as the numbers on the answer sheet. Note that each number on the answer sheet is followed by numbers ranging from 1 to 7. For each question, then, you have seven choices for expressing your ideas about what will take place during your next psychotherapy hour.

EXAMPLE: How strongly do you expect to talk about your feelings with your patient?

Your task is to estimate the extent to which you anticipate doing so. Then circle the number on the answer sheet for that question which best expresses your estimate, bearing in mind that

1 represents - - - - NOT AT ALL
4 represents - - - - MODERATELY
7 represents - - - - VERY STRONGLY

Don't hesitate to use numbers other than 1, 4, and 7; try to be as exact as you can. Please answer every question. If a question is not quite clear to you, put a little check mark beside it on the ANSWER SHEET, but answer it anyway. Also, if some questions seem to repeat themselves, don't go back to see how you answered it before.

This questionnaire is used only for the purpose of research. Whatever you say will be held in strict confidence.

DO NOT WRITE ON THIS PAGE

DURING YOUR NEXT HOUR OF PSYCHOTHERAPY - - - -

1. How strongly do you expect to be reassuring?

2. How strongly do you expect your patient to say whatever comes into his mind?

3. How strongly do you expect your patient to act as freely as he would with his best friend?

4. How strongly do you expect your patient to feel "free" and "open"?

5. How strongly do you expect your patient to watch your behavior for "helpful hints" as to the desirable behavior during the hour?

6. How strongly do you expect your patient to feel like opening up without any help from you?

7. How strongly do you expect to be gentle in phrasing your opinions about an important topic?

8. How strongly do you expect your patient to behave in a spontaneous manner?

9. How strongly do you expect your patient to be concerned with the impression he makes on you?

10. How strongly do you expect your patient to make efforts to please you?

11. How strongly do you expect your patient to be comfortable in expressing his feelings to you?

12. How strongly do you expect your patient to feel as though he were "in charge" of the hour?

DO NOT WRITE ON THIS PAGE

DURING YOUR NEXT HOUR OF PSYCHOTHERAPY - - - -

13. How strongly do you expect to give definite advice to your patient?

14. How strongly do you expect to discover what's responsible for your patient's current problems?

15. How strongly do you expect to suggest what your patient should do about his problem?

16. How strongly do you expect your patient to be the one who begins the talking?

17. How strongly do you expect to clearly announce your value judgments about your patient's behavior?

18. How strongly do you expect your patient to be concerned with how he appears to you?

19. How strongly do you expect your patient to "carry the ball" conversationally?

20. How strongly do you expect your patient to discuss whatever comes to mind without "pulling punches"?

21. How strongly do you expect your patient to seek "answers" from you?

22. How strongly do you expect your patient to initiate the conversation?

23. How strongly do you expect your patient to lead the way in bringing up topics to talk about?

24. How strongly do you expect to pick ideas apart and criticize them?

# THERAPIST PSYCHOTHERAPY EXPECTANCY INVENTORY

## ANSWER SHEET

Therapist's Name:_____ Date:_____

Patient's Name:_____

PLEASE REMEMBER THAT

1 = NOT AT ALL; 4 = MODERATELY; 7 = VERY STRONGLY

---

| | | | |
|---|---|---|---|
| 1. | 1 2 3 4 5 6 7 | 13. | 1 2 3 4 5 6 7 |
| 2. | 1 2 3 4 5 6 7 | 14. | 1 2 3 4 5 6 7 |
| 3. | 1 2 3 4 5 6 7 | 15. | 1 2 3 4 5 6 7 |
| 4. | 1 2 3 4 5 6 7 | 16. | 1 2 3 4 5 6 7 |
| 5. | 1 2 3 4 5 6 7 | 17. | 1 2 3 4 5 6 7 |
| 6. | 1 2 3 4 5 6 7 | 18. | 1 2 3 4 5 6 7 |
| 7. | 1 2 3 4 5 6 7 | 19. | 1 2 3 4 5 6 7 |
| 8. | 1 2 3 4 5 6 7 | 20. | 1 2 3 4 5 6 7 |
| 9. | 1 2 3 4 5 6 7 | 21. | 1 2 3 4 5 6 7 |
| 10. | 1 2 3 4 5 6 7 | 22. | 1 2 3 4 5 6 7 |
| 11. | 1 2 3 4 5 6 7 | 23. | 1 2 3 4 5 6 7 |
| 12. | 1 2 3 4 5 6 7 | 24. | 1 2 3 4 5 6 7 |

To all psychotherapy practicum students:

In responding to the following two questions, consider your current theoretical framework for doing psychotherapy and your anticipations for this year's psychotherapy practicum.

