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A study of the effects of patient-therapist expectations regarding short-term therapy on therapeutic outcome.

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A STUDY OF THE EFFECTS OF PATIENT-THERAPIST EXPECTATIONS REGARDING SHORT-TERM THERAPY ON THERAPEUTIC OUTCOME

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INTRODUCTION

An individual's expectations, regarding a wide variety of human behaviors, have been shown in many experimental findings to be a significant determiner of the form these behaviors eventually take (Kelly, 1955; Rotter, 1954; Allport, 1955). In one extensive review by Goldstein (1962), he reports that a person's expectations have been found to be potent influences on future behaviors in such diverse areas of research as perception, learning, level of aspiration, experimenter bias, behavior under stress, stuttering, interpersonal perception, attitude formation, etc. Rotter (1954), for example, has written about the general concept of expectations that:

> "The occurence of a behavior of a person is determined not only by the nature or importance of goals or reinforcements, but also by the person's anticipation or expectancy that these goals will occur .... Behavior is a function of the expectations of the subject .... The basic formulation of social learning theory states that one of the major predictors of behavior is the subject's expectancy regarding the outcome of his behavior in a given situation" (1954, p. 102).

Expectancies have also been studied in the area of psychotherapy research. The expectations of both patient and therapist are viewed as keys to success in brief psychotherapy by Baum and Felzer (1964). The initial interview often creates a lasting impression on the patient's and therapist's expectations and is often critical to success (Burdon, 1963). Perhaps the prime researcher of psychotherapeutic prognostic expectations has been Arnold P. Goldstein,

whose research consisted of a series of articles culminating in his 1962 book - Therapist-Patient Expectancies in Psychotherapy. Since that time, not much significant psychotherapy research has been conducted to explore the relationship between expectancies of psychotherapeutic success and future behavior in psychotherapy as measured by outcome scales. It is the purpose of this review to point out that expectations regarding psychotherapy are worthy of further research and that the research literature in this area represents, at best, a rough beginning that needs both refinement and expansion.

Patient Expectations and Therapeutic Outcome

A patient's expectations regarding a future psychotherapeutic encounter can range from being highly positive and optimistic to being highly negative and pessimistic. Perhaps most often they are a mixture of both. Psychologists have theorized as to what influences a patient to have positive expectations that therapy will be able to help him with his problems. Rosenthal and Frank (1956) believe that a patient enters therapy with a certain degree of belief in its efficacy that is generally consistent with his previous experiences with doctors, his suggestibility, and his confidence in his therapist. Goldstein (1960b) elaborates that the therapist's own faith in his patient's capacity to benefit from treatment provides another influence on the patient's expectations. Cultural influences are another noted factor that affects a patient's

expectations, with psychotherapy being predominantly the treatment of choice for emotional problems of the middle class, while the lower class people might turn elsewhere. Referral source and other pre-interview cues about the therapist or his clinic also influence expectations (Frank, 1959; Goldstein and Shipman, 1961). Similarly, patient characteristics such as motivation for psychotherapy and client dependency (Dollard and Miller, 1950; Heller and Goldstein, 1961) have also been shown to influence a patient's expectancies. Another patient characteristic that has been shown to be related to success of therapy is the patient's initial anxiety or distress level. Strupp et. al. (1963) report that degree of initial disturbance correlated $r = +.60$ with success of therapy. While Roth et. al. (1964) found that single score global estimates of severity of disturbance were unrelated to outcome, Clems and D'Andrea (1965), Jacobs et. al. (1967), and Frank (1968), all agree that distress level ratings taken specifically on the patient s' presenting complaints are important prognostic indicators. Thus patient expectancy factors have been shown to be significant predictors of future outcome. Luborsky et. al. (1971) in an extensive review of the quantative research on factors influencing outcome in psychotherapy, found that by far the largest number of significant predictors dealt with patient factors, and relatively few with therapist or treatment factors. Thus, one can understand how many psychologists have theorized that the more positive a patient's expectations are, the better the prognosis that exists.

A patient's expectations as he enters therapy are multi-dimensional. He has expectations about whether or not therapy can work to produce behavioral changes (therapy's efficacy expectations), how long therapy will take (durational expectations), how much personality change or symptom reduction will occur during therapy (prognostic expectations), and how the therapist will behave and work toward the patient and how the patient will behave toward the therapist (role expectancies). Other sets of expectations could perhaps be identified, but even limiting ourselves to these it becomes apparent that even each of these four types of expectancies represents a complex, cognitive factor in an individual's perceptual understanding. Only two types of therapeutic expectations have been studied sufficiently with relation to outcome measures to be covered in this review, namely prognostic expectancies and role expectancies. Such expectancies are based on a person's experiences and learning and are modifiable by future experiences and learning. Not only is it reasonable to assume that any patient who comes to therapy has a set of expectations that could influence his reactions and actions in therapy, but it is also reasonable to assume that the therapist he will work with has his own set of expectations, and that the particular combination or interaction of these two sets of expectations will have its own particular effect on the successfulness of their therapeutic encounter. In a similar manner, this review of the literature will be divided into three sections: Patient (prognostic and role)

expectancy; Therapist (prognostic and role) expectancy; and Patient-Therapist similarity (congruence) of expectancies. In each of these sections particular emphasis will be paid on relating therapeutic expectancy to consequent therapeutic outcome.

Patient Expectations and Therapeutic Outcome

Patient prognostic expectations. The research literature relating the level of positiveness of a patient's prognostic expectancies (expectancies regarding the degree of patient improvement anticipated) to positive therapeutic outcome presents a mixed picture. It would seem logical to find a positive linear relationship between a patient's expectation of success and his resultant success in therapy. Indeed several studies by Lipkin (1954), Friedman (1963), and most recently Uhlenhuth and Duncan (1968) have reported such a positive linear relationship. These studies, however, are in the minority. The results of most of the other studies fall into two groups - those which found the absence of any significant relationship between patient prognostic expectation and outcome (Brady et. al., 1960; Goldstein, 1959; and Goldstein, 1960a) and those which found the presence of a positive curvilinear relationship between prognostic expectancy and outcome (Chance, 1960; Goldstein and Shipman, 1961; and Goldstein, 1962). In an attempt to sort out these discrepant findings, the earlier studies by Lipkin (1954), Goldstein (1959 and 1960a) and Brady et. al. (1960) can be criticized from several methodological points of view. Most important of these is the highly heterogeneous

random sample of hospital patients used in these studies. Secondly these studies employed an overly global measurement of patient expectations, and used the questionable criteria of duration of treatment. The studies by Friedman (1963) and Uhlenhath and Duncan (1968) finding a linear relationship are methodologically more sound but both use a somewhat heterogeneous patient sample.

Turning to the reports of more interest to this study which found a positive curvilinear relationship between expectancy and outcome (moderate expectancy level relates to highest outcomes), the methodology appears more sophisticated and the results are backed up by a large body of literature in social psychology on level of aspiration research. (Sears, 1941; Irwin, 1944). Chance, (1960) summarizes these investigations in writing "two patterns appear to be more often characteristic of maladjusted subjects than others, either very high (compensatory or wishful) or very low (protective) levels of aspiration." (1960, p. 111). Goldstein and Shipman (1961) have similarly reported finding that moderate prognostic expectors reported the greatest subjective symptom reduction while extreme (high and low) expectors reported minimal symptom reduction. Luborsky (1962) seems in agreement with this conclusion when he writes "those who improve are better off to begin with than those who do not; and one can predict response to treatment by how well off they are to begin with" (p. 115). Viewing these findings and theoretical statements, Goldstein (1966) concludes that "If, therefore, less maladjusted individuals tend

to have both moderate aspiration levels and the highest improvement rate in psychotherapy, one may logically predict that those patients with moderate prognostic expectancies should change the most, and those with extreme prognostic expectancies should benefit least from their psychotherapeutic experience" (p. 37). Thus the present concensus arrived at by the most recent and methodologically sound studies in the literature on the topic of prognostic expectancies is that moderate levels of expectancy appears to be the most realistic and indicative of a healthy attitude toward therapy which should make such patients most capable of therapeutic change.

Patients' Role Expectations. The other type of patient expectancies which has been researched in relation to outcome is patients' role expectations. These consist of the expectations patients have in regard both to how they anticipate behaving in therapy and to how they anticipate their therapist to behave. In a theoretical paper on this issue Cartwright and Cartwright (1959) listed four beliefs or role expectations and postulate their effect or outcome. These beliefs are: 1) the belief that certain effects will result from therapy, 2) the belief in the therapist as a source of help, 3) the belief in the therapeutic techniques as a source of help, and 4) the belief in the patient himself as a source of help. The Cartwrights write that from their clinical experience they see no positive relationship between the presence or absence of the first three factors and successful outcome. They

do hypothesize, however, that the fourth belief (or patient role expectation) is related in a positive linear fashion to success in psychotherapy. Thus they propose that if a patient perceives himself as a source of help he will likely make rapid progress, while if a patient has a weak belief in himself as a source of help he has a poor prognosis for change.

Following Cartwright's lead, several studies have attempted to define the sets of expectations patients have about the kind of patient-therapist relationship they anticipate before entering the therapist's office. One study by Apfelbaum (1958) reports that the type of "transference expectations" a patient holds before therapy are not related at all to outcome. However, most other studies do report relationships between patient role expectations and therapy. An important factor in understanding these discrepant results is the nature of the definition of role expectancies. Szasz and Hollander (1956) and Heine and Trosman (1960) have described at least two sets of expectations that patients have. One set, which is described as "Guidance Expectations", consists in its extreme form as anticipations that the therapist will behave in a very directive way, prescribing medicine or giving advice and that the patient will merely cooperate without having any say as to what goes on. Symptoms are seen as non-psychological, more medically-oriented events. Often these patients interpret the shortness of therapy as an indication of indifference and that the therapist or the clinic does not care (McGuire, 1965). The second

set of expectations is described as "Participation Expectations" which consist of anticipating the therapist-patient relationship as one in which the patient will work with the therapist rather than just follow his advice, and in general the patient will expect to share the responsibilities of what goes on in therapy. Symptoms are seen as related to interpersonal events and to the patient's feelings. Such expectations are akin to Cartwrights' statement about a patient's belief in himself as a source of help. Studies by Heine and Trosman (1960), Clemes and D'Andrea (1965) and Overall and Aronson (1963) administered role expectation questionnaires to patients before entering therapy and followed those patients to termination. In all studies it was found that if a patient perceived his first interview as compatible with his expectations, his prognosis was good. But if a patient found his first interview at variance with his expectations he would experience greater anxiety during the session and either change his expectations or, more commonly, discontinue therapy. They also found that patients who rated their role expectations as anticipating "passive cooperation" with the therapist rather than "active cooperation" as a means of reaching their therapeutic goals also tended to prematurely terminate. Overall and Aronson (1963) report that those lower-class patients, whose role expectations of how their therapist would act were most incongruent with how the therapist rated his own behavior, were the least likely patients to continue therapy. Further substantiating evidence comes from two studies

by Schroeder (1960) and Battle et. al. (1966) which found a patient's willingness to accept responsibility for his problems to be directly related to the amount of movement in treatment.

Thus the literature suggests that patients who have a certain set of role expectations, namely those ("participant") expectations similar to the ones the therapists are postulated to hold, are more likely to succeed in therapy. The specific nature of such a relationship between a patient's participant role expectations and outcome has not been documented, but the literature indicates it to be of a positive linear nature in contrast to the positive curvilinear relationship that the literature posits between patient prognostic expectancy and outcome. This study provides a further investigation into the specific nature of both of these relationships.

Therapist Expectations and Therapeutic Outcome

While many studies have attempted to relate patient personality variables, such as psychotherapeutic expectancy, to outcome, relatively few studies have explored therapists-personality variables and how they affect the course of therapy. As Butler (1952) has written "the therapist's behavior is so intimately interconnected with the behavior of the client that exact observation of the therapist is a necessary precondition to understanding the behavior of the client " (p. 378). That people in strange, unstructured situations are likely to behave as an

authority in that situation expects them to, is an assumption verified by Rosenthal's (1960) studies on experimenter influence on subjects and Krasner's (1965) and Bandura's (1956) studies on therapists as operant conditioners of their patients. Heller and Goldstein (1963) write that a therapist's expectancies are usually subtly communicated to his patient and how the patient responds to them will depend on such variables as the patient's suggestibility, therapist's attractiveness, etc. Other major studies by Luborsky (1952), Sapolsky (1960, 1965) and Strupp (1960) all indicate that therapist characteristics are of major importance to patient behavior and to therapeutic outcome.

Therapist prognostic expectations. It is also agreed upon that the therapist's prognostic prediction (which is very similar to his prognostic expectations) is one of the best predictors known, and the most commonly used measure of outcome. Goldstein (1960a) found inferential support for this in a study which compared patients who perceived positive therapeutic change in themselves after therapy with patients who perceived negative change. He reports that the therapists of the first group had expected significantly more patient improvement from those patients than had the therapists of the second group of patients. Goldstein concludes that this result does not just confirm that therapists are good predictors, but that the therapists' expectations affected the therapeutic relationship and outcome. Investigations by Fiedler (1953) and

Chance (1960) provide essentially confirming evidence that therapists' prognostic expectancies influence treatment outcome. An interesting example of how a therapist's expectations can influence his patient's behavior is provided by a study by Schlien (1959) who found that those patients who were told by their therapists that they had 20 sessions to their therapy did as well on outcome measures as a matched group of patients who were told they could have all the time they needed and averaged 55 sessions each. Similarly, Frank (1959), Phillips and Johnston (1954), Small (1971) and others all stress that the speed of improvement may be largely influenced by a patient's expectancies as conveyed to him by this therapist. Such a finding suggests that favorable prognostic expectancies may be of more critical importance to the short-term therapy, such as this study will investigate, than to longer, more open-ended therapy. In short-term therapy a patient has less time to alter his expectations or to converge his values towards those of his therapist and it would seem that initial patient-therapist congruence could be of more crucial importance in this situation. Thus, there seems to be a good deal of theoretical agreement, with some inferential experimental support, that the level of a therapist's prognostic expectancy is related to the degree of successful outcome. However the nature of this relationship, other than it appears to be of a positive nature, is not clear. The present study attempts to explore this relationship in more detail.

Therapists' role expectations. While it is acknowledged that therapist prognostic expectancies vary between therapists, it is generally assumed that therapists' role expectations, regarding how they would anticipate a patient to ideally act, are pretty constant for all therapists and an "ideal" patient type exists for them. Wallach and Strupp (1960) write,

> "The therapist, as a function of his life experiences, approaches each initial interview with needs, expectations, and wishes of his own.... if his expectations are sufficiently realized, he will consider the situation as "rewarding", and a "warm" attitude toward the patient is likely to develop. More specifically, if in an initial interview the prospective patient approximates the therapist's concept of an "ideal patient" he may develop a warm attitude toward the patient" (p. 316).

Most expectancy studies have ignored the therapist's role expectancies, assuming that they are relatively homogeneous for all therapists. Heine and Trosman (1960) describe some of these "model expectations of the therapists" they studied as:

1) The patient should desire a relationship in which he has an opportunity to talk freely about himself and his discomfort.

2) The patient should see the relationship as instrumental to the relief of his difficulties, rather than expecting them to be relieved by an impersonal manipulation on part of the therapist alone.

3) Hence the patient should perceive himself as in some degree responsible for the outcome.

Heine and Trosman (1960) also describe some well defined reservations therapists had formulated about seeing patients:

1) They did not expect to give diagnostic information or drug information.

2) They did not intend to be led into an active directive role if the patient adopted a passive attitude.

Thus the therapist's expectations described here are looking for a particular patient who is relatively self-reliant and expects to participate responsibly in therapy. A patient with such expectations is rewarded with the therapist's interest and attention, while another patient (for example, with "guidance expectations" which aren't unrealistic in a medical setting) is in effect often rejected. In response to this biased situation Rotter (1954) originally suggested telling the patient of the therapist's expectations by a process of "successive structuring" of the patient's expectations to make them more consistent with the therapists'. The Johns Hopkins' research group has done extensive research on this topic and has developed a "role induction interview" that explains to the patient quite clearly and specifically what the role of the therapist will be and how the patient would be expected to conduct himself. Patients who received the interview showed more movement in therapy than did the control group (Hoehn-Saric et. al., 1964). Related to this is Frank's (1968) findings in placebo studies that the use of tests and questionnaires seem to have as much beneficial placebo help as a

pill or a therapist's positive suggestions, indicating that any interaction which heightens expectation of help will lead to symptom decrease and mood improvement. The degree of such improvement in short-term therapy, furthermore, is positively correlated with the initial intensity of the patient's distress.

Thus the majority of research on therapist's role expectations suggests most therapists agree in their expectations of patients and if a patient has congruent expectations, the chance of a successful outcome is improved. However, there has been some recent evidence that therapist's expectations may not be so homogeneous. Welkowitz et. al. (1967) found that therapists don't have a common value scheme but were just as heterogeneous as the patients they treated. It was hypothesized for examination in this study that therapists do differ in their role expectations regarding the "ideal" patient, and that the important factor in regard to facilitating positive outcome is not the type of expectations the patient brings to therapy, but how similar (congruent) they are to his therapist's expectations. This discussion of expectations will now turn to a fuller examination of this topic, namely the interaction of a patient and his therapist's expectations and which combinations are optional for successful therapy.

Patient-Therapist Congruence of Expectations

To examine certain characteristics of the patient or therapist outside of the interactive process, many psychologists feel (Rogers,

1963; Goldstein and Dean, 1966), is to lose a great deal of information about the psychotherapeutic process. As Bordin (1959) writes "the key to the influence of psychotherapy on the patient is in his relationship with the therapist... Virtually all efforts to theorize about psychotherapy are intended to describe and explain what attributes of the interactions between the therapist and the patient will account for whatever behavior change results" (p. 235). This study is concerned with the interaction during therapy of a patient's expectations with those of his therapist, and in particular with the identification of those patient-therapist expectancy combinations which are present in successful psychotherapeutic dyads. The theoretical literature abounds with formulations of optimal pairing of patients and therapists on a range of variables such as their personalities, values, and therapy expectancies. In virtually all dimensions the emphasis is on matching for similarity, with the assumption that prognosis for therapy success is a positive function of degree of similarity (Schillinger, 1970). In their thorough review Kessell and McBreaty (1967) cite over twenty authors covering a wide range of theoretical positions who stress the importance of matching therapists and patients for similarity of values and attitudes, including, for example, such antithetical theorists as Alexander (1963) and Meehl (1959); Fenichel (1945) and Fromm-Reichmann (1949); and Szasz (1960) and Wolberg (1954).

Expectations are one form of a person's belief and value system and the experimental findings on value similarity are felt to be quite relevant to expectancy research. Studies by Carson and Heine (1962) and Mendelsohn (1966) on matching patient-therapist dyads in short-term therapy situations report findings that tend to confirm the hypothesis that initial dyad congruence of values is predictive of successful outcome. Cook (1966) in one of the only studies that has set out to investigate the nature of relationship between patient-therapist value similarity and outcome of therapy (short-term), found the relationship to be a curvilinear one. Cook reports finding a medium degree of value similarity resulted in the most positive change. Strupp and Bergin (1969), reviewing these findings, suggest that there may be an optimal level of congruence and dissonance that reflect complex contingencies of patient-therapist value differences that work best. In addition to the concept of initial value congruence, research also demonstrates a tendency for values to converge toward congruence between the patient therapist as treatment progresses and that this is an essential ingredient of the therapeutic process (Lennard and Bernstein, 1960; Pepinsky and Karst, 1964). Studies which have reported value convergence between therapist and patient as a function of outcome include Schrier (1953), Rosenthal (1955), Parloff et. al. (1960), Holzman (1961), Peternoy (1966), etc. One interesting variation on this theme was done by Glad (1959) who demonstrated that improvement during therapy is contingent upon the similarity of the patient's

personality to the therapist's methods and goals of treatment. Perhaps the most comprehensive study is that of Welkowtiz et. al. (1967) which demonstrated, with a large sample of patients and therapists, that there was a greater value similarity between a therapist and his own patients than between a therapist and random patients who were not his own. Furthermore the study found that the degree of value similarity was greater for those patients who had been in therapy longer and these patients were rated by their therapists as most improved. Thus, patient-therapist value research shows a concensus that initial value congruence (of either moderate or high degree) and value convergence during therapy tend to be related to the success of the outcome.

Another area of psychotherapy literature that is relevant to expectancy research is that of patient-therapist personality similarity and its relation to treatment success. However, the findings on this topic are not as unified as the value literature, and has produced a great deal of confusion and contradictory results. Much of these differences can be attributed to the different designs used in these studies. Almost every study had its own set of personality scales which were usually very global in nature. There are also great differences in the patient samples studied (usually heterogeneous samples of patients), the outcome measures used (usually duration of therapy), and therapist samples used (often advanced graduate students). Positive relationships between patient-therapist personality similarity and therapeutic

success have been reported by Axelrod (1951), Tuma and Gustad (1957) and Mendelsohn (1962). A negative relationship was reported by Synder (1961). However these studies were done with highly heterogeneous patient samples and their personality measures were global ones, difficult to generalize from. In a more controlled series of studies, Mendelsohn and Geller (1965) and Mendelsohn (1966) found that high similarity dyads did not show the highest levels of treatment success. Carson and Heine (1962) similarly report that a too close personality match can have negative effects on the psychotherapeutic relationship by causing the therapist to over-identify with his patient and his problems. If on the other hand there was very low similarity, the therapist might not be able to appreciate or understand the patient's problems. They reason that if it is therapeutic for a therapist to maintain a balance between empathy and objectivity, then a medium degree of personality similarity would be optimal. Both Fiedler (1951) and Carson and Heine (1962) did find such a curvilinear relationship between patient-therapist personality similarity and therapeutic success (as measured by therapist's ratings). However all of these studies have used such global scales that Strupp and Bergin (1969) comment that future research in this area should focus on which specific therapist personality characteristics are more often related to positive outcome with regard to which specific patient characteristics. They forsee the development of complex outcome contingencies for each personality characteristic and for how similar the patient and

therapist are on that characteristic. This study is designed to investigate the specific functions of patient-therapist similarity of both prognostic and role expectations with outcome.

Congruence of patient-therapist prognostic expectations. Only one study has been reported on the relationship patient-therapist similarity of prognostic expectancies with outcome. This is the study by Goldstein (1960a) reported earlier that measured both patient and therapist prognostic expectancies and correlated these singularly and in combination (mean score of patient and therapist expectancies) with outcome (duration of therapy). Results indicated that the expectation of patient improvement held by the therapist had a more potent influence on outcome than did either the patient's own expectation or the combined expectation. Frank (1968) also states his belief that the therapist is the most important ingredient of the therapeutic relationship in stimulating a patient's expectation of relief. One other study which dealt with this effect of patient-therapist interaction on prognostic expectancies is reported by Heller and Goldstein (1961). They found that the amount of the patient's favorable attitudes or attraction toward the therapist related significantly to the degree of improvement (prognostic expectancy) which the therapist expected to take place in the patient. However, in both studies no measures were taken of patient-therapist congruence of prognostic expectations and it appears that such a test has not been reported in the literature.

The present study investigates the relationship between degree of similarity of patient-therapist prognostic expectancy and outcome.

Congruence of patient-therapist role expectations. Although to the author's knowledge, congruence of prognostic expectancies has not been examined, congruence of role expectancies has been investigated in several studies. Gliedman et. al. (1957) report that those patients with expectations congruent with role expectations representing major schools of contemporary psychotherapy (as defined by Gliedman et. al.) stayed in therapy significantly longer than those whose expectations were non-congruent. Hankoff et. al. (1960) did a drop out of therapy study and similarly report that most drop-out patients were among those whose expectations were incompatible with their therapists' expectations. Clemes and D'Andrea (1965) found that patients who received an interview with a psychiatric resident that was compatible with their expectations were significantly less anxious than those who had an interview that was perceived as being in conflict with their expectations. The therapists in this study rated the incompatible sessions as more difficult to conduct. Those congruent patients also remained in therapy longer. Both Goin et. al. (1965) and Levitt (1966) show findings that lead them to conclude that a patient is helped more when he receives therapy that is congruent with his expectations. Looking more specifically at expectancies, Heine and Trosman (1960) found that neither the presenting complaint

nor stated expectancies regarding the efficacy of treatment bore any relationship to continuance (duration) of therapy. But they found that patient's expectations regarding the nature of psychotherapy, its purpose and methods, did relate significantly to continuance. Those patients with "participation expectancies" had better success in therapy than those with "guidance expectancies". Freedman et. al. (1950) and Clemes and D'Andrea (1965) found similar results, and along with Heine and Trosman (1960) they all assume that all therapists have participation expectations and want patients who are similar. However therapists are rarely tested on their role expectations and one recent study that surveyed a large proportion of the American Psychological Association reports finding great heterogeneity among therapists in describing the patients they would like to work with (Goldmein and Mendelsohn, 1969). Thus while findings in general indicate a lack of similarity between patient and therapist role expectations is associated with increased "strain" during therapy (Lennard and Bernstein, 1960), and early patient drop-outs (Heine and Trosman, 1960; Overall and Aronson, 1963) this does not necessarily mean that there is one standard set of patient expectations that will be congruent with all therapists' role expectations. The ideal expectations for a patient would appear to depend on the nature his therapist's expectations and, Clemes and D'Andrea (1965) suggest, it is conceivable that too close a match between expectations might not be optimal for future behavior change, but just act as a reinforcement of the

expectation. As Appel (1960) and Gliedman et. al. (1957) both demonstrate, convergence of patient expectations toward therapist expectations occurs during therapy and may be a positive component of successful therapy.

Thus in regard to patients' and therapists' role expectations, this study tested both patients and therapists on their expectations of both patients' and therapists' role-related behaviors. From these ratings more accurate measures of patient-therapist congruence were calculated on their expectations of patient role behavior (operationally called patient self-reliance) and therapist role behavior (operationally called therapist-directiveness). These expectation congruence measures were then related to outcome to investigate the specific nature of these relationships. The bulk of the literature indicates a positive linear relationship, but several articles have hinted at the possibility of a curvilinear relationship. In general this study used one set of measures to test several hypotheses pertaining to how patient and therapist expectations and their interaction related to success of treatment. Such a design attempted to begin to tie together the scattered findings from studies using less than optimal therapist samples, patient samples, and measurement of independent and dependent variables. It also extended beyond those studies into the area of patient-therapist congruence of both prognostic expectations and specific role expectations.

Experimental Hypotheses

Prognostic Expectancy and Outcome

Hypothesis 1

Both the level of patient expectancy and the level of therapist expectancy are significantly related to the amount of outcome, with therapist expectancy being a significantly stronger prediction of outcome than patient expectancy.

Hypothesis 2

a) Those patients with medium expectancy levels will have significantly higher therapeutic outcome scores than either those patients with low expectancy levels or those patients with high expectancy levels.

b) Those patients with medium expectancy levels whose therapists also have medium (congruent) expectancies for those patients will have significantly higher outcome scores than those patients with medium expectancy levels whose therapists have either high or low (incongruent) expectancies for those patients.

Congruence of Prognostic Expectancy and Outcome

Hypothesis 3

There will be a significant positive relationship between the level of patient-therapist prognostic expectancy congruence after the first therapy session with the level of therapeutic outcome scores. High expectancy congruence dyads will have higher

outcomes than low expectancy congruence dyads.

Role Expectancy and Outcome

Hypothesis 4

There will be a significant positive relationship between the level of the patient's self-reliance score and his therapeutic outcome score. High self-reliant patients will have higher outcomes than low self-reliant patients.

Congruence of Role Expectancy and Outcome

Hypothesis 5

There will be a significant relationship between the level of patient-therapist congruence of pretherapy self-reliance expectation scores with therapeutic outcome scores. Those T-P dyads with high congruence of self-reliance scores will have higher outcomes than low congruence dyads.

Hypothesis 6

There will be a significant relationship between the level of patient-therapist congruence on pretherapy therapist-directiveness expectation scores with therapeutic outcome scores. Those T-P dyads with high congruence of therapist-directiveness scores will have higher outcomes than low congruence dyads.

Exploratory Hypotheses

1. Mean patient expectancy level is higher than mean therapist expectancy level. Mean patient outcome #1 level is higher than

mean therapist outcome #2 level.

2. Severity of the patient's 3 post-first session Distress Level ratings are positively related to the patient's 3 corresponding post-first session patient expectancy ratings and to his 3 corresponding final outcome #4 ratings.

EXPERIMENTAL METHOD

The Setting

This study was conducted at the University of Massachusetts Mental Health Service, an outpatient psychotherapy clinic which is part of the University Health Service. The Mental Health Service offers students short-term individual and group psychotherapy. At the time of his initial contact with the clinic, each student was given a brief written description of the service, which included a statement that under most circumstances treatment would be limited to one semester, or about 12 sessions. However most students terminated before the 12 session limit and the overall average was about 5 visits per student. Statistics kept over the past 8 years indicate that approximately 40% of the patients (Ps) were seen for only 1 visit, 35% of the Ps were seen for 2-4 sessions, and about 25% of the Ps were seen for 5-20 sessions. Those students who required more extensive help were occasionally seen by a staff member on a long term basis, but most were referred to private therapists or community agencies. Most students were seen within a few days after contacting the clinic and were randomly given an appointment with whichever therapist (T) was most readily available, except when a student requested to see a specific T. Every staff T did intake and usually followed the case to completion.

Patient sample. The P population seen at the Mental Health Service yearly represents about 7% of the total student body which was about 1,300 students for the 1970-1971 academic year. The majority of these students were self-referred, with most of the rest being referred by a friend, professor, health service physician, or dormitory counselor. Patients ranged from freshman to graduate students, almost all being between the ages of 17 and 30, and covering all socio-economic classes. Most frequently distress was of recent onset and was associated with conflict about a current situation. Although a diagnosis for each P was required for state records, the reliability of such diagnoses is questionable and were not specifically used in this study. The issue of diagnosis invariably elicits conflicting opinions. Many mental health workers are reluctant to attach a psychiatric label to every student seen. In many instances the opprobrium of labeling is lessened by the use of "adjustment reaction" for those Ps who present problems of a transitory nature. Similarly, a P may present what initially appears to be neurotic symptomatology, but it is later found that the extent of the pathology does not warrant the diagnosis of neurosis. Anxiety and depression are often the symptoms of adjustment reactions, rather than truly neurotic patterns (Siddall, 1971).

Previous statistics indicated that the 3 largest categories of Ps seen at the Mental Health Service were diagnosed as adjustment reaction to adolescence (40%), personality disorders (15%), and

psychoneurotic reactions (15%) (Allen and Janowitz, 1965). An alternate method of P classiciation that has been frequently suggested (Strupp and Bergen, 1969; Battle et. al., 1966; Rosenthal and Frank, 1956) is to classify by P's presenting complaints or target symptoms. Such an approach allows for simpler, more objective classification in that each P is classified according to those problems which are bothering him and for which he is seeking help at the time. Such a classification system is also consistent with the short-term therapy approach used at the Mental Health Service which is to alleviate the immediate pressure of crisis problems rather than attempt extended personality reorganization. (The American Psychiatric Association's diagnostic system is probably more applicable to the long-term rather than short-term psychotherapy approach.)

Therefore, Ps for this study were selected by their description of their presenting problems. To standardize the sample of Ps whose target symptom descriptions would be used in this study, each P contacting the Mental Health Service was asked to fill out a modified Mooney Problem Check List - College Form - which consisted of 120 items which are divided into 11 "problem areas" such as Home and Family; Health and Physical Development; Adjustment to College; etc. The Ps this study was interested in were those who did not have a single circumscribed problem or complaint, but who had more generalized, amorphous concerns that were scattered over many

problem areas on the Mooney Problem Check List. It was felt that such Ps with more poly-undifferentiated concerns would more likely provide a large amount of variance of expectancies, would more likely elicit a wide variance of expectancies from the Ts, and would provide a suitably large sample population. Operationally these Ps were selected for this study by their response pattern on the Mooney Check List. Those Ps who indicated a significant number of problems in 6 or more of the 11 problem areas were classified as possible candidates for this study. The significant number of problems for a category was operationally defined as 1/11 of the total number of problems that the P checked as bothering him very much (3) or extremely (4) on a 4 point scale that follows each problem. (This problem bothers me: 1) Not at all; 2) A little; 3) Very much; 4) Extremely). Those Ps who did not have the significant number of problems in 6 or more problem areas, as for instance a P who had most of his problems all in one or two areas, were excluded from the study. Further restrictions excluded those Ps who had a previous therapy experience of more than 2 sessions, those Ps who requested a particular T, those Ps who had only 2 or less sessions with their T, and those Ps who had not completed therapy at the end of the data collection period.

These experimental Ps were selected from those students requesting help at the Mental Health Service during the Spring semester and the beginning of the Summer semester of 1971. Only a very few Ps refused to cooperate in completing the questionnaires,

ruling out a possible response bias.

Psychotherapist sample. The psychotherapist raters consisted of 1 psychiatrist, 4 clinical psychologists, and 1 social worker on the Mental Health Service staff. Professional and demographic characteristics of all the members of the staff were collected before ratings of the experimental Ps were begun (see Appendix 1). The model therapist was a 36 year old, white, married man, and was brought up in middle class surroundings. Professional identification was described as psychoanalytic, experiential and eclectic and treatment method followed the short-term, crisis intervention model. The T sample was highly experienced, with an average of 7 2/3 years experience beyond doctoral or medical degree.

Experimental Measures

Mooney Problem Check List - modified version. The Mooney Problem Check List (PCL) is a list of 330 problems found to be common in college students (Mooney and Gordon, 1950). The problems are divided into 11 problem areas, 30 items in each area. When used in other college settings, one experimenter wrote that the check list "helped to locate areas of student problems, give a quick overview of students' felt difficulties, and offered a good basis for an opening conference" (Marsh, 1942, p. 339). One of the test's purposes is to give students an opportunity to express their problems and review those areas of particular concern before starting counseling (James, 1953).

It must be kept in mind that the PCL gives only a picture of those problems that the P is aware of and is willing to admit either to himself or others. It also may be possible that the problems of some students may not be listed on the PCL. Thus while the PCL provides a self-perceived or self-reported foci of difficulties, this picture does not purport to be an accurate or complete representation of underlying conflicts.

In its standard form the Mooney PCL uses the instructions of checking those problems which are troublesome to the person and then to go back and give a double check to those items which are of most concern. Such a procedure does not assure a constant n for each subject, and is not designed to produce standard scores. Nor are normative or correlational data supplied so that it cannot be assessed with regard to the usual concepts of reliability and validity. Nevertheless, reports have indicated that the problem areas do pull responses from students that have those problems and that repeating the test after an interval of one week shows a fairly high stability (rank order coefficient = +.90) in the number of problems marked in each general area (Bedall, 1949). Several other studies, done specifically on the validity question of the PCL claim to find "prima facie" validity for the PCL successfully determining that students recognize their problems, find their problems represented in the check list, and record them (McIntyre, 1953). Similarly other studies successfully attempted to correlate

students responding to problem areas with outside criteria, such as difficulty in schoolwork, etc. (Carr, 1955; Congdon, 1943; Gallager, 1954).

The Mooney PCL was chosen for this study, however, because it offers perhaps the most comprehensive list of college problems of any test. Those items, with modified instructions, were used both to identify those Ps who had problems scattered over many areas of concern, and to provide a rough global measure of each P's perceived changes with respect to these problems over the course of therapy. To obtain a standard pattern of responding to the PCL each P was asked to read each item and decide how much that particular problem concerned or troubled him. He then was asked to put a check mark in one of four boxes which referred to how much that problem troubled him. The four boxes were: "Not at all" (1); "A little" (2); "Quite a bit" (3); and "Extremely" (4). Each P was asked not to leave out any items.