1. About how long do you expect a patient to remain in therapy with you?

| (1) | (2) | (3) | (4) | (5) | (6) | (check one) |
|---|---|---|---|---|---|---|
| less than 1 month | 1 month | 2 months | 4 months | 6 months | more than 6 months | |

2. About how long after a patient begins therapy do you expect him to notice some results? (check one)

| (1) | (2) | (3) | (4) | (5) | (6) | (7) |
|---|---|---|---|---|---|---|
| less than 1 month | 1 month | 2 months | 4 months | 6 months | more than 6 months | after therapy has terminated |

# APPENDIX C

## BEHAVIORAL CORRELATES SCALE-Revised

### INSTRUCTIONS TO THE THERAPIST FOR RATINGS AFTER INITIAL CONTACT HOUR WITH A PATIENT.

The following series of statements refer to behaviors which frequestly emerge during the course of psychotherapy.

In rating each item, let yourself be guided by the patient's actual behavior as observed by you over the initial contact hour.

Your fram of reference is a seven point scale with "1" representing "not at all evident" and "7" representing "highly evident."

For example, if an item reads "Critical of self," you would think over the hour you've had with this patient and try to decide to what extent self-critical behaviors were in evidence. Circle your decision on the answer sheet, taking as guides the following:

"1" means the behavior was not at all evident

"4" means the behavior was evident to a moderate degree but not highly so

"7" means the behavior was highly evident

Do not deliberate obsessively, even when an item may contain parts which seem inconsistent to you. We would appreciate your treating each item in a global, yet also careful, fashion.

Please keep this booklet available for use with the special answer sheets which will be provided for each patient you see. Thank you very much for your time and cooperation. This rating scale is used only for the purpose of research, and whatever you say will be held in strict confidence.

1. Concerned with the correctness of his reasoning
2. Compliant ("I am as you desire me" attitude)
3. Treats you as basically a "good listener"
4. Seems free to mix levels of maturity (e. g. , can be silly or facetious, can "regress at will," etc. )
5. Interested in placing the responsibility for current problems on past events or traumas
6. Seeks approval or sympathy or reassurance
7. Does most of the talking at all times (possibly "over-controls" the hour)
8. Behaves spontaneously with you
9. Wants you to "label" (his behavior, values, etc. )
10. Exudes "niceness," "correctness" (e. g. , neatly dressed, language "always proper," "best foot forward")
11. Continuously displays "independence" and initiative
12. Relaxed posture
13. Asks for answers, reasons, motives
14. Treats you as his teacher (or "expert," "model," "magic helper")
15. Stresses self-selected topics the most
16. Shows good rapport (e. g. , appears "involved," displays a breadth of emotions and tcpics, enjoys the hour)
17. Fears criticism, therefore presents material in a defensive or "rational" form

18. Given to imitating, rather suggestible

19. Generally initiates the conversation

20. Loose and casual, few airs or pretensions (e.g., maintains comfortable eye contact with you, does not seem to be "laboring")

21. Acts like a "bug under the microscope"

22. Exhibits "therapy-appropriate," "good patient" behavior (acts as though he has to earn your regard)

23. Displays a problem-solving orientation (e.g., self-scrutinizing, guilt-assuming, intropunitive, give "progress reports," "works" at therapy)

24. Relates to you as though you both had had similar experiences or human problems

25. "Works" in the hope of obtaining concrete solutions

26. Puts forth a consistently upheld image, a "facade"

27. Leads the way in introducing topics

28. Engages in emotional give and take with you

29. Tries to elicit value judgments

30. Places you on a pedestal

31. Controls the selection and direction of topics

32. Interested in his relationship with you

33. Displays freedom of expressiveness

34. Works to maintain your helpfulness

BEHAVIORAL CORRELATES SCALE-Revised

ANSWER SHEET

Therapist's Name:_____ Date:_____

Patient's Name:_____

Please remember: 1 = "NOT AT ALL EVIDENT"
7 = "VERY EVIDENT"