To initially identify those experimental Ps with scattered amorphous areas of difficulty, 120 items of the Mooney PCL considered by the author to be most relevant to the patient sample, were given to each P at the pretherapy administration. After that, a briefer form of 60 items was used. There were several reasons for this. For one, the 120 items form was quite ominous and time-consuming to most Ps and might have led to some Ps refusing to fill out the questionnaires. A second reason was that to design a global outcome measure (outcome measure #3) on the basis of change in

responses to 120 items over the course of therapy was not only too unwieldy (possible score range would be from 0 to 480) but also would supply a minimum of validity. As Mooney and Gordon (1950) have pointed out, the items on the check list are not of equal significance. One item may prove to be more indicative of an important problem than 10 others which the client may also have underlined. Goldstein (1960a) suggested a feasible remedy to this problem by attempting to roughly equate items in terms of the severity of pathology they experienced. In his study, he had advanced psychology graduate students rank the 30 items within each of 4 problem areas from "most" to "least" on a severity of psychopathology continuum. Of the 120 items he eliminated the 55 items judged to represent the least severe pathology. A similar technique was used in this study to obtain a manageable number of roughly equated items for rating the amount of P's pretherapy to post-therapy perceived changes over a more global set of problems than the target Complaint Rating scale provided. The pool from which these 60 items were drawn consisted of 120 problem statements from 6 areas of the PCL (Social-Psychological Relations; The Future; Vocational and Educational; Personal-Psychological Relations; Courtship, Sex, and Marriage; and Home and Family). These items were ranked by 5 psychology department faculty members on a severity of pathology continuum. The 60 items which were rated as representing the least severe psychopathology were eliminated (see Appendices 3 and 5).

Self Reliance Scale. The scale consisted of 15 statements about possible patient attitudes and beliefs about therapy which were listed under the 3 main headings of 1) "Your reasons for coming to the Mental Health Service"; 2) "What do you most want from the Mental Health Service"; and 3) "How do you expect to get what you want from the Mental Health Service" (see Appendix 2). Each P was asked to respond to each statement by circling either "Yes" or "No". Responses to each statement were scoreable either as a "Self-Reliant" response or as a "Therapist-Reliant" response. Thus for each rater a self-reliance score of from 0 to 15 was possible. Ts were also asked to fill out the scale as they would perceive an "ideal patient" would fill it out (see Appendix 1, questions 1, 2, 3). The items initially devised by Heine and Trosman (1960) and slightly modified into the style used in this study by Clemes and D'Andrea (1965). These items have been reliably rated by Heine and Trosman (1960) as either describing "active participation" or "passive participation" and by Clmes and D'Andrea who labeled these factors as "participant expectation" and "guidance expectations" in therapy. As stated above, in this study these 2 factors were called "self-reliant expectation" and "therapist reliant expectation" for therapy.

Therapist Directiveness Measure-D Scale. This 15 item measure was taken from the McNair and Lorr (1964) AID (Analytical, Impersonal Directive) Scale. The 15 items used in this study (see Appendix 1, questions 6-20 and Appendix 2, questions 16-30) comprise the D factor

of this scale. The AID was designed as an instrument for "objectively characterizing psychotherapists and testing their contribution to treatment outcome" (Lorr and McNair, 1966, p. 581). It was derived essentially from three sources: (a) Fiedler's study (1951) of therapists' concepts about therapy relationships; (b) Fey's study (1958) of the interrelationship of demographic and professional variables with a 30 item questionnaire; and, most of all, from (c) Sundland and Barker's major research (1962) in this area which produced the Therapist Orientation Questionnaire (TOQ). McNair and Lorr took many of the TOQ items and some of Fey's items plus constructing some new ones. They hypothesized and confirmed a three factor solution, which they named AID -- (A) for the psychoanalytic orientation, (I) for the impersonal versus personal polarity, and (D) for the directive versus nondirective dimension of the therapists' style. Schillinger (1970) writes "without doubt, the AID has better methodologic roots and factorial validity than other available instruments concerned with therapists' concepts and values about psychotherapy".

The original version of the AID consisted of 57 items. This was reduced to 37 items by the elimination of items that failed to retain adequate factor loadings on further replication of the factor analysis. Lorr and McNair (1966) describe Factor D (directive) as appearing "to tap the extent to which therapists assume active control of the treatment task. It is defined by techniques for planning therapy, for actively implementing those plans, and for shaping the therapeutic interaction in a therapist-determined direction

(p. 587). While the AID is written for therapists, a modified parallel form of the AID items has been developed by Begley and Lieberman (1970) to be understandable for patients to fill out. Both therapist and patient forms of the 15 item D scale were used in this study (providing a complimentary measure to the patient self-reliance scale) to measure both Ps' expectation of therapist directiveness and Ts' perception of their own directiveness.

Target Complaint Rating Scales. In the past, psychotherapy studies have most commonly used as criteria therapists' gross improvement ratings. These have been preferred in that they are easily collected and the one score is psychometrically advantageous (Luborsky et. al., 1971). Using several outcome measures has the problem that the correlations between them are usually low and not significant (Strupp and Bergin, 1969). The alternative of using pre and post-therapy administration of a psychometric measure and obtaining the difference score as the criterion has been found to be not only psychometrically burdensome, but also most studies that have used difference scores have found zero or negative correlations between these outcome measures and the original predictors (Luborsky et. al., 1971). The general concensus seems to be that many kinds of change occur in psychotherapy, and a measure of one kind of change probably will not measure another kind of change. It is therefore suggested that the outcome measures be tailored to the type of change that the patient and therapist being studied are seeking to obtain.

The target complaint rating scale is one such measure. The Johns Hopkins research group has conducted several studies exploring the validity of using a P's spontaneously expressed presenting complaints as criteria for evaluating response to psychotherapy (Battle et. al., 1966). The basic problem with this approach has been how to compare patients with different complaints. The best solution to this problem is to establish a relatively homogeneous patient sample as has been done in this study. Richards (1965) suggests the second safeguard of tailoring the outcome criteria to each individual patient and using each as his own control. Pascal and Zax (1956), Battle et. al. (1966), Jacobs et. al. (1967), and Luborsky et. al (1971) all agree that using the alleviation of a patient's presenting complaints as the criteria for the efficacy of treatment is a valid approach. They also write, that for short-term psychotherapy which is centered on just such symptom reduction rather than global personality change, that target symptoms are the criteria of choice especially if ratings can be obtained from the therapist, patient, and a third judge.

Several indirect sources of evidence are available on the validity of target complaints as criteria. For one, they correspond to the complaints obtained in an intensive psychiatric interview. Secondly, target complaints correlated significantly with other outcome measures in a controlled study on psychotherapy (Battle et. al., 1966). The results of these studies also indicate that patients have to be considerably influenced to change their target

symptoms over a short period of time. Thus, while it is often true that target symptoms are only superficial manifestations of a deeper disorder that might be uncovered in extensive psychotherapy, at the present they do seem to offer the most promising measure of short-term therapeutic change.

The Target Complaint Rating Scale used in this study (see Appendix 2) asked the P to describe the 3 problems that were presently bothering him the most, as specifically and briefly as possible. The patient described his 3 problems before entering therapy and then again after his first session with his therapist (at this post-first session rating he is allowed to change these problems from his pre-therapy descriptions). Battle et. al. (1966) report that patients who described their problems a second time usually formulated them in a more precise way. These post-first session target complaints were designated as the outcome criteria for that patient and were accordingly copied onto his T's post-first session rating form (see Appendix 4) and also onto the P's and T's post-therapy rating forms (see Appendices 5 and 6) for final outcome evaluations.

Distress Level Scales. This scale directly followed the patient's description of his 3 target complaints on each questionnaire. Under each of the three complaints the P and T (see Appendices 3 and 4) were asked to rate how much each problem bothered the patient at that time. The scale consisted of 10 points which described how much the problem was currently bothering the

patient. The scale ranged from: "Very little" (1); "Pretty much" (4); "Very much" (7); to "Couldn't be worse" (10). The rater was advised that while only certain points on the scale were defined, he could check any one point on the continuum. A second Global Distress Level Scale was included in the patient's pre-therapy questionnaire and on both of the therapists' questionnaires (see Appendices 2, 4, and 6). This scale, developed by Jacobs et. al. (1968), asked the rater to evaluate how much overall pain and discomfort the patient had felt during the past week. However since this scale did not refer to the 3 target symptoms used as outcome criteria, it was decided not to include it in the results of this study. Such a decision was also made on the basis of Roth's (1964) findings with a similar global distress scale which he reported as having showed no significant relation to outcome.

Prognostic Expectancy Scales. This 15 point scale asked both patient and therapist to rate their 3 prognostic expectations concerning each of the patient's 3 target complaints (see Appendices 2, 3, and 4). The patient's instructions for rating the 3 identical scales read "You have just identified 3 problems and their magnitude. For each of these we would like to learn about your expectations for their change because of your sessions here. Rate your expectations for each of these 3 problems by putting a check on each of the scales below." The therapist's instructions read "On the lines below are copied verbatim those three most pressing problems

as your patient has described them. Please rate each of these problems as you perceive them as troubling your patient during his first session with you." The 15 point scale of prognostic expectancies ranged from: "It will be worse" (1); "It will be the same" (5); "It will be a little better" (4); "It will be better" (12); to "It will be much better" (15). The rater was advised that while only certain points on the scale were defined, he could check any one point on that continuum.

Outcome Measure #1 - patient perceived improvement. This outcome measure consisted of three 15 point scales identical in format to the prognostic expectancy measures except that the instructions were different and the presentation of items on these scales were reversed from that of the expectancy scales to rule out the possibility of a response set bias. These 3 scales (one rating each target complaint) were administered to each P after termination of therapy. The instructions given to each P at this time were "Referring to the 3 problems (copied on the preceding page) that you identified after your first session at the Mental Health Service, would you please rate the amount of change between how much each problem bothered you then and how much each bothers you now." The 15 point scale for each target complaint ranged from "It is worse" (1) to "It is much better" (15). Thus each P rated himself with 3 Outcome #1 scores (see Appendix 5).

Outcome Measure #2 - therapist-perceived improvement. This outcome measure also consisted of three 15 point scales identical to Outcome Measure #1. Only the instructions were slightly different, addressing the T as follows: "Rate each of your patients' 3 problems as to how much it has changed since the first session. This rating should be based on your perception of how much each problem bothered your patient then and how much it bothers him now." Thus for each of his Ps a T rated 3 Outcome #2 scores (see Appendix 6).

Outcome Measure #3 - modified PCL global improvement measure. This 60 item scale (with a score of 1 to 4 for each item) has been described under the Mooney Problem Check List measure. Outcome Score #3 was operationally defined as the difference between each P's pre-therapy score (which had a possible range of 60 to 240) and the P's post-therapy score on those same items. Thus the possible range of Outcome #3 difference scores was 0 to 180 for each P (see Appendices 2 and 5).

Outcome Measure #4 - average patient-therapist perceived improvement. This measure was designed to reduce the psychometric complexity of this study and was used for those hypotheses where more specialized outcome measures were not necessary or appropriate. For each P-T dyad 3 Average Outcome #4 scores were computed, one for each of the 3 target symptoms. This was done by taking the mean of the P's Outcome #1 rating and the T's Outcome #2 rating for each of those target symptoms.

Experimental Procedure

Questionnaires were administered to each P and his T at 3 points before, during, and after therapy. In order to most simply clarify this data collection, a summary description of the scales in order of their administration at each point in therapy is provided below in tabular form.

Pre-Therapy Questionnaires

Patient Data (see Appendix 2)	Therapist Data (see Appendix 1)
Self-Reliance Scale (one score, range = 0-15)	Demographic Data Questions
Therapist Directiveness Scale (one score, range = 0-15)	Self-Reliance Scale (with instructions to be filled out for an "ideal therapy patient". (one score, range = 0-15)
Modified Mooney PCL (one score, range = 0-480)	Therapist Directiveness Scale (one score, range = 0-15)
Target Complaint Rating Scales (3 descriptions of target symptoms)	
Distress Level Scales (3 scores, range = 1-10 for each)	
Prognostic Expectancy Scales (3 scores, range = 0-15 for each)	
Global Distress Level Scale (one score, range = 1-10)	

Post-First Session Questionnaires

Patient Data (see Appendix 3)	Therapist Data (see Appendix 4)
Modified Mooney PCL (one score, range = 0-240)	Distress Level Scales (3 scores, range = 0-10 for each)
Target Complaint Rating Scales (3 descriptions of target symptoms)	Prognostic Expectancy Scales (3 scores, range = 0-15 for each)
Distress Level Scales (3 scores, range = 1-10 for each)	Global Distress Level Scale (one score, range = 0-10)
Prognostic Expectancy Scales (3 scores, range = 0-15 for each)	Supplementary Notes on the Therapist's Rating Scales (standardized instructions for the therapists on rating procedures)

Post-Therapy Questionnaires

Patient Data (see Appendix 5)	Therapist Data (see Appendix 6)
Self-Reliance Scale (one score, range = 0-15)	Distress Level Scales (3 scores, range = 0-10 for each)
Therapist Directiveness Scale (one score, range 0-15)	Outcome Measures #2 (3 scores, range = 0-15 for each)
Modified Mooney PCL (one score, range = 0-240)	Global Distress Level Scale (one score, range = 0-10)
Distress Level Scales (3 scores, range = 0-10 for each)	
Outcome Measures #1 (3 scores, range = 0-15 for each)	

Procedural Changes. Thus from each patient and therapist 5 types of ratings were obtained that were reported in this study: a Self-Reliance rating; a Therapist-Directiveness rating; a Distress Level rating for each of the 3 target symptoms; a Prognostic Expectancy rating for each of the 3 target symptoms; and a Perceived Outcome rating for each of the 3 target symptoms. Patient ratings on the Mooney Problem Check List which were proposed as a global Outcome Measure #3, are presented in Table 1 but were not included in the analyses in this study. The decision to use an average of the Patient-Perceived Outcome #1 and Therapist Perceived Outcome #2 (the averaged outcome to be labeled Outcome #4) alone without including the Mooney global Outcome #3 rating, was made after inspection of the data for several reasons. For one reason, the global ratings, after they had been transformed into a 1 to 15 scale that was congruent with outcome measures #1 and #2, showed an insignificant relationship ($r = +.110$) to the other 2 outcome measures. This is understandable in that Outcome Measures #1 and #2 rate only the 3 specific target symptoms that the patient wishes to concentrate on in therapy, while the global score provides a different type of rating of a more pervasive, generalized type of personality change. Since expectations regarding this generalized personality change were not rated in this study, its inclusion was felt to only confound the analyses. Secondly, to try to combine each P's single global outcome measure with the 3 specific target symptom outcome measures that were obtained for each P-T dyad was

also contraindicated because this would have forced a single mean outcome score for each dyad, making a comparison with the 3 expectation scores meaningless. While the global Outcome Measures #3 were not included in the statistical analyses to be presented, it is of interest to report (see Tables 2a and 2b) that there was a significant change ($F = 8.40$, $df = 1/86$, $p<.005$) for the better during short-term therapy in the level of patients' felt difficulties in the 60 problem areas listed on the Modified Mooney Problem Check List.

The second alteration of this study's originally proposed statistical procedure was also decided on upon after inspection of the data. It was originally proposed in the analyses of the relationships between P and T Expectancy scores and resultant Outcome scores to use for each P-T dyad one expectation score (averaging the 3 target symptom expectations) for the patient, one expectation score for the therapist and one combined outcome score for P-T dyad. However, it was discovered that to average a P's or T's 3 expectation scores, which rated 3 quite distinct problems, would produce a meaningless single average expectation score. Similarly to average a P's or T's 3 outcome ratings on the 3 target symptoms proved equally meaningless. One alternative method of analysis was to do 3 separate analyses for Patient and Therapist Expectation and Outcome scores for Symptom #1, Symptom #2, and Symptom #3. However, since the questionnaire instructions, which asked each patient to describe the 3 most troublesome

problems he would like to work on in therapy, made no requirements that these target problems be listed in any order (such as by severity or by level of expectation for success) there is no validity in grouping all Symptom #1's together in contrast to Symptom #2's or Symptom #3's. In fact, as Tables 3a and 3b indicate, there are no significant differences ($F = 0.459$, $df = 2/129$, $p = NS$) between the outcome scores for Symptoms #1, #2, and #3. By inspection it is also clear that patients' felt level of distress did not differentiate symptoms #1, #2, or #3. Thus the alternative of using 3 separate analyses was rejected and it was decided to pool the 3 symptoms for each of the 44 patients and 44 therapists to yield a sample of 132 scores. Thus with this corrected procedure, one piece of data would consist of the P's expectancy rating, his T's expectancy rating, and the average of both of their outcome ratings on one target problem. Such a statistical approach violates the assumption of independence for the analysis of variance, but is preferable, both from a statistical and heuristic point of view, to the alternative models. It must be stressed that the results obtained from such analyses are slightly bias. However, such results do provide a conservative but reasonable description of the clinical behavior under examination.

RESULTS

Prognostic Expectations and Outcome

Table 1 presents the means and standard deviations of Patient and Therapist Prognostic Expectancy and Outcome ratings. These ratings are divided, for simplicity, into their totals for each of the 6 therapists. The means and standard deviations for the total pooled sample are also presented. Inspecting the total sample means with a t test for critical differences between means shows that mean Patient Expectancy ($\bar{x}$ = 10.53) is significantly (t = 1.26>crit. diff. = .49, p<.001) higher than mean Therapist Expectancy ($\bar{x}$ = 9.27) confirming Exploratory Hypothesis 1 (Hays, 1963). The Pearson-Product Moment correlation of Patient and Therapist Expectations showed no significant (r = +.146) agreement between the post-first session expectations of P-T dyads. However, at the end of therapy when these P-T dyads again rated the target symptoms for Outcome #1 and #2 scores, they did show a significant agreement (r = +.462, p<.05). Examining the sample means further, it is also of note that mean Patient Expectancy ($\bar{x}$ = 10.53) is significantly higher (p<.05) than mean Patient Outcome ($\bar{x}$ = 9.80) while mean Therapist Expectancy ($\bar{x}$ = 9.27) is not significantly different from mean Therapist Outcome ($\bar{x}$ = 9.62). In view of the similarity of the means for Average Patient-Therapist Expectancy ($\bar{x}$ = 9.90) and Average Patient-Therapist Outcome ($\bar{x}$ = 9.71) it is suggested that within a P-T dyad there is a trend over therapy for both members' outcome ratings to converge toward the mean of

their original expectancy ratings.

Hypothesis 1 predicted that both level of Patient Expectancy and Therapist Expectancy are significantly related to the level of outcome, with Therapist Expectancy being a significantly stronger prediction of outcome than Patient Expectancy. Table 4a lists the Pearson Product-Moment correlation coefficients which confirm this hypothesis by reporting significant relationships between both Patient Expectancy and outcome ($r = +.494$, $p<.05$), and Therapist Expectancy and outcome ($r = +.406$, $p<.05$). As previously suggested, another predictor of outcome was Average Patient-Therapist Expectancy ($r = +.521$, $p<.05$). However a test for significant differences (see Table 4b) shows there to be no significant difference between these 3 ratings of prognostic expectancy in their ability to predict outcome. It is also noted that Table 4a contains correlations between Patient and Therapist Expectancy with Patient Perceived Outcome #1 and Therapist Perceived Outcome #2. These were included as a check on the validity of the choice of Average Patient-Therapist Outcome #4 as the basic outcome measure for this study. Tests for significant differences between these dependent correlations (see Table 4c) revealed that the correlations of Outcome #4 with Patient Expectancy and Therapist Expectancy did not differ significantly from similar correlations using Outcome #1 or Outcome #2 scores. This rules out the possibility of either Outcome #1 or Outcome #2 creating a strong bias effect on Outcome #4.

To obtain a more thorough test of hypothesis 1, a 4 x 4 analysis of variance (Myers, 1966) was calculated to compare Outcome #4 scores over interacting levels of Patient and Therapist Prognostic Expectancy. Patient and Therapist Prognostic Expectancy scores were each rank-ordered and, as necessitated by the distribution of scores, were divided in 4 groups each (Low Expectancy, Medium-Low Expectancy, Medium-High Expectancy, and High Expectancy) rather than the 3 levels (Low, Medium, High) that were originally planned. The analysis of variance, presented in Table 5a, once again confirms Hypothesis 1 by yielding a highly significant Patient Effect ($F = 17.26$, $df = 3/116$, $p<.001$) and a significant Therapist Effect ($F = 8.40$, $df = 3/116$, $p<.001$). It is important to note the insignificant Patient x Therapist Interaction Effect ($F = 0.94$, $df = 9/116$, $p = NS$) which increased the validity of the Patient and Therapist Main Effects. This assumption is verified by inspection of the group means (see Table 5b) which clearly reflect linear relationships between both Patient Prognostic Expectancy with Outcome and Therapist Prognostic Expectancy with Outcome. Duncan's Multiple Range Test (Bruning and Kintz, 1968) further substantiates this linearity by indicating that the Patient Main Effect was due to significant ($p<.001$) differences between all 4 group means (see Table 6a). Similarly Duncan's Multiple Range Test substantiates the linearity of the Therapist Main Effect by showing significant ($p<.05$) differences between all 4 group means (see Table 6b).

Hypothesis 2a predicted that patients with medium levels of Prognostic Expectations would have significantly higher outcome scores than patients with either low or high levels of Prognostic Expectations. The Medium-Low and Medium-High Patient Expectancy groups (see Table 5b) were combined to form a Medium Patient Expectancy group to test this hypothesis. The analysis of variance (Table 7a) on these 3 groups yielded a significant Between Groups Effect ($F = 6.93$, $df = 2/129$, $p<.005$). Although the 3 levels of Patient Expectancy were found to differ, an inspection of the group means (see Table 7b) indicates that they do not vary in the predicted curvilinear fashion, but rather in a linear fashion. Duncan's Multiple Range Test confirmed the positive linear nature of the relationship between Patient Expectancy and outcome by showing that all 3 group means differed significantly ($p<.001$) from each other (see Table 7c).

Hypothesis 2b proposed a more detailed look within the medium level of Patient Prognostic Expectancy to inspect how the outcome might be effected over the interacting low, medium, and high levels of Therapist Prognostic Expectancy. In this inspection the medium level of Therapist Expectancy was predicted to be significantly higher. However, the absence of a significant Patient x Therapist Interaction Effect ($F = 0.96$, $df = 9/116$, $p = NS$) in the overall analysis of variance (see Table 5a) indicated that the predicted curvilinear relationship was not present. An inspection of the 3 group means (see Table 8a) suggests that once again a linear relationship exists.

Duncan's Multiple Range Test confirmed this by designating significant mean differences between all of the group means (see Table 8b).

Patient-Therapist Congruence of Prognostic Expectations and Outcome

Hypothesis 3 predicted a significant difference in outcome between those P-T dyads that gave highly congruent prognostic expectations for the patients' target symptoms and those dyads that showed low agreement in their prognostic expectancies. Since each P and his T gave prognostic expectancy ratings on 3 target problems, each dyad contributed 3 congruence scores (congruence being operationally defined as the difference between T and P ratings) to the data pool. These 132 congruence scores were rank-ordered and divided into 2 nearly equal groups. The high congruence group had T-P expectancy difference scores of ($\pm$ 0,1,2) while the low congruence group had difference scores of ($\pm$ 3,4,5,6,7,8). Table 9a presents the analysis of variance comparing high and low congruent dyads and showed that a significant difference was not present ($F = 0.027$, $df = 1/130$, $P = NS$). Inspecting the outcome means for these 2 groups in Table 9b shows them to be almost identical. On inspection of the data a clinical inference was made that those P-T dyads which started therapy in close expectational agreement about what outcomes they would reach in therapy would logically be the dyads most likely to fulfill those expectations. Therefore a second set of analyses was done with these high and low

expectancy congruence groups to correlate their average pretherapy expectations with their final outcome #4 scores. As might be expected, High Expectancy Congruence dyads evidenced a Pearson Product-Moment correlation of $r = +.616$ between their prognostic expectancies and resultant outcome, while Low Expectancy Congruence dyads evidenced a correlation of $r = +.318$. A test for difference between dependent correlations signified the High Congruence dyads as significantly ($z = 3.15$, $p<.05$) better predictors of outcome than Low Congruence dyads.

Role Expectations and Outcome

Hypothesis 4 predicted a significant positive relationship between the level of a P's Self-Reliance score and his therapeutic outcome score. It should be noted that the Ps' scores on the Self-Reliance scale were skewed toward the high level of self-reliance and were all bunched between the scores of 7 and 12 ($\bar{x} = 9.4$). Since each P only had 1 Self-Reliance score (in contrast to his 3 target symptom expectancy and outcome scores) it was proposed that 3 separate analyses be done correlating the P's Self-Reliance score with each of his 3 target symptom Outcome #4 scores. An additional correlation which pooled all the Outcome #4 scores for all 3 symptoms was also calculated. Table 10a presents these correlation coefficients and shows that the predicted positive linear relationship was not confirmed. Rather the data for all symptoms consistently evidence

low negative correlations. Table 10b designates that none of these correlations differ significantly from zero which signifies the lack of any relationship between Patient Self-Reliance scores and Outcome #4 scores. Similarly it was found that Ps' Therapist-Directiveness Scores also correlated insignificantly ($r = +.154$) with outcome.

Patient-Therapist Congruence of Role Expectations and Outcome

Hypothesis 5 predicted a significant relationship between the level of Patient-Therapist Congruence of their Patient Self-Reliance scores with respective therapeutic Outcome #4 scores. To test this hypothesis T-P Self-Reliance congruence scores (operationally defined as the difference between the T's ideal Patient Self-Reliance score and his P's Self-Reliance score) were rank ordered and divided into the 3 best fitting, nearly equal groups--High Congruence (T-P difference range of 0,1,2,3), Medium Congruence (T-P difference range of 4,5) and Low Congruence (T-P difference range of 6,7,8,9). Due to the fact that there was virtually no variability between the 6 Ts' ideal patient self-reliance ratings (Ts' scores ranged from 13 to 15, with all Ts preferring high levels of Patient Self-Reliance), there was only one instance of a P rating himself higher than his T's ideal. Thus what the Therapist-Patient Congruence scores mean in most instances is nothing more than the level of the Ps' perceived Self-Reliance score. Table 11a presents the analysis of variance which shows a significant difference ($F = 5.00$, $df = 2/129$,

$p<.01$) in outcome scores between the 3 levels of Patient-Therapist Congruence of Self-Reliance. Inspection of the means(see Table 11b) of these 3 groups indicates that the predicted positive linear relation between Self-Reliance Congruence and Outcome was not supported since medium level of congruence showed higher outcome scores than high congruence, which suggests a curvilinear relationship. Duncan's Multiple Range Test (see Table 11c) verifies this curvilinearity by showing significant differences ($p<.001$) between all 3 means.

. Similarly, Hypothesis 6 predicted a positive linear relationship between the level of Patient-Therapist Congruence of Therapist-Directiveness scores with their respective therapeutic outcome scores. Once again Patient-Therapist Congruence of Therapist-Directiveness scores was operationally defined as the difference between the T's score and his P's score on the Therapist-Directiveness scale (D scale). In this instance, Ts' D Scale ratings showed sufficient variance (range of 5-12) to permit a meaningful analysis of P-T congruence. The congruence scores were rank ordered and on the basis of the scatter plot were divided into the most meaningful comparison groups--High Congruent (P-T difference scores of $\pm$ 0,1,2) and Low Congruent (P-T difference scores of $\pm$ 3,4,5,6,7,8). The analysis of variance (see Table 12a) between these two groups yielded a significant Between Groups Effect ($F = 16.34$, $df = 1/130$, $p<.001$). Inspection of the means (see Table 12b) supported the predicted positive linear relationship between level of Congruence of Therapist Directiveness scores and outcome. Duncan's Multiple Range Test (see

Table 12c) verified Hypothesis 6 by designating that all the means differed significantly ($p<.001$) from each other in a positive linear fashion.

A Comparison of Patients' Distress Level with Expectancy and Outcome Scores

A Distress Level score was obtained after the first therapy session from each P and his T for each of the 3 target symptoms, which asked for their ratings of how much that symptom was bothering the patient at that time. For each target symptom the P and his T's average rating of Patient Distress Level were calculated. A Pearson Product-Moment Correlation compared Average Distress Level scores for each target symptom with the Average Patient-Therapist Expectancy score for that symptom (see Table 13a). Distress Level and Expectancy Level were found to relate in a positive fashion ($r = +.506$, $p<.001$). A second Pearson Product-Moment correlation was computed between Average Distress Level scores and resultant Outcome #4 scores. This relationship was found to be of a highly significant positive nature ($r = +.811$, $p<.001$) which confirmed exploratory hypothesis 2. In fact, Average Distress Level was found to be a better predictive measure of Outcome #4 than any other scale reported in this study. To examine these relationships further, the Average Distress Level scores were rank-ordered and divided into 2 nearly equal groups. Low Distress scores ranged from 0 to 7 and High Distress scores ranged from 7.5 to 10. Table 13b presents a

comparison between High and Low Distress groups for their mean Expectancy levels. Duncan's Multiple Range Test (see Table 13c) designated that the mean Expectancy of the Low Distress group ($\bar{x}$ = 7.11) was significantly ($p<.001$) lower than the mean Expectancy ($\bar{x}$ = 13.62) for the High Distress Group. Similarly the mean Outcome #4 scores for the High and Low Distress Groups were calculated and are presented in Table 13b. Duncan's Multiple Range Test (see Table 13d) indicated that the Low Distress Group's mean Outcome #4 score ($\bar{x}$ = 6.75) was significantly ($p<.001$) different from the High Distress Group's mean Outcome #4 score ($\bar{x}$ = 13.61). These findings indicate a clearly significant positive linear relationship between how high a P and his T rate the Patient's Distress Level on a particular target symptom and how high they rate their Expectancy for improvement of that symptom and also how high they will finally rate that symptom as improved after therapy.

Table 1

Means and Standard Deviations of Patient and Therapist Prognostic Expectancy and Outcome Measures

Therapist	Number of Patients	Number of Target Symptoms	Patient Expectancy	Therapist Expectancy	Average Patient-Therapist Expectancy	Global Outcome Rating #3	Patient Outcome Rating #1	Therapist Outcome Rating #2	Average Patient-Outcome #4
Therapist #1	8	24							
Mean			8.25	8.08	8.16	7.28	7.37	7.29	7.33
S.D.			2.75	2.34	2.84	1.73	2.90	2.14	2.14
Therapist #2	8	24							
Mean			11.17	10.17	10.67	10.86	10.75	10.83	10.79
S.D.			1.95	2.42	2.63	1.00	2.91	2.07	1.84
Therapist #3	7	21							
Mean			11.43	9.43	10.45	10.47	10.38	10.19	10.29
S.D.			2.46	3.63	3.23	2.29	1.24	2.32	2.64
Therapist #4	8	24							
Mean			10.75	10.13	10.44	9.83	10.83	10.29	10.56
S.D.			3.44	1.67	3.12	2.09	1.49	2.36	2.84

Table 1 (continued)

Therapist	Number of Patients	Number of Target Symptoms	Patient Expectancy	Therapist Expectancy	Average Patient-Therapist Expectancy	Global Outcome Rating #3	Patient Outcome Rating #1	Therapist Outcome Rating #2	Average Patient-Outcome #4
Therapist #5	7	21							
Mean			11.38	8.62	10.00	9.49	10.52	10.10	10.31
S.D.			2.52	2.33	2.42	1.51	1.62	1.22	1.66
Therapist #6	6	18							
Mean			10.39	9.00	9.70	9.25	9.22	9.22	9.22
S.D.			2.48	2.35	2.61	2.19	2.34	3.27	2.82
Total Sample	44	132							
Mean			10.53	9.27	9.90	9.52	9.80	9.62	9.71
S.D.			2.78	2.58	2.83	2.06	3.49	2.62	2.64

Table 2a

Analysis of Variance of Pre-Therapy and Post-Therapy Change in Patients' Global Outcome Ratings on the Modified-Mooney Problem Check List

Source	DF	SS	MS	F	P
Total	87	62,784.08			
Between Groups	1	5,584.12	5,584.12	8.40	.005
Within Groups	86	57,199.96	665.12		

Table 2b

Means and Standard Deviations of Pre-Therapy and Post-Therapy Patients' Global Ratings on the Modified Mooney Problem Check List

	Pretherapy	Post-Therapy
Mean	120.32	104.39
S.D.	25.64	25.93
n	44	44

Table 3a

Analysis of Variance of Outcome #4 Scores
Between Target Symptoms #1, #2, and #3

Source	DF	MS	SS	F	P
Between Groups	2	6.33	3.17	0.459	NS
Within Groups	129	890.80	6.91		

Table 3b

Means and Standard Deviations for Outcome #4
Scores for Symptoms #1, #2, and #3

	Sympton #1	Symptom #2	Symptom #3
Mean	10.00	9.69	9.47
S.D.	2.65	2.64	2.59
n	44	44	44

Table 4a

Pearson Product-Moment Correlations Between Patient and Therapist Prognostic Expectancy Scores and Outcome S ores

	Combined Outcome #4	Patient Outcome #1	Therapist Outcome #2
Patient Expectancy	+ .494*	+ .533*	+ .308*
Therapist Expectancy	+ .406*	+ .303*	+ .401*
Average Patient-Therapist Expectancy	+ .521*		

*significant at .05

Table 4b

Tests for Significant Differences Between Different Dependent Correlations of Prognostic Expectancy with Outcome #4

r			r	n	z	p
Patient Expectancy	(.494) vs.	Therapist Expectancy	(.406)	132	0.90	NS
Patient Expectancy	(.494) vs.	Average Patient-Therapist Expectancy	(.521)	132	0.26	NS
Therapist Expectancy	(.406) vs.	Average Patient-Therapist Expectancy	(.521)	132	1.16	NS

Table 4c

Tests for Significant Difference Between
Different Dependent Correlations of
Prognostic Expectancy with Outcomes #1, #2, and #3

r			r	n	z	p
Patient Expectancy and Outcome #4 (.494)	vs.	Patient Expectancy and Outcome #1	(.533)	132	0.40	NS
"	vs.	Patient Expectancy and Outcome #2	(.308)	132	1.04	NS
"	vs.	Therapist Expectancy & Outcome #1	(.303)	132	1.01	NS
"	vs.	Therapist Expectancy & Outcome #2	(.401)	132	0.93	NS
"						
Therapist Expectancy and Outcome #4 (.406)	vs.	Patient Expectancy and Outcome #1	(.533)	132	1.32	NS
	vs.	Patient Expectancy and Outcome #2	(.308)	132	0.93	NS
"	vs.	Therapist Expectancy & Outcome #1	(.303)	132	0.90	NS
"	vs.	Therapist Expectancy & Outcome #2	(.401)	132	0.04	NS

Table 5a

4x4 Analysis of Variance Using the Method of Unweighted Means to Compare Outcome #4 Scores Between Levels of Patient and Therapist Prognostic Expectancy Scores

Source	df	SS	MS	F	P
Patient Expectancy	3	25.87	8.63	17.26	.001
Therapist Expectancy	3	12.60	4.20	8.40	.001
Patient & Therapist Interaction	9	4.22	.47	0.94	NS
Within Groups	116	57.45	.50		

Table 5b

Means and Standard Deviations of Outcome #4 Scores Between Levels of Patient and Therapist Prognostic Expectancy

Expectancy Levels	Low Therapist	Medium-Low Therapist	Medium-High Therapist	High Therapist	Total
Low Patient					
Mean	6.72	7.19	9.44	9.50	8.08
S.D.	1.77	1.83	2.35	1.79	2.12
n	9	8	8	6	31
Medium-Low Patient					
Mean	7.09	9.14	9.36	10.50	8.80
S.D.	2.14	2.89	2.25	2.26	2.58
n	11	7	11	6	35
Medium-High Patient					
Mean	8.95	10.70	11.36	11.10	10.49
S.D.	2.44	1.60	2.42	1.47	2.27
n	11	5	11	10	32
High Patient					
Mean	11.25	10.92	12.11	11.63	11.55
S.D.	2.04	1.85	2.60	1.25	1.99
n	6	6	9	8	29
Total					
Mean	8.23	9.25	10.58	10.90	
S.D.	2.62	2.55	1.93	1.79	
n	37	26	39	30	132

Table 6a

Duncan's Multiple Range Test for Nearly Equal n's Comparing Outcome #4 Means Between 4 Levels of Patient Prognostic Expectancy

Patient Expectancy Levels	Means	(1) Patient Low 8.08	(2) Patient Medium-Low 8.80	(3) Patient Medium-High 10.49	(4) Patient High 11.55	(5) Shortest Significant Ranges
Patient Low	8.08		.72*	2.41*	3.47*	R_2 = .334
Patient Medium Low	8.80			1.69*	2.75*	R_3 = .338
Patient Medium High	10.49				1.06*	R_4 = .352
Patient High	11.55					