---

| | | | |
|---|---|---|---|
| 1. | 1 2 3 4 5 6 7 | 18. | 1 2 3 4 5 6 7 |
| 2. | 1 2 3 4 5 6 7 | 19. | 1 2 3 4 5 6 7 |
| 3. | 1 2 3 4 5 6 7 | 20. | 1 2 3 4 5 6 7 |
| 4. | 1 2 3 4 5 6 7 | 21. | 1 2 3 4 5 6 7 |
| 5. | 1 2 3 4 5 6 7 | 22. | 1 2 3 4 5 6 7 |
| 6. | 1 2 3 4 5 6 7 | 23. | 1 2 3 4 5 6 7 |
| 7. | 1 2 3 4 5 6 7 | 24. | 1 2 3 4 5 6 7 |
| 8. | 1 2 3 4 5 6 7 | 25. | 1 2 3 4 5 6 7 |
| 9. | 1 2 3 4 5 6 7 | 26. | 1 2 3 4 5 6 7 |
| 10. | 1 2 3 4 5 6 7 | 27. | 1 2 3 4 5 6 7 |
| 11. | 1 2 3 4 5 6 7 | 28. | 1 2 3 4 5 6 7 |
| 12. | 1 2 3 4 5 6 7 | 29. | 1 2 3 4 5 6 7 |
| 13. | 1 2 3 4 5 6 7 | 30. | 1 2 3 4 5 6 7 |
| 14. | 1 2 3 4 5 6 7 | 31. | 1 2 3 4 5 6 7 |
| 15. | 1 2 3 4 5 6 7 | 32. | 1 2 3 4 5 6 7 |
| 16. | 1 2 3 4 5 6 7 | 33. | 1 2 3 4 5 6 7 |
| 17. | 1 2 3 4 5 6 7 | 34. | 1 2 3 4 5 6 7 |

# APPENDIX D

Rotated Derived Factor Loadings on Patient Initial PEI-R (N=82) Compared to Original Loadings

| Role Expectation Factor | | | | | |
|---|---|---|---|---|---|
| Approval-seeking | | | Advice-seeking | | |
| Item | Derived Loading | Original Loading | Item | Derived Loading | Original Loading |
| 6 | .68 | .57 | 15 | .77 | .64 |
| 10 | .82 | .76 | 16 | .69 | .84 |
| 11 | .74 | .65 | 19 | .72 | .71 |
| 20 | .88 | .72 | 24 | .52 | .66 |
| 1 | .19 | .47 | 14 | .39 | .81 |
| 8 | .22 | .65 | 28 | .39 | .62 |
| Audience-seeking | | | Relationship-seeking | | |
| 7 | .45 | .51 | 2 | .72 | .68 |
| 13 | .52 | .61 | 4 | .78 | .69 |
| 18 | .77 | .81 | 5 | .85 | .83 |
| 21 | .66 | .77 | 9 | .63 | .71 |
| 26 | .88 | .86 | 12 | .73 | .69 |
| 27 | .71 | .79 | 23 | .60 | .75 |

## APPENDIX D (continued)

Rotated Derived Factor Loadings on "typical therapy patient" T-PEI (N=44) Compared to Patient Initial PEI-R Loadings

| Item | Role Expectation Factor: Approval-seeking — Therapist Derived Loading | Approval-seeking — Patient Derived Loading | Item | Advice-seeking — Therapist Derived Loading | Advice-seeking — Patient Derived Loading |
|---|---|---|---|---|---|
| 5 | .72 | .68 | 14 | .16 | .77 |
| 9 | .88 | .82 | 15 | .91 | .69 |
| 10 | .86 | .74 | 17 | .64 | .72 |
| 18 | .87 | .88 | 21 | .30 | .52 |
| 1 | .23 | .19 | 13 | .79 | .39 |
| 7 | -.08 | .22 | 24 | .35 | .39 |
| | Audience-seeking | | | Relationship-seeking | |
| 6 | .04 | .45 | 2 | .71 | .72 |
| 12 | .58 | .52 | 3 | .53 | .78 |
| 16 | .79 | .77 | 4 | .75 | .85 |
| 19 | .82 | .66 | 8 | .85 | .63 |
| 22 | .76 | .88 | 11 | .75 | .73 |
| 23 | .63 | .71 | 20 | .82 | .60 |