*p<.001

Table 6b

Duncan's Multiple Range Test for Nearly Equal n's Comparing Outcome #4 Measures Between 4 Levels of Therapist Expectancy

Therapist Expectancy Levels	Means	(1) Therapist Low 8.23	(2) Therapist Medium Low 9.25	(3) Therapist Medium High 10.58	(4) Therapist High 10.80	(5) Shortest Significant Ranges
Therapist Low	8.23		1.02*	2.35*	2.57*	R_2 = .358
Therapist Medium L	9.25			1.33*	1.55*	R_3 = .369
Therapist Med-H	10.58				.22**	R_4 = .377
Therapist High	10.80					

* p<,001 **p<.05, R_4 = .208

Table 7a

Analysis of Variance Using the Method of Unweighted Means to Compare Outcome #4 Scores Between 3 Levels of Patient Prognostic Expectancy

Source	df	SS	MS	F	P
Between Groups	2	3.13	1.04	6.93	.005
Within Groups	129	19.36	.15		

Table 7b

Means and Standard Deviations of Outcome #4 Scores Between 3 Levels of Patient Prognostic Expectancy

Patient Prognostic Expectancy Level	Low	Medium	High
Mean	8.08	9.67	11.55
S.D.	2.26	2.52	1.95
n	31	72	29

Table 7c

Duncan's Multiple Range Test for Nearly Equal n's Comparing Outcome #4 Means Between 3 Levels of Patient Prognostic Expectancy

Patient Prognostic Expectancy Level	(1) Low	(2) Med	(3) High	(4) Shortest Significant Ranges
Means	8.08	9.67	11.55	
P. Low	8.08	1.59*	2.47*	R_2 = .301
P. Med	9.67		.88*	R_3 = .312
P. High	11.55			

* $p<.001$

Table 8a

Means and Standard Deviations of Outcome #4 Scores Between the 3 Levels of Medium Patient Prognostic Expectancy

		Low Therapist Prognostic Expectancy	Medium Therapist Prognostic Expectancy	High Therapist Prognostic Expectancy
Medium Patient Prognostic Expectancy	Mean	8.02	10.16	10.88
	S.D.	2.44	2.47	1.75
	n	22	34	16

Table 8b

Duncan's Multiple Range Test for Nearly Equal n's Comparing Outcome #4 Means Between 3 Levels of Medium Patient Prognostic Expectancy

P-T Prognostic Expectancy Level	Means	(1) P Medium-T Low 8.02	(2) P Medium-T Medium 10.16	(3) P Medium-T.High 10.88	(4) Shortest Significant Ranges
P-Medium-T-Low	8.02.		2.14*	2.88*	.501
P-Medium-T-Medium	10.16			.72*	.517
P-Medium-T-High	10.88				

*p<.001

Table 9a

Analysis of Variance with the Method of Unweighted Means Comparing Outcome #4 Scores Between Patient and Therapist Dyads with High vs Low Congruence of Prognostic Expectancy

Source		SS	MS	F	P
Between Groups	1	.0025	.0025	0.027	NS
Within Groups	130	11.99	.092		

Table 9b

Means and Standard Deviations of Outcome #4 Scores Between 2 Levels of Patient-Therapist Dyad Congruence of Prognostic Expectation

	Low Congruence P-T Dyads	High Congruence P-T Dyads
Mean	9.72	9.79
S.D.	2.33	2.62
n	65	67

Table 10a

Pearson Product-Moment Correlation Coefficients of Patient Self-Reliance Scores and Outcome #4 Scores for Symptoms #1, #2, #3 and #1, #2, #3 Pooled

	n	Correlation of Self-Reliance and Outcome Scores
Symptom #1	44	- .096
#2	44	- .142
#3	44	- .130
Pooled Symptoms 1, 2, 3	132	- .122

Table 10b

Test for Significant Differences Between Dependent Correlations of Patient Self-Reliance with Outcome #4 Scores Compared with Zero Correlation

	r		r	n	z	
Symptom #1	(-.096)	vs	(.000)	44	.43	NS
#2	(-.142)	vs	(.000)	44	.64	NS
#3	(-.130)	vs	(.000)	44	.59	NS
Pooled Symptoms 1,2,3	(-.122)	vs	(.000)	132	.94	NS

Table 11a

Analysis of Variance Using Method of Unweighted Means Comparing Outcome #4 Scores Between 3 Levels of Patient-Therapist Congruence of Self-Reliance Scores

SV	df	SS	MS	F	P
Between Groups	2	.90	.45	5.00	.01
Within Groups	129	11.68	.09		

Table 11b

Means and Standard Deviations of Outcome #4 Scores Between 3 Levels of Patient-Therapist Congruence of Self-Reliance Scores

	High Congruence	Medium Congruence	Low Congruence
Mean	8.92	10.22	9.85
S.D.	2.42	2.63	3.08
n	42	57	33

Table 11c

Duncan's Multiple Range Test for Nearly Equal n's Comparing Outcome #4 Means Between 3 Levels of Patient-Therapist Congruence of Self-Reliance Scores

Level of P-T Congruence		(1) High	(2) Low	(3) Medium	(4) Shortest Significant Ranges
	Means	8.92	9.85	10.22	
High	8.92		.93*	1.30*	R_1 = .095
Low	9.85			.37*	R_2 = .098
Medium	10.22				

*p<.01

Table 12a

Analysis of Variance Comparing Outcome #4 Scores Between 2 Levels of Patient-Therapist Congruence of Therapist-Directiveness Scores

Source	df	SS	MS	F	P
Total	131	897.12			
Between Groups	1	100.19	100.19	16.34	.001
Within Groups	130	796.93	6.13		

Table 12b

Means and Standard Deviations of Outcome #4 Scores Between 2 Levels of Patient-Therapist Congruence of Therapist-Directiveness Scores

	Low Congruence	High Congruence
Mean	8.85	10.59
S.D.	2.60	2.34
n	66	66

Table 12c

Duncan's Multiple Range Test for Nearly Equal n's Comparing Outcome #4 Means Between 2 Levels of Patient-Therapist Congruence of Therapist-Directiveness Scores

Level of P-T Congruence	Means	(1) Low 8.85	(2) High 10.59	(3) Shortest Significant Ranges
Low	8.85		1.74*	$R_1 = 1.46$
High	10.59			

*p<.001

Table 13a

Pearson Product-Moment Correlation Coefficients
Between Average Patient-Therapist Distress Level
with Average Patient-Therapist Expectancy and
with Outcome #4

	Average P-T Distress Level	
Average P-T Expectancy	r = + .506	p<.001
Outcome #4	r = + .811	p<.001

Table 13b

Means and Standard Deviations
For Average Patient-Therapist Expectancy Levels
and Outcome #4 Levels Between High and Low Distress Groups

	Av. P-T Expectancy			Outcome #4		
	Mean	S.D.	n	Mean	S.D.	n
Low Distress	7.11	7.98	75	6.75	2.31	75
High Distress	13.62	2.72	57	13.61	3.14	57

Table 13c

Duncan's Multiple Range Test for Nearly Equal n's Comparing Average Patient-Therapist Expecting Means Between High and Low Distress Groups

	Means	(1) Low Distress	(2) High Distress	(3) Shortest Significant Ranges
Low Distress	7.11		6.51*	$R_1 = 1.31$
High Distress	13.62			

*p<.001

Table 13d

Duncan's Multiple Range Test for Nearly Equal n's Comparing Outcome #4 Means Between High and Low Distress Groups

	Means	(1) Low Distress 6.75	(2) High Distress 13.61	(3) Shortest Significant Ranges
Low Distress	6.75		6.86*	$R_1 = 1.33$
High Distress				

*p<.001

DISCUSSION

The purpose of this study was to investigate how the prognostic and role expectations held by both a patient and his therapist related to the outcome of their therapy. Past research reported contradictory findings on these topics. Much of this discrepancy, it was hypothesized, was due to the different experimental designs these studies used, the heterogeneous patient and therapist samples studied, and the various experimental measures administered. This study attempted to integrate some of these findings by improving on the statistical design, using more homogeneous and reliable patient and therapist samples, and by employing more sophisticated measures of expectations and outcome.

Prognostic Expectations and Outcome

The results of this study provide a description of the prognostic expectations that patients and their therapists hold about short-term therapy in a college mental health service. These results indicate that college patients initially enter therapy with significantly higher expectations for symptom reduction than those held by their therapists. These patient-therapist dyads started out with no significant level of agreement in their initial prognostic expectancies concerning the improvement of the patient's three target complaints. However, by the end of therapy (on the average about 6 sessions later) the outcome ratings of these 3 symptoms did show a

significant level of patient-therapist agreement. The findings of this study indicate that while patients' final outcome ratings were lower than their initial expectancy ratings, the therapists' outcome ratings were higher than their initial expectancy ratings, which resulted in closer agreement of patients and their therapists on outcome ratings. This process of patient-therapist convergence adds support to those studies which claim that convergence is an essential ingredient of the therapeutic process (Gliedman et. al., 1957; Appel, 1960; Lennard and Bernstein, 1960; Pepinsky and Karst, 1964; and Welkowitz et. al., 1967).

The results of this study also indicate that level of outcome is significantly related to both level of patient expectancy and level of therapist expectancy. This agrees with the early expectational research in the area of social learning theory (Rotter, 1954; Kelly, 1955; Allport, 1955). Looking more closely at patient and therapist expectations as predictors of outcome, it was found that patient expectations were slightly better predictors than therapist expectations. However, a slightly better predictor than both of these was found to be the average patient-therapist expectation scores. But this may have been due to the fact that the outcome scores used here were also average scores of patient-therapist outcome ratings. Nevertheless, while all three expectational predictors related significantly to outcome, none of them was a significantly more powerful predictor than any of the others. These findings are in accord with reports that have

concluded that the amount of therapeutic improvement is significantly influenced by the therapist's expectations (Frank, 1959; Phillips and Johnson, 1954; and Small, 1971). They are also consistent with the conclusions reached in the extensive psychotherapy review by Luborsky et. al. (1971) which concluded that patient predictors are more commonly found to relate to outcome than therapist predictors, but a combination of the expectancies of both offers an even superior predictor. One study by Goldstein (1960a) found opposing results, that therapists' expectations had a more powerful influence on outcome than did either patients' or average patient-therapists' expectations. A plausible explanation for the superiority of therapists' predictions in Goldstein's study was that he used standard expectational statements which his therapists and patients rated by the Q-sort technique, which therapists may have become skilled at rating after a few patients. The present study on the other hand, used patients' own descriptions of their problems for the expectational measures, which might have given them a predictive edge over the therapist who was only briefly acquainted with these problems during the first session.

The central focus of this study was on the specific nature of this relationship between prognostic expectations and resultant outcome. This study found there to be a highly significant positive linear relation between outcome and both patient and therapist expectations. This confirms the results of Lipkin (1954), Friedman (1963), and Uhlenhuth and Duncan (1968). However, the findings

of such a linear relationship are descrepant with those of Chance (1960) and Goldstein and Shipman (1961) who reported finding a curvilinear relationship. Other studies also in opposition to this finding of linearity include those by Brady et. al. (1960) and Goldstein (1959 and 1960a) which reported the absence of any significant relationship between patient expectations and outcome. As suggested earlier, much of the disagreement between the results of these studies and the present one may be a function of the various designs used. Some of the more crucial differences between these studies and the present one include their testing of predominantly lower socio-economic class, city hospital patients with wide variations in presenting symptomotology. These studies also used medical student therapists. The statistical designs varied between studies, but such questionable measures were used as single score global expectancy ratings, Q-sort expectancy ratings, therapists' global outcome ratings and duration of therapy outcome ratings. The major study by Goldstein and Shipman (1961), which produced the only clear-cut quantative data supporting a curvilinear relationship between patient prognostic expectancy and outcome, refers to the difference of measures taken on patients before and after only one session of therapy. In response to these studies the present study was more tightly designed, testing only college students with relatively homogeneous symptomotology who ranged over all socio-economic classes. Therapists were all highly experienced. Furthermore, this study collected data at crucial process points

before, during, and after therapy. Expectation and outcome ratings were based on patients' specifically relevant target complaints. Thus it is conceivable that under different circumstances, such as those tested in some of these studies just discussed, patient prognostic expectancy may show different relationships to outcome. Under the conditions of this study which are similar to those investigated by Friedman (1963) and Uhlenhuth and Duncan (1968), patient prognostic expectancies were found to offer direct predictions, in a positive linear fashion, of resultant outcome scores.

Another area this study examined was how levels of patient-therapist congruence of prognostic expectations related to outcome. A close look was paid to those patients with medium expectations to see if better outcomes would result if they had therapists who also had medium (congruent) expectations in contrast to having a therapist with high or low (incongruent) expectations. The results revealed no such interaction effect, but once again reflected the strong linear relationships between outcome and both patient and therapist expectations. Thus it was found that medium expectation patients with medium expectation therapists have higher outcome scores than those medium expectation patients with low expectation therapists, but not as high outcome scores as medium expectation patients with high expectation therapists indicating that expectational congruence was not a significant factor in outcome. Similar results were obtained when this analysis was extended to patient-therapist dyads of all levels. What this suggests is that

the most therapeutically promising expectations to get from either a patient or his therapist are not those of medium level, nor those that are congruent. Rather the best expectations for a patient or his therapist were found to be the high ones - the higher the better. Those with low prognostic expectations were found to have little or no success with short-term psychotherapy.

Although patient-therapist congruence of prognostic expectations were not found to relate to outcome, there was some value in these ratings. Namely, high congruence dyads were very accurate predictors of their resultant outcome, and were significantly better predictors than those low congruence dyads. What this tells us is that those patient-therapist dyads that agreed at the start of therapy on what would happen (for better or for worse) usually found out at the end that they were right.

Role Expectations and Outcome

The secondary focus of this study was to examine how patients' role expectations, by themselves and in congruence with their therapists' role expectations, related to therapeutic outcome. The results indicate that by themselves, neither patients' therapist-directiveness scores nor patients' self-reliance scores were significantly related to success in therapy. The lone study on therapist-directiveness scores by Begley and Lieberman (1970), who reformulated the scale for patient use, similarly found no significant relation to outcome measures. Turning to the literature on the self-reliance scale, which was of more interest to this

study, only Apfelbaum (1958) found a lack of results similar to the present study. Significant relations between self-reliance scores and outcome were reported by Szasz and Hollander (1956), Heine and Trosman (1960), Overall and Aronson (1960), and Clemes and D'Andrea (1965). It should be noted that these studies used a different form of administration of the scale than was used in this study, obtaining only 3 scores rather than 15. But perhaps a more important reason for the descrepancy between the results of these studies and the present one is found in the applicability of the items of this self-reliance scale to college students. This scale was devised to test lower educational and socio-economic class hospital patients which was the sample dealt with in those studies reporting significant findings.

In reporting their significant findings Clemes and D'Andrea (1965) also reported the finding that a patient's educational level was directly related to his level of self-reliance. They also found that inpatients had lower self-reliance expectations than outpatients. The present study dealt with a highly educated level of college outpatients and found, as Clemes and D'Andrea (1965) did, that college patients' scores tended to cluster at the high levels of the self-reliance continuum. This lack of a more sufficient range of self-reliance scores may have accounted for this study's insignificant findings. A second criticism to be voiced is in regards to the composition of the self-reliance scale itself. The items were formulated for lower educational populations

and are poorly suited for college students. Most items are written in an overly simplistic language and are highly medical in orientation, which might have made these items appear inappropriate or condescending to some college students (almost all of whom had been acquainted with therapy in psychology courses). It is recommended that a more sophisticated scale be used to measure self-reliant expectations in future studies with college-level outpatients.

Further complications were encountered in testing the hypothesis that level of patient-therapist congruence of self-reliance expectations would relate in a positive linear manner to outcome. Such findings had been attested to by the voluminous research indicating that patient-therapist value and personality congruence related to outcome (see summaries by Kessel and McBreaty, 1967 and Schillinger, 1970). This study failed to find such a positive linear relationship. However, it appears that this was a function of the low level of variance in the patients' self-reliance scores and also of obtaining practically no variance at all in the therapists' ratings of their "ideal patient". This similarity among therapists in their role expectations for their ideal patient (all therapists expected him to be highly self-reliant) supports Heine and Trosman's (1960) assumption that therapists have homogeneous expectations for patients. However, any generalization should be cautioned in that the therapists of the mental health service used in this study are probably not representative of all therapists, and

are perhaps unusually homogeneous with respect to their specialized method of treating college students. Since variance is especially crucial to difference ratings such as congruence, the validity of these findings is questionable.

With this caution in mind, what the self-reliance ratings did show was that patient-therapist congruence of self-reliance did relate to outcome in a significantly positive curvilinear fashion. Although such a finding is statistically suspect, it does have a good deal of confirmation in the literature. Cook's (1966) study of short-term therapy similarly reported that medium levels of patient-therapist value similarity resulted in the most positive change. Further support is found in reports by Strupp and Bergin (1967) and Clemes and D'Andrea (1965) who wrote that "too close a match between patient and therapist expectations would lead to little if any behavior change other than perhaps reinforcement of the expectation" (p. 404). Inspecting the literature on this topic a plausible explanation can be advanced for medium levels of congruence resulting in highest improvement. Appel (1960) reported that those patients whose expectations differed most from their therapists changed more in their expectations than did those whose expectations were close to their therapists' ideal. On the other hand, the present study and those of Freedman et. al. (1950), Heine and Trosman (1960) and Clemes and D'Andrea (1965) have indicated that too great a disagreement between a patient and therapist can lead to premature termination or low levels of outcome. Integrating

these findings suggests that perhaps an optimal level of discrepancy of patient and therapist self-reliance expectations is most conducive to behavior change - a level of moderate difference at which the patient remains in therapy, but which offers sufficient discrepancy so that the patient and therapist have to deal with the difference.

The sources of complication which beset the ratings of self-reliance did not appear in the therapist-directiveness ratings. Adequate variances of both patient and therapist expectational ratings were obtained, perhaps because in this case the shoe was on the other foot, with patients rating how they expected their therapists to work. As found in the studies of Welkowitz et. al.(1967) and Goldmein and Mendelsohn (1969) this study also reports that when therapists rated their own therapeutic values and techniques they differ significantly between themselves. Such variability made these measures of patient-therapist congruence meaningful and the results confirmed the presence of the hypothesized positive linear relationship between level of patient-therapist congruence of therapist-directiveness scores and level of resultant outcome. This finding confirms with the results of studies by Gliedman et. al. (1957), Hankoff et. al. (1960), Goin et. al. (1965), and Levitt (1966).

The role expectation findings of this study indicate that when taken alone, the patients' ratings of their own self-reliance and their therapists' directiveness did not show any relation to

therapeutic success. However when patient role expectations were combined with those of their therapist in the form of congruence scores, they were found to relate positively to therapeutic success. This suggests the relevance of congruence scores for future research on role expectations.

Patient Distress Level

On the inviestigation of an exploratory hypothesis dealing with distress level scores, some highly significant results were found. What was revealed was that the average ratings of a patient and his therapist concerning the patient's distress level on each of his three target symptoms not only correlated significantly ($r = +.506$) with their average expectational ratings for those symptoms, but also correlated even more significantly ($r = +.811$) with their average outcome ratings on those symptoms. Findings of a similar nature have been reported by Jacobs et. al. (1967) who report good progress for high distress patients, and by Frank (1968) whose placebo studies indicated that the degree of patient improvement with placebos was positively correlated with the initial intensity of patient distress. The most significant finding was reported in a study by Strupp (1960) who found initial distress to correlate $r = +.60$ with outcome.

In view of the fact that the correlations obtained in this study were higher than those reported elsewhere in the literature, it was decided to investigate the distress level data more thoroughly. The 132 target symptoms rated by the 44 patient-therapist

dyads were divided into 2 groups consisting of those target symptoms with low average distress ratings and those target symptoms with high average distress ratings. What this revealed was that those symptoms that therapists and patients rated as being of low distress were also given ratings by them of very low prognostic expectancies. In fact, these low distress symptoms were given expectational ratings whose mean fell near the bottom of the scale which read "It will be the same". In other words they were given virtually no expectation for change. In contrast to this the patient-therapist dyads viewed those high distress target symptoms with very high expectations, whose mean was near the top of the expectation rating scale which read "It will be much better". Perhaps the high similarity here between level of distress and level of expectation for a particular symptom was influenced somewhat by a set effect, in that the expectancy scale was rated immediately after the distress scale on the questionnaires. Nevertheless, it can be hypothesized that these ratings, which were taken after the first session, were both influenced in a similar fashion by the nature of the patient-therapist interaction in that session. Burdon (1963) and Baum and Felzer (1964) have both stressed the importance of the initial session in influencing both the patient's and the therapist's hope, or lack of hope, for success in working together on particular problems. If the patient appears genuinely distressed by a particular symptom and is motivated to change, and the therapist is empathic to that problem and offers some hope for therapeutic

change, then both parties would probably finish the session with high expectations. On the other hand, if this same patient has a second symptom of a lower distress level, or if all of a patient's symptoms are of low distress levels, then these problems are likely to be viewed by the therapist as less critical and less in need of intensive treatment. If such a low distress symptom is seen by the therapist as characterological and long-standing in nature he may even view it as inappropriate for short-term therapy. In either case such an initial interaction might leave both patient and therapist with low prognostic expectations for working on those target symptoms.

The results of this study further indicate that the final outcome ratings on these low distress symptoms were as low as the patient and therapist's expectations had predicted. In other words, the low distress target complaints were given a mean rating that showed them as having stayed the same over therapy. The high distress target complaints also lived up to the high expectations the patient-therapist dyads had given them and were rated such that their mean rating indicated that they had gotten much better. In the case of these high distress target complaints it should be noted that their high improvement rate may have partly been an artifact of these problems having more room to improve than those which were not bothering the patient very highly to begin with.

Nevertheless, what the results of this study suggest is that

short-term therapy works best with problems that are highly distressing to the college patient and furthermore that these problems appear to be sufficiently relieved by such an approach. Those problems of low distress to patients appear to have poor prognoses and were not found to have been altered to any significant degree by the short-term therapy given them.

A Critical Evaluation of the Results

The results of this study were obtained under sufficient controls so that their generalization is questionable beyond the parameters of the short-term therapy approach with a homogeneous and sophisticated sample of college patients as conducted by highly experienced therapists. Speaking of controls, one possible criticism of the design of this study is the lack of a control group. The decision to use each patient as his own control was necessitated by the policies of the university mental health service which could not allow students to be put on a waiting list. Recent studies, however, by Roth et. al. (1964) and Uhlenhuth and Duncan (1968) have reported that such long waits before therapy are negatively related to outcome. This signifies that waiting list control groups have a negative impact on future psychotherapy and thus the waiting list experience cannot be accepted as a neutral, no-therapy period (Luborsky, 1971). One set of controls that was not instituted was to rule out the possibility that patients were obtaining concurrent aid other than psychotherapy that was effecting the patients' target symptoms. Perhaps including

a final scale on the patient's post-therapy questionnaire that would ask the patient to rate each target symptom on how much it was changed or hindered by influences outside of the therapy situation would provide some initial evidence on the extent of extraneous factors working with or against the therapists.

As has been stressed before, the statistical findings are to be viewed conservatively, in that several of the analyses pooled the 44 dyads' ratings of three target symptoms which violated the assumption of independence. Such a procedure might have increased the probability of alpha errors in some analyses. However, in most analyses the levels of significance were either very high or very low to assure that they were providing a reasonable description of the behavior that took place. A second statistical procedure that can be criticized is the use of patient-therapist average scores in calculating some of the expectancy, outcome, and distress level scores. Such a procedure may have biased certain findings, especially the correlational analyses, but the alternative of calculating separate patient and therapist analyses would have over-extended the depth and compexity for which this study was designed.

Several of the procedures instituted by this study deserve favorable evaluations. Perhaps the most valuable rating technique used was the target complaint approach to rating distress, expectations and outcome. Such a procedure allows for more relevance and flexibility of criteria. As has often been observed, a small

change in a crucial area may make a huge difference for a patient and the target symptom approach can easily incorporate such cases. Similarly the rating of both therapists and patients on all the measures throughout the therapy processnot only allowed for the consideration of important congruence measures but also offered a provocative look at the process of convergence that a therapeutic dyad goes through. It is felt that a more detailed and controlled investigation (perhaps adding a third rating of an unpartial judge) of this phenomena of therapeutic convergence is a fruitful area of study.

While this study had a tendency to over-extend itself, the prime purpose was the examination of the relationship between prognostic expectations and outcome. This purpose was fulfilled, but not in the predicted direction, by obtaining results that indicated a clearly positive linear relationship between prognostic expectations and outcome. In speculating about what factors of the psychotherapeutic process could produce such clear-cut results from such short-term therapeutic encounters (between 3 and 12 sessions), it would seem plausible that certain factors of suggestion or placebo effects may be at work. One of these might have been induced by the very administration of this study's lengthy questionnaires which have been shown by Friedman (1960) to engage the patients in the therapeutic process and to heighten expectations of help. Similarly more experienced and confident therapists, such as those rated in this study, tend to evoke higher

levels of patient prognostic expectancy (Goldstein, 1960b; Small, 1971). It is also suggested that these therapists may have capitalized upon their patients' positive expectations (when they were realistic) by expressing similar positive expectations for therapeutic change which has been shown to induce significantly higher outcomes than therapists who do not reinforce patient expectations for relief (Frank, 1968). The very policy of the clinic, which is given to each new patient, includes the expectational statement that all cases are treated in 12 sessions or less. Such time-limited expectations have been shown to produce comparable results to longer therapies in the time that was structured (Phillips and Johnson, 1954; Poscal and Zax, 1956; Frank, 1959; and Shlien, 1962). Considering such placebo effects is intriguing and calls for the use of follow-up measures to test the long-term efficacy of the symptom reductions that were perceived by the therapists and patients in this study.

These results present implications for future studies testing the most beneficial ways to engage in short-term therapy with college students. A procedure might be devised for rating patients' and therapists' expectations to produce optimal levels of expectational pairing. An alternative to this, which is being currently researched by the Johns Hopkins clinic, is the method of using role induction interviews to educate patients to have the most productive expectations. Finally, the results of this study suggest an investigation having several of the therapists

used in this study, under similar situations, concentrate heavily on patients with high distress and high expectations for change and give very little time to those patients with low distress and low expectations. The outcome scores of that experiment could be compared with those of the present study to see if such a procedure would be beneficial to both the clinic and to the patients.

SUMMARY

The prognostic and role expectations of 44 college outpatients and their therapists were rated by questionnaire scales administered before, during and after short-term therapy. The target symptom rating approach was used to obtain three target symptoms from each patient and these were the criteria referred to by the patients and therapists in their ratings of both prognostic and role expectations and of their perceptions of outcome.

It was predicted that prognostic expectancy would relate to outcome in a curvilinear fashion as previous studies had indicated. However the results demonstrated that both patients' and therapists' prognostic expectations related in a highly positive linear fashion with outcome. The hypothesized linear relationship between the levels of patients' self-reliance expectations and outcome was not found. The remaining hypotheses predicted that the congruence levels of patient-therapist dyads' prognostic expectations, patient self-reliance expectations, and therapist-directiveness expectations would all relate in a positive linear fashion to outcome. The results indicated that congruence of prognostic expectations showed no significant relationship to outcome while congruence of patient self-reliance expectations related in a positive curvilinear fashion to outcome and congruence of therapist-directiveness expectations related in the predicted positive linear fashion. An exploratory hypothesis that predicted patients' initial distress levels concerning their three target symptoms would relate in a

positive linear fashion to both prognostic expectancy levels and to outcome levels was also confirmed.

These findings suggest that using the target symptom approach in the rating of patient and therapist prognostic expectations and patient distress level provides several valuable predictors of therapeutic outcome. The implications of these results were discussed in terms of the factors involved in the short-term therapeutic process, with special attention being paid to possible placebo factors. The experimental paradigm developed for this study was proposed for a future investigation that would explore the efficacy of emphasizing the treatment of high distress, high expectation target symptoms and de-emphasizing the treatment of low distress, low expectancy target symptoms.

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Appendix 1

Therapist Pre-Therapy Questionnaire: Demographic, Self-Reliance Scale, and Therapist-Directiveness Scale

THERAPIST RESEARCH QUESTIONNAIRE

Name:
Age:
Religion:
Professional Degree:
Number of years experience beyond degree:
School or Theory of psychotherapy basically followed:

Please answer the following questionnaire as you would envision an "ideal patient" would answer it. Circle one answer (yes or no) for each question that best reflects the attitudes you would like an ideal patient (for you to work with) to have.

1. Please indicate your reasons for coming to the Mental Health Service. (Answer each question even if you have to guess)

Yes No a. I do not know the reason. I was just sent here.
Yes No b. I have some personal problems which I cannot handle on my own.
Yes No c. I have trouble controlling my feelings.
Yes No d. I have trouble with my nerves.
Yes No e. I have physical complaints which I believe are brought on by my nervousness.

2. What do you most want from the Mental Health Service?

Yes No a. Information as to what is wrong with me.
Yes No b. A chance to tell a doctor about my problems.
Yes No c. Medicine to make me feel less nervous.
Yes. No d. A chance to talk over my problems and get help on deciding what to do.
Yes No e. Get specific advice on how to go about solving my problems.
Yes No f. Help in changing myself so I won't have the same problems in the future.

3. How do you expect to get what you want from the Mental Health Clinic?

Yes No a. By doing what the doctor tells me to do about my problem.
Yes No b. By working with a doctor toward an understanding of my feelings toward myself and other people.
Yes No c. By answering whatever personal questions about myself the doctor asks.
Yes No d. Through the doctor's figuring out the right medical treatment and giving it to me.

The following statements describe some therapeutic techniques and therapist attitudes. Please put a circle around the answer you choose for each question as best characterizing your own particular approach to therapy. If you have mixed feelings on a question, please make a forced choice of the answer you feel more strongly about.

Agree	Disagree	1.	When a patient relates a dream in therapy, the therapist should try to help him understand its meaning.
Agree	Disagree	2.	It is necessary for patients to learn how early childhood experiences have left a mark on them.
Agree	Disagree	3.	Usually (with proper timing) a therapist should analyze the patient's resistance.
Agree	Disagree	4.	Understanding the reasons for one's behavior is essential for lasting change to occur.
Agree	Disagree	5.	A therapist should ask many of his patients to free associate.
Agree	Disagree	6.	A therapist should decide at one of the first sessions what the goals are for his patient.
Agree	Disagree	7.	A therapist avoids advising his patients about how they should cope with problems.
Agree	Disagree	8.	A therapist should suggest to the patient new ways of behaving to experiment with.
Agree	Disagree	9.	With most patients, it is important to lead the interview into fruitful areas of discussion.
Agree	Disagree	10.	A major aim of a therapist should be to improve the patient's adjustment to other people.
Agree	Disagree	11.	A treatment plan is not important for successful therapy.
Agree	Disagree	12.	The overall goals of therapy should be set by the patient only.
Agree	Disagree	13.	A therapist should interrupt the patient to make comments.
Agree	Disagree	14.	A therapist should deliberately vary his role according to the patient's problem.
Agree	Disagree	15.	A therapist will not express approval or disapproval of anything the patient tells him about himself.
Agree	Disagree	16.	Therapists should make an overal treatment plan for each case.
Agree	Disagree	17.	A therapist should take the lead in deciding what to talk about.
Agree	Disagree	18.	Whatever direction a patient chooses to move (short of murder, suicide, etc.) should be satisfactory to the therapist.

Agree Disagree 19. During most of the sessions, the therapist will listen and remain silent while the patient speaks.

Agree Disagree 20. A therapist will ask deep probing personal questions.

Agree Disagree 21. Effective psychotherapy can often be conducted without recourse to the concept "unconscious" determinents of behavior.

Agree Disagree 22. A good therapist "interprets" his patient's behavior--in the sense of telling him its real significance or meanings of which he is unaware.

Agree Disagree 23. It is important to interpret symptomatic behavior, such as slips of the tongue, mannerism of the patient, etc.

Agree Disagree 24. For a patient to improve his current way of life, he must come to understand his early childhood relationships.

Agree Disagree 25. An important part of therapy is the analysis of the transference reactions of the patient.

Appendix 2

Patient Pre-Therapy Questionnaire: Self-Reliance Scale, Therapist-Directiveness Scale, Modified Mooney Problem Check List (complete form), Target Complaint Scales, Distress Level Scales, Prognostic Expectancy Scales, Global Distress Scale

Name _____ Date _____

Age _____ Class _____

INSTRUCTIONS

A study is being conducted to learn why people come to the Mental Health Service and what ideas people have about how therapy works. Mental Health staff members are also participating by giving their opinions on these topics. Your participation in this research project is not mandatory and will in no way affect your relationship with the Mental Health staff member you see. You may find however that the questionnaires help you focus your thinking on your problems and on how you can work on them. Your cooperation will also help us to better understand how the Mental Health Service can best help you and others in the future.

Three questionnaires will be issued to you: this first one (which is the longest of the three) to be filled out before your first visit; a second one after that first session; and a final one after your last session. It is important that you fill out these forms at those times, so please plan for some time after your first and last visits. If you only have one visit you will fill out the first two questionnaires only. The Mental Health staff member you see will be shown only one item from your second questionnaire so that his opinion can be rated also. That item will be clearly identified for you and you can be assured that all information will be strictly confidential and used solely for research purposes.

Please indicate your reasons for coming to the Mental Health Service by circling either "Yes" or "No" on each of the following items. (Answer each item even if you have to guess)

Yes No 1. I do not know the reason. I was just sent here.
Yes No 2. I have some personal problems which I cannot handle on my own.
Yes No 3. I have trouble controlling my feelings.
Yes No 4. I have trouble with my nerves.
Yes No 5. I have physical complaints which I believe are brought on by my nervousness.

What do you want most from the Mental Health Service?

Yes No 6. Information as to what is wrong with me.
Yes No 7. A chance to tell a doctor about my problems.
Yes No 8. Medicine to make me feel less nervous.
Yes No 9. A chance to talk over my problems and get help on deciding what to do.
Yes No 10. Get specific advice on how to go about solving my problems.
Yes No 11. Help in changing myself so I won't have the same problems in the future.

How do you expect to get what you want from the Mental Health Service?

Yes No 12. By doing what my doctor tells me to do about my problem.
Yes No 13. By working with a doctor toward an understanding of my feelings toward myself and other people.
Yes No 14. By answering whatever personal questions about myself the doctor asks.
Yes No 15. Through the doctor's figuring out the right medical treatment and giving it to me.

The following questions are to find out what ideas people have about psychotherapists. Put a circle around the answer that best describes how <u>you</u> expect a therapist to work. (Answer each question even if you have to guess)

Agree Disagree 16. I expect the therapist to suggest new ways of behaving to experiment with.
Agree Disagree 17. The therapist will take a different approach with different patients.
Agree Disagree 18. I expect the therapist to decide what goals we plan to accomplish.
Agree Disagree 19. A major aim of the therapist should be to improve the patient's adjustment to other people.

Agree Disagree 20. The wise therapist avoids giving advice to the patient about how to cope with problems.

Agree Disagree 21. I believe that therapy is sometimes successful without a therapy plan.

Agree Disagree 22. A therapist will usually take the lead in bringing up topics that should be discussed.

Agree Disagree 23. During the therapy sessions the therapist will interrupt the patient to make comments.

Agree Disagree 24. The patient and only the patient should decide what changes are necessary for successful therapy.

Agree Disagree 25. The therapist will never express approval or disapproval of anything the patient tells him about himself.

Agree Disagree 26. During most of the sessions, the therapist will listen and remain silent while the patient speaks.

Agree Disagree 27. The therapist should make a treatment plan for each patient.

Agree Disagree 28. I expect the therapist to take the lead in deciding what we talk about.

Agree Disagree 29. The therapist will ask deep, probing questions.

Agree Disagree 30. I expect the therapist to go along with my own ideas about what I need.