APPENDIX D (continued)

Rotated Derived Factor Loadings on BC Scale* (N=52)

| Role Behavior Factor | | | |
|---|---|---|---|
| Item | Approval-seeking Derived Loading | Item | Advice-seeking Derived Loading |
| 2 | .77 | 9 | .66 |
| 6 | .51 | 13 | .58 |
| 14 | .76 | 25 | .48 |
| 18 | .50 | 29 | .75 |
| 22 | .63 | 17 | .23 |
| 30 | .71 | 26 | -.03 |
| | Audience-seeking | | Relationship-seeking |
| 7 | .57 | 4 | .79 |
| 15 | .89 | 8 | .74 |
| 19 | .74 | 16 | .72 |
| 27 | .86 | 20 | .74 |
| 31 | .83 | 28 | .69 |
| 3 | .18 | 33 | .79 |

*Original loadings not available. However, according to Berzins (1971a) in no instance did an item correlate less than .35 with the particular factor.

APPENDIX E

Intercorrelations (Decimals Omitted) Among Patient Variables

| Variable | N | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Duration of Psychotherapy | | | | | | | | | | | | | | | | | |
| 1. No. of Sess. | 85 | 25a | -09 | -17 | 03 | 25a | 01 | 08 | -06 | 20 | -06 | 01 | 02 | -16 | 26a | 02 | -10 |
| Prognostic Expectations | | | | | | | | | | | | | | | | | |
| 2. Duration Expectation | 66 | | 28a | -01 | -20 | 100b | -18 | 05 | -15 | 26a | -07 | -15 | 13 | 01 | 31a | -02 | -07 |
| 3. Rate Expectation | 67 | | | 03 | 26a | 28a | 11 | 06 | -07 | 10 | 23 | 02 | 35b | 21 | 27a | 05 | 11 |
| 4. Direction of Belief | 46 | | | | -16 | -01 | 02 | -04 | -23 | -08 | -12 | -03 | 09 | -05 | -14 | 17 | 06 |
| 5. Strength of Belief | 65 | | | | | -20 | 11 | 07 | 13 | 06 | 14 | -16 | 07 | -09 | 10 | -14 | 03 |
| 6. Realistic Dur. Expect. | 66 | | | | | | -18 | 05 | -15 | 26a | -07 | -15 | 13 | 01 | -31a | -02 | -07 |
| 7. Realistic Rate Expect. | 67 | | | | | | | -21 | -09 | 09 | -09 | -20 | 24 | 12 | 15 | 09 | 14 |
| Preference Satisfaction | | | | | | | | | | | | | | | | | |
| 8. Age Pref. Satis. | 67 | | | | | | | | -05 | 18 | -06 | 11 | 20 | 14 | -02 | 02 | -08 |
| 9. Sex Pref. Satis. | 57 | | | | | | | | | -05 | -18 | -04 | -08 | -04 | 23 | 04 | -30a |
| Therapy Related Measures | | | | | | | | | | | | | | | | | |
| 10. Prior Therapy | 83 | | | | | | | | | | -19 | -18 | 22a | 23a | 20 | -05 | 02 |
| 11. Ref. Source (Self vs. Other) | 81 | | | | | | | | | | | 58b | -19 | 12 | 10 | 13 | 24 |
| 12. Ref. Source (Auth. vs. Other) | 81 | | | | | | | | | | | | -20 | 05 | -14 | 19 | 19 |
| Demographic | | | | | | | | | | | | | | | | | |
| 13. Age | 85 | | | | | | | | | | | | | 17 | 31a | 08 | -27a |
| 14. Sex | 85 | | | | | | | | | | | | | | 20 | 23a | 08 |
| 15. SES | 64 | | | | | | | | | | | | | | | -04 | -36b |
| 16. Ethnicity | 85 | | | | | | | | | | | | | | | | 15 |
| 17. Educational Level | 69 | | | | | | | | | | | | | | | | |

Note.—All p values are for a 2-tailed test with the smaller N determining the df.

a $p<.05$
b $p<.01$

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