How many visits do you think you will need? (check the <u>one</u> statement that comes closest to your expectation)

_____a. One or two appointments with a therapist.
_____b. Three or four appointments with a therapist.
_____c. Between five and ten appointments with a therapist.
_____d. Ten or more appointments with a therapist.

Check those forms of contact you have had with psychology.

_____Reading
_____Courses
_____Previous brief consultation, i.e. not more than two visits.
_____Previous therapy with:
Psychiatrist? Length of treatment _____.
Psychologist? Length of treatment _____.
Other (specify) _____ Length of treatment _____.

Listed below are common problems which often face students in college--problems of health, money, social life, personal feelings, religion, studying and the like. Please read each of these problems carefully and decide how much the statement is like you or not like you now. There are no right or wrong answers to these statements. We are only interested in a description of your feelings about them. Circle one answer for each statement.

If the statement is: not at all like you — circle 1
a little like you — circle 2
quite a bit like you — circle 3
very much like you — circle 4

	not at all	a little	quite a bit	very much
1. Not getting individual help from teachers.	1	2	3	4
2. Hard to study in living quarters.	1	2	3	4
3. University too indifferent to my needs	1	2	3	4
4. Too much work required in some courses	1	2	3	4
5. Dull classes	1	2	3	4
6. Teachers lacking interest in students	1	2	3	4
7. Classes too large	1	2	3	4
8. Too many rules and regulations	1	2	3	4
9. Unable to take courses I want	1	2	3	4
10. Courses too unrelated to each other	1	2	3	4
11. Not as strong and healthy as I should be	1	2	3	4
12. Gradually losing weight	1	2	3	4
13. Frequent headaches	1	2	3	4
14. Trouble with digestion or elimination	1	2	3	4
15. Not very attractive physically	1	2	3	4
16. Managing finances poorly	1	2	3	4
17. Having less money than my friends	1	2	3	4
18. Family worried about finances	1	2	3	4
19. Not getting satisfactory diet	1	2	3	4
20. Getting through school on too little money	1	2	3	4

	not at all	a little	quite a bit	very much
21. Too little time to myself	1	2	3	4
22. Not living a well-rounded life	1	2	3	4
23. Not using my leisure time well	1	2	3	4
24. Awkward in meeting people	1	2	3	4
25. Dating weekends	1	2	3	4
26. Being ill at ease with other people	1	2	3	4
27. Losing friends	1	2	3	4
28. Feelings too easily hurt	1	2	3	4
29. Being watched by other people	1	2	3	4
30. Feeling inferior	1	2	3	4
31. Too easily moved to tears	1	2	3	4
32. Thoughts of suicide	1	2	3	4
33. Sometimes bothered by thoughts of insanity	1	2	3	4
34. Lacking self-confidence	1	2	3	4
35. Feeling life has given me a raw deal	1	2	3	4
36. Too few dates	1	2	3	4
37. Too inhibited in sex matters	1	2	3	4
38. Sexual needs not satisfied	1	2	3	4
39. Disappointment in a love affair	1	2	3	4
40. Thinking too much about sex matters	1	2	3	4
41. Being criticized by my parents	1	2	3	4
42. Worried about a member of my family	1	2	3	4
43. Home life unhappy	1	2	3	4
44. Parents expecting too much of me	1	2	3	4
45. Carrying heavy home responsibilities	1	2	3	4

		not at all	a little	quite a bit	very much
46.	Doubting the value of a college degree	1	2	3	4
47.	Doubting college prepares me for working	1	2	3	4
48.	Not knowing what I really want	1	2	3	4
49.	Deciding whether to leave college for a job	1	2	3	4
50.	Doubting I can get a job in my chosen vocation	1	2	3	4
51.	Easily distracted from my work	1	2	3	4
52.	Fearing failure in college	1	2	3	4
53.	Not really interested in books	1	2	3	4
54.	Unable to express myself well in words	1	2	3	4
55.	Afraid to speak up in class discussions	1	2	3	4
56.	Differing from my family in religious beliefs	1	2	3	4
57.	Not going to church often enough	1	2	3	4
58.	Doubting the value of worship and prayer	1	2	3	4
59.	Having a troubled or guilty conscience	1	2	3	4
60.	Can't forget some mistakes I've made	1	2	3	4
61.	Feeling tired most of the time	1	2	3	4
62.	Occasional pressure and pain in my head	1	2	3	4
63.	Frequent colds	1	2	3	4
64.	Not getting enough sleep	1	2	3	4
65.	Sometimes feeling faint or dizzy	1	2	3	4
66.	Too many financial problems	1	2	3	4
67.	Disliking financial dependence on others	1	2	3	4
68.	Lacking privacy in living quarters	1	2	3	4
69.	Unsure of my future financial support	1	2	3	4
70.	Receiving too little help from home	1	2	3	4
71.	Awkward in making a date	1	2	3	4
72.	Slow in getting acquainted with people	1	2	3	4
73.	Trouble in keeping a conversation going	1	2	3	4
74.	Too little social life	1	2	3	4
75.	Wanting more worthwhile relations with people	1	2	3	4

		not at all	a little	quite a bit	very much
76.	Being timid or shy	1	2	3	4
77.	Being too easily embarrassed	1	2	3	4
78.	Having no close friends at college	1	2	3	4
79.	Being left out of things	1	2	3	4
80.	Having feelings of extreme loneliness	1	2	3	4
81.	Moodiness, having the blues	1	2	3	4
82.	Failing in so many things I try to do	1	2	3	4
83.	Sometimes wishing I'd never been born	1	2	3	4
84.	Nervousness	1	2	3	4
85.	Finding it difficult to relax	1	2	3	4
86.	Afraid of close contact with the opposite sex	1	2	3	4
87.	Wondering if I'll ever find a suitable mate	1	2	3	4
88.	Breaking up a love affair	1	2	3	4
89.	Disturbed by ideas of sexual acts	1	2	3	4
90.	Disturbing thoughts about members of my own sex	1	2	3	4
91.	Being treated like a child at home	1	2	3	4
92.	Clash of opinions between me and parents	1	2	3	4
93.	Family quarrels	1	2	3	4
94.	Wanting love and affection from parents	1	2	3	4
95.	Not getting along with a member of my family	1	2	3	4
96.	Purpose in going to college not clear	1	2	3	4
97.	Wondering if I'll be successful in life	1	2	3	4
98.	Concerned about military service	1	2	3	4
99.	Not knowing where I belong in the world	1	2	3	4
100.	Wanting to quit college	1	2	3	4
101.	Getting low grades	1	2	3	4
102.	Worrying about examinations	1	2	3	4
103.	Not spending enough time in study	1	2	3	4
104.	Unable to concentrate well	1	2	3	4
105.	Not getting studies done on time	1	2	3	4

		not at all	a little	quite a bit	very much
106.	Affected by racial or religious prejudice	1	2	3	4
107.	Sometimes lying without meaning to	1	2	3	4
108.	Troubled by lack of religion in others	1	2	3	4
109.	Sometimes not being as honest as I should be	1	2	3	4
110.	Parents old fashioned in their ideas	1	2	3	4
111.	Being too envious or jealous	1	2	3	4
112.	Feeling that no one understands me	1	2	3	4
113.	Having no one to tell my troubles to	1	2	3	4
114.	Finding it hard to talk about my troubles	1	2	3	4
115.	Hurting other people's feelings	1	2	3	4
116.	Too many personal problems	1	2	3	4
117.	Can't make up my mind about things	1	2	3	4
118.	Unhappy too much of the time	1	2	3	4
119.	Worrying about unimportant things	1	2	3	4
120.	Too easily discouraged	1	2	3	4

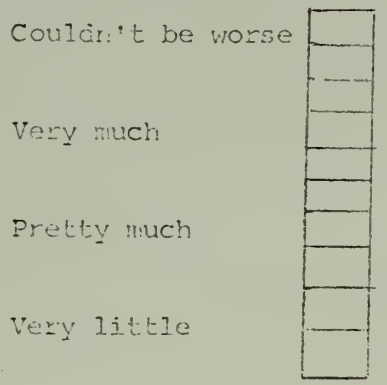
Filling out the above problem check list may have been helpful to you in sorting out particularly troublesome problems and in focusing on the specific problems you would like to discuss with a therapist. On the lines below please describe as briefly and specifically as possible the 3 most pressing problems that are troubling you now.

Problem #1 _____ Problem #2 _____ Problem #3 _____

_____ _____ _____

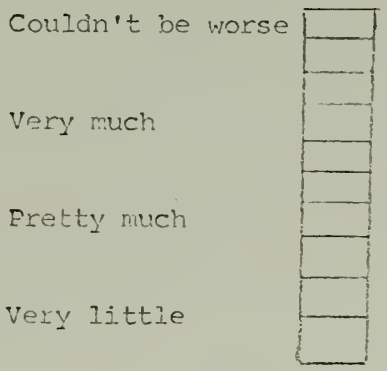
_____ _____ _____

Below rate how much Problem #1 bothers you now.

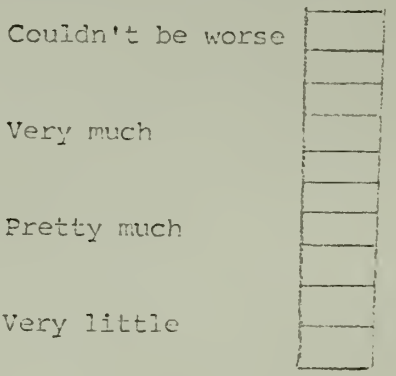


Only certain points are defined, but you may check any one box on the continuum.

Below rate how much Problem #2 bothers you now.



Below rate how much Problem #3 bothers you now.



Only certain points are defined, but you may check any one box on the continuum.

You have just identified 3 problems and their magnitude. For each of these we would like to learn about your expectations for their change because of your sessions here. Rate your expectations for each of these 3 problems by putting one check on each of the scales below.

Expectation for Problem #1

It will be much better

It will be better

It will be a little better

It will be the same

It will be worse

Only certain points are defined, but you can check any one box on the above continuum.

Expectation for Problem #2

It will be much better

It will be better

It will be a little better

It will be the same

It will be worse

Expectation for Problem #3

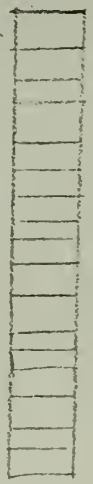
It will be much better

It will be better

It will be a little better

It will be the same

It will be worse



Only certain points are defined, but you can check any one box on the above continuum.

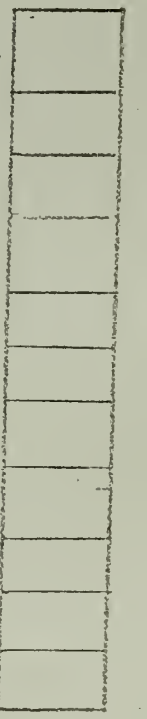
This is a level of distress rating scale which reflects how you have felt during the past few days. Rate how much your overall difficulties are interfering with your present functioning. Only certain points along the continuum are defined, but you may rate yourself at any point.

I feel continuously incapacitated by overwhelming unpleasant problems and concerns. I am in so much pain that I feel unable to function in my ordinary manner.

Although I experience very intense unpleasant problems and concerns, I continue to function in my environment, but with marked impairment in efficiency. My problems are both clearly evident and frequent, but not with me all the time.

My problems and concerns interfere with my ability to function in that they make me unhappy, anxious, angry, or dissatisfied. My problems are evident but less frequent and I can and do function in my ordinary manner.

I have vague feelings of apprehension, irritations, blues or associated aches and pains that make me feel uncomfortable, but I am entirely able to function in my ordinary manner with no noticeable impairment in efficiency.



Appendix 3

Patient Post-First Session Questionnaire:
Modified Mooney PCL, Target Complaint Scales,
Distress Level Scales, Prognostic Expectancy Scales

Instructions: Please fill out this questionnaire immediately after your first visit to the Mental Health Service. Return the completed form to the secretary before leaving.

Thank you.

Name _____

Date _____

Listed below are common problems which often face college students. Please read each of the problems carefully and decide how much each statement is like you or not like you now. There are no right or wrong answers to these problems. We are only interested in a description of your feelings about them. Circle one answer for each statement.

If the statement is: not at all like you — circle 1
a little like you — circle 2
quite a bit like you — circle 3
very much like you — circle 4

		not at all	a little	quite a bit	very much
1.	Sometimes feeling faint or dizzy	1	2	3	4
2.	Not getting enough sleep	1	2	3	4
3.	Frequent colds	1	2	3	4
4.	Occasional pressure and pain in my head	1	2	3	4
5.	Feeling tired most of the time	1	2	3	4
6.	Having feelings of extreme loneliness	1	2	3	4
7.	Being left out of things	1	2	3	4
8.	Having no close friends at school	1	2	3	4
9.	Being too easily embarrassed	1	2	3	4
10.	Being timid or shy	1	2	3	4
11.	Finding it difficult to relax	1	2	3	4
12.	Nervousness	1	2	3	4
13.	Sometimes wishing I'd never been born	1	2	3	4
14.	Failing in so many things I try to do	1	2	3	4
15.	Moodiness, having the blues	1	2	3	4

		not at all	a little	quite a bit	very much
16.	Disturbed by ideas of sexual acts	1	2	3	4
17.	Disturbing thoughts about members of my own sex	1	2	3	4
18.	Wondering if I'll ever find a suitable mate	1	2	3	4
19.	Afraid of close contact with the opposite sex	1	2	3	4
20.	Breaking up a love affair	1	2	3	4
21.	Not getting along with a member of my family	1	2	3	4
22.	Family quarrels	1	2	3	4
23.	Wanting love and affection from parents	1	2	3	4
24.	Clash of opinions between me and my parents	1	2	3	4
25.	Being treated like a child at home	1	2	3	4
26.	Feeling inferior	1	2	3	4
27.	Being watched by other people	1	2	3	4
28.	Feelings too easily hurt	1	2	3	4
29.	Losing friends	1	2	3	4
30.	Being ill at ease with other people	1	2	3	4
31.	Feeling life has given me a raw deal	1	2	3	4
32.	Lacking self-confidence	1	2	3	4
33.	Sometimes bothered by thoughts of insanity	1	2	3	4
34.	Thoughts of suicide	1	2	3	4
35.	Too easily moved to tears	1	2	3	4
36.	Thinking too much about sex matters	1	2	3	4
37.	Disappointment in a love affair	1	2	3	4
38.	Sexual needs not satisfied	1	2	3	4
39.	Too inhibited in sex matters	1	2	3	4
40.	Too few dates	1	2	3	4
41.	Carrying heavy home responsibilities	1	2	3	4
42.	Parents expecting too much of me	1	2	3	4
43.	Home life unhappy	1	2	3	4
44.	Worried about a member of my family	1	2	3	4
45.	Being criticized by my parents	1	2	3	4

		not at all	a little	quite a bit	very much
46.	Doubting I can get a job in my chosen vocation	1	2	3	4
47.	Deciding whether to leave college for a job	1	2	3	4
48.	Not knowing what I really want	1	2	3	4
49.	Doubting college prepares me for working	1	2	3	4
50.	Doubting the value of a college degree	1	2	3	4
51.	Being too envious or jealous	1	2	3	4
52.	Feeling that no one understands me	1	2	3	4
53.	Having no one to tell my troubles to	1	2	3	4
54.	Finding it hard to talk about my troubles	1	2	3	4
55.	Hurting other peoples' feelings	1	2	3	4
56.	Too many personal problems	1	2	3	4
57.	Can't make up my mind about things	1	2	3	4
58.	Unhappy too much of the time	1	2	3	4
59.	Worrying about unimportant things	1	2	3	4
60.	Too easily discouraged	1	2	3	4

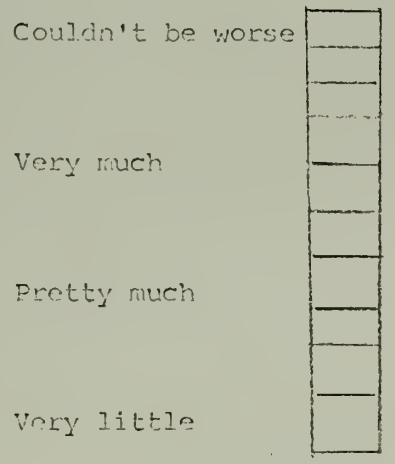
Filling out the above problem check list may have been helpful to you in sorting out particularly troublesome problems and in focusing on the specific problems you would like to discuss with a Mental Health staff member. On the lines below describe as briefly and specifically as possible the 3 most pressing problems that are troubling you now. NOTE: Your description of these 3 problems will be shown to your therapist so his opinion can be rated also.

Problem #1 _____ Problem #2 _____ Problem #3 _____

_____ _____ _____

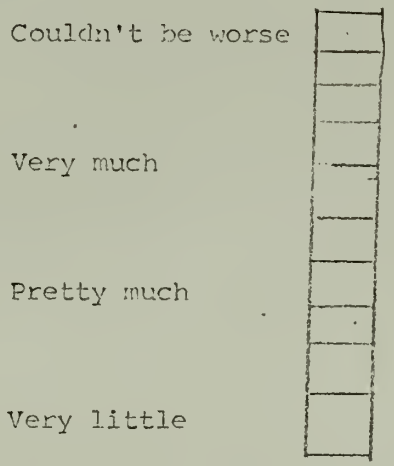
_____ _____ _____

Below rate how much Problem #1 bothers you now.



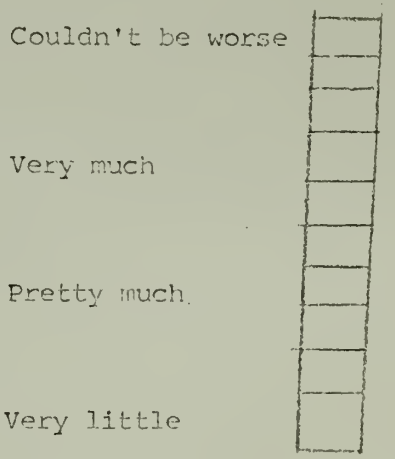
Check any one box

Below rate how much Problem #2 bothers you now.



Check any one box

Below rate how much Problem #3 bothers you now.



Check any one box

You have just identified 3 problems and their magnitude. For each of these we would like to learn about your expectations for their change because of your sessions here. Rate your expectations for each of these 3 problems by putting a check on each of the scales below.

Expectation for Problem #1

It will be much better

It will be better

It will be a little better

It will be the same

It will be worse

Only certain points are defined, but you can check any one box on the above continuum.

Expectation for Problem #2

It will be much better

It will be better

It will be a little better

It will be the same

It will be worse

Expectation for Problem #3

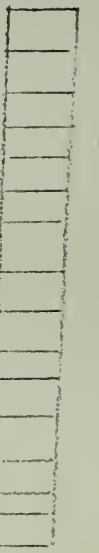
It will be much better

It will be better

It will be a little better

It will be the same

It will be worse



Only certain points are defined, but you can check any one box on the above continuum.

Appendix 4

Therapist Post-First Session Questionnaire: Distress Level Scales, Prognostic Expectancy Scales, Global Distress Level Scale, Supplementary Notes on Therapists' Rating Scales

Therapist: _____

Patient: _____

Session Date: _____

Therapist's Rating Scales

On the lines below are copied verbatim those three most pressing problems as your patient has described them. Please rate each of these problems as you perceive them as troubling your patient during his first session with you.

Problem #1 _____

_____

_____

Below rate how much Problem #1 bothered your patient

Couldn't be worse

Very much

Pretty much

Very little

Only certain points are defined, but you can check any one box on the continuum.

Problem #2 _____

_____

_____

Below rate how much Problem #2 bothered your patient

Couldn't be worse

Very much

Pretty much

Very little

Problem #3 _____

_____

_____

Below rate how much Problem #3 bothered your patient

Couldn't be worse

Very much

Pretty much

Very little

Only certain points are defined, but you can check any one box on the continuum.

How much do you estimate Problem #1 will bother your patient after therapy?

It will be much better

It will be better

It will be a little better

It will be the same

It will be worse

Only certain points are defined, but you can check any one box on the continuum.

How much do you estimate Problem #2 will bother your patient after therapy?

It will be much better

It will be better

It will be a little better

It will be the same

It will be worse

How much do you estimate Problem #3 will bother your patient after therapy?

It will be much better

It will be better

It will be a little better

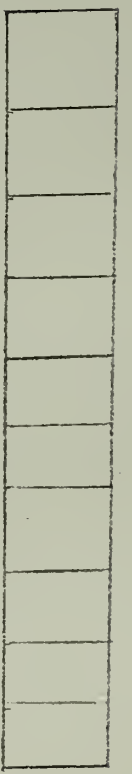
It will be the same

It will be worse

Only certain points are defined, but you can check any one box on the continuum.

Therapist's Rating of Distress Level

This rating scale asks for your perception of how your patient's overall difficulties are incapacitating his present functioning. Only certain points along the distress continuum are defined, but you may rate your patient at any point.



Patient feels continuously incapacitated by overwhelming unpleasant affect or somatic derivatives. Such feelings as despondency, panic, or fury evidenced. He is so much in pain that he feels unable to function in his ordinary manner.

Although very intense unpleasant affect or derivatives are experienced, patient continues to function in his current environment but with marked impairment in efficiency. Symptoms are both clearly evidenced and frequent, but not continually present.

Moderate degree of symptomatology evidenced which interferes with patient's ability to function in the sense that he is unhappy, anxious, angry or dissatisfied, but he can and does function in his ordinary manner. Symptoms are less frequent and intense but evident.

Minimal signs of distress. Vague feelings of apprehension, irritation, blues or associated minor aches and pains which make the patient uncomfortable, but he is entirely able to function in his ordinary manner.

Supplementary Notes on the Therapist's Rating Scales

Page 1

The 3 ratings are to be your objective judgments, based on your diagnostic observations during your first (or final) session with your patient, as to how much each problem is subjectively bothering your patient at this time (during the last few days and on the day of the session). In other words, you are asked to make a judgment as to how much disturbance or distress your patient is experiencing because of each problem he has listed. If you haven't talked about one of the problems he describes, then extrapolate as accurately as possible how much you judge such a problem would bother this person on the basis of your understanding of his personality, dynamics, etc.

Page 2

The 3 ratings ask for your prognostic assessments of how much your work with this patient will reduce, leave the same, or increase, his subjective distress caused by each of his three problems. You are to rate the amount of expected change in your patient's sense of disturbance over each problem that will occur over the time (which will vary from patient to patient) you will be seeing him in therapy.

Page 3

This 1 rating asks for your objective judgment of 1) how much overall distress your patient is experiencing because of all of his current difficulties in his present life situation (which probably goes beyond those 3 problems he has described) and 2) how much these distressing difficulties are interfering with or incapacitating his present functioning (which refers to his model way of living and behaving as he would like it to be).

In those instances where level of distress (D) and level of incapacitation (I) are discrepant, you can put a D in the box that describes level of distress, an I in the box that describes level of incapacitation, and then average the two levels and put a check in the averaged box.

Please fill out the therapist's rating scales as soon as possible after they are put in your mailbox and place the completed forms in the box next to the mailbox.

The final questionnaire for each of your patients in this study will be placed in your patient's folder and I hope you will

remember to give it to him at the time of your last session together. Please ask him to fill it out immediately before leaving the Mental Health Service (it takes about 15 minutes) and then return it to the secretary. If this is impossible, ask him to please fill out the questionnaire that day and either return it in person or mail it in as soon as possible.

If your patient cancels, FKA's, or otherwise does not get his final questionnaire and you do not think you will see him again, please put that final patient questionnaire in the box by the mailboxes and I will attempt to call that patient to ask him to fill out the final questionnaire.

Thank you all very much.

Appendix 5

Patient Post-Therapy Questionnaire:
Self-Reliance Scale, Therapist-Directiveness
Scale, Modified Mooney Problem Check List,
Distress Level Scales, Outcome Measures #1

Name _____

Instructions: Please fill out this questionnaire immediately after the last session with your therapist. Your time and effort in answering these forms is sincerely appreciated. Hopefully, you will be interested in the results of this research project, which is investigating both students' and therapists' judgments and opinions about the process of psychotherapy and how well it works. A summary of these results will be made available to participants at request from the Mental Health secretary in September. Thank you for your cooperation.

Please indicate your reasons for coming to the Mental Health Service by circling either "Yes" or "No" on each of the following items. (Answer each item even if you have to guess)

Yes No 1. I do not know the reason. I was just sent here.
Yes No 2. I have some personal problems which I cannot handle on my own.
Yes No 3. I have trouble controlling my feelings.
Yes No 4. I have trouble with my nerves.
Yes No 5. I have physical complaints which I believe are brought on by my nervousness.

What do you want most from the Mental Health Service?

Yes No 6. Information as to what is wrong with me.
Yes No 7. A chance to tell a doctor about my problems.
Yes No 8. Medicine to make me feel less nervous.
Yes No 9. A chance to talk over my problems and get help on deciding what to do.
Yes No 10. Get specific advice on how to go about solving my problems.
Yes No 11. Help in changing myself so I won't have the same problems in the future.

How do you expect to get what you want from the Mental Health Service?

Yes No 12. By doing what my doctor tells me to do about my problems.
Yes No 13. By working with a doctor toward an understanding of my feelings toward myself and other people.
Yes No 14. By answering whatever personal questions about myself the doctor asks.
Yes No 15. Through the doctor's figuring out the right medical treatment and giving it to me.

The following questions are to find out what ideas people have about psychotherapists. Put a circle around the answer that best describes how <u>you</u> expect a therapist to work. (Answer each question even if you have to guess)

Agree Disagree 16. I expect the therapist to suggest new ways of behaving to experiment with.
Agree Disagree 17. The therapist will take a different approach with different patients.
Agree Disagree 18. I expect the therapist to decide what goals we plan to accomplish.
Agree Disagree 19. A major aim of the therapist should be to improve the patient's adjustment to other people.

Agree	Disagree	20.	The wise therapist avoids giving advice to the patient about how to cope with problems.
Agree	Disagree	21.	I believe that therapy is sometimes successful without a therapy plan.
Agree	Disagree	22.	A therapist will usually take the lead in bringing up topics that should be discussed.
Agree	Disagree	23.	During the therapy sessions the therapist will interrupt the patient to make comments.
Agree	Disagree	24.	The patient and only the patient should decide what changes are necessary for successful therapy.
Agree	Disagree	25.	The therapist will never express approval or disapproval of anything the patient tells him about himself.
Agree	Disagree	26.	During most of the sessions, the therapist will listen and remain silent while the patient speaks.
Agree	Disagree	27.	The therapist should make a treatment plan for each patient.
Agree	Disagree	28.	I expect the therapist to take the lead in deciding what we talk about.
Agree	Disagree	29.	The therapist will ask deep, probing questions.
Agree	Disagree	30.	I expect the therapist to go along with my own ideas about what I need.

Listed below are common problems which often face college students. Please read each of the problems carefully and decide how much each statement is like you or not like you now. There are no right or wrong answers to these problems. We are only interested in a description of your feelings about them. Circle one answer for each statement.

If the statement is: not at all like you — circle 1
a little like you — circle 2
quite a bit like you — circle 3
very much like you — circle 4

		not at all	a little	quite a bit	very much
1.	Sometimes feeling faint or dizzy	1	2	3	4
2.	Not getting enough sleep	1	2	3	4
3.	Frequent colds	1	2	3	4
4.	Occasional pressure and pain in my head	1	2	3	4
5.	Feeling tired most of the time	1	2	3	4
6.	Having feelings of extreme loneliness	1	2	3	4
7.	Being left out of things	1	2	3	4
8.	Having no close friends at school	1	2	3	4
9.	Being too easily embarrassed	1	2	3	4
10.	Being timid or shy	1	2	3	4
11.	Finding it difficult to relax	1	2	3	4
12.	Nervousness	1	2	3	4
13.	Sometimes wishing I'd never been born	1	2	3	4
14.	Failing in so many things I try to do	1	2	3	4
15.	Moodiness, having the blues	1	2	3	4

	not at all	a little	quite a bit	very much
16. Disturbed by ideas of sexual acts	1	2	3	4
17. Disturbing thoughts about members of my own sex	1	2	3	4
18. Wondering if I'll ever find a suitable mate	1	2	3	4
19. Afraid of close contact with the opposite sex	1	2	3	4
20. Breaking up a love affair	1	2	3	4
21. Not getting along with a member of my family	1	2	3	4
22. Family quarrels	1	2	3	4
23. Wanting love and affection from parents	1	2	3	4
24. Clash of opinions between me and my parents	1	2	3	4
25. Being treated like a child at home	1	2	3	4
26. Feeling inferior	1	2	3	4
27. Being watched by other people	1	2	3	4
28. Feelings too easily hurt	1	2	3	4
29. Losing friends	1	2	3	4
30. Being ill at ease with other people	1	2	3	4
31. Feeling life has given me a raw deal	1	2	3	4
32. Lacking self-confidence	1	2	3	4
33. Sometimes bothered by thoughts of insanity	1	2	3	4
34. Thoughts of suicide	1	2	3	4
35. Too easily moved to tears	1	2	3	4
36. Thinking too much about sex matters	1	2	3	4
37. Disappointment in a love affair	1	2	3	4
38. Sexual needs not satisfied	1	2	3	4
39. Too inhibited in sex matters	1	2	3	4
40. Too few dates	1	2	3	4

	not at all	a little	quite a bit	very much
41. Carrying heavy home responsibilities	1	2	3	4
42. Being criticized by my parents	1	2	3	4
43. Worried about a member of my family	1	2	3	4
44. Home life unhappy	1	2	3	4
45. Parents expecting too much of me	1	2	3	4
46. Doubting the value of a college degree	1	2	3	4
47. Doubting college prepares me for working	1	2	3	4
48. Not knowing what I really want	1	2	3	4
49. Deciding whether to leave college for a job	1	2	3	4
50. Doubting I can get a job in my chosen profession	1	2	3	4
51. Hurting other people's feelings	1	2	3	4
52. Finding it hard to talk about my troubles	1	2	3	4
53. Having no one to tell my troubles to	1	2	3	4
54. Feeling that no one understands me	1	2	3	4
55. Being too envious or jealous	1	2	3	4
56. Worrying about unimportant things	1	2	3	4
57. Unhappy too much of the time	1	2	3	4
58. Can;t make up my mind about things	1	2	3	4
59. Too many personal problems	1	2	3	4
60. Too easily discouraged	1	2	3	4

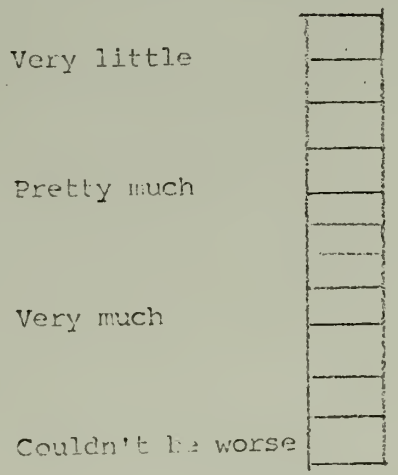
Copied below are the 3 problems you identified after your first session at the Mental Health Service. Would you please rate these 3 problems below on how much each bothers you <u>now</u>.

Problem #1 _____ Problem #2 _____ Problem #3 _____

_____ _____ _____

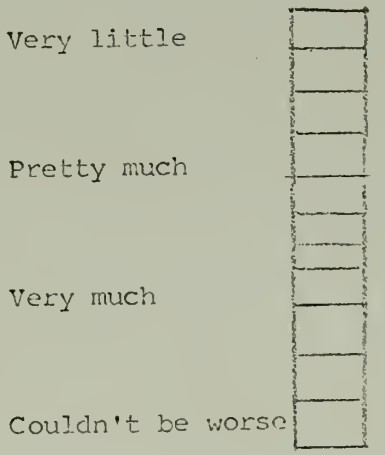
_____ _____ _____

Below rate how much Problem #1 bothers you now.



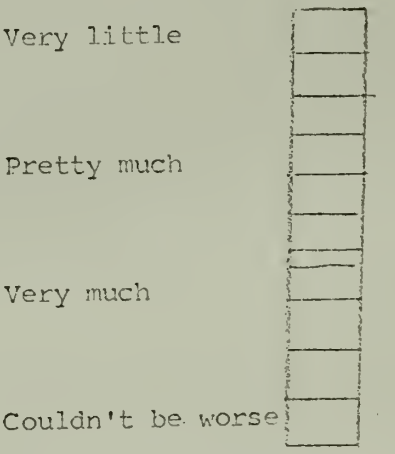
Check any one box

Below rate how much Problem #2 bothers you now.



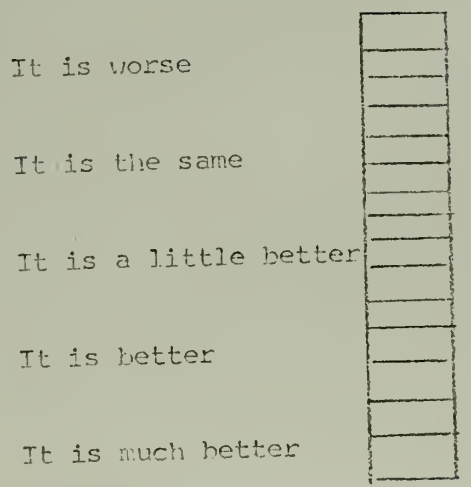
Check any one box

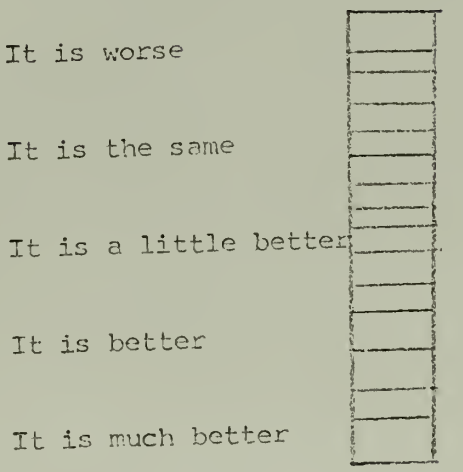
Below rate how much Problem #3 bothers you now.

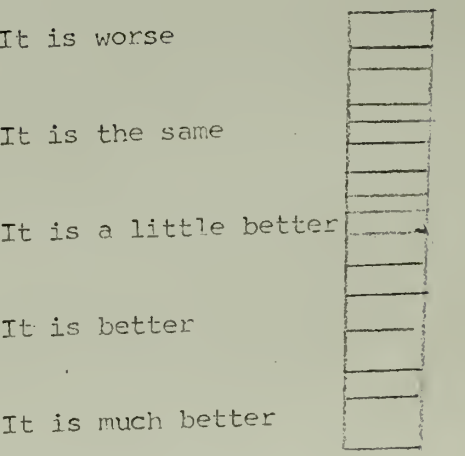


Check any one box

Referring to the 3 problems (copied on the preceding page) that you identified after your first session at the Mental Health Service, would you please rate the amount of change between how much each problem bothered you then and how much each bothers you now.







Only certain points are defined, but you can check any one box on each of the above scales.

Note: Please return this completed questionnaire to the Mental Health Service secretary immediately after filling it out or use the enclosed envelope to mail in this form as soon as possible. Results of your efforts will be made available to you in September.

Thank you very much for your cooperation.

Appendix 6

Therapist Post-Therapy Questionnaire:
Distress Level Scales, Outcome Measures #2,
Global Distress Level Scale

Therapist: _____

Patient: _____

Session Date: _____

Therapist's Rating Scales

On the lines below are copied verbatim those three most pressing problems as your patient has described them. Please rate each of these problems as you perceive them as troubling your patient during his final session with you.

Problem #1 _____

_____

_____

Below rate how much Problem #1 bothered your patient

Couldn't be worse

Very much

Pretty much

Very little

Only certain points are defined, but you can check any one box on the continuum.

Problem #2 _____

_____

_____

Below rate how much Problem #2 bothered your patient

Couldn't be worse

Very much

Pretty much

Very little

Problem #3 _____

_____

_____

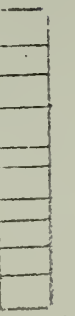
Below rate how much Problem #3 bothered your patient

Couldn't be worse

Very much

Pretty much

Very little



Only certain points are defined, but you can check any one box on the continuum.

Rate each of your patient's 3 problems as to how much it has changed since the first session. This rating should be based on your perception of how much each problem bothered your patient then and how much it bothers him now.

Problem #1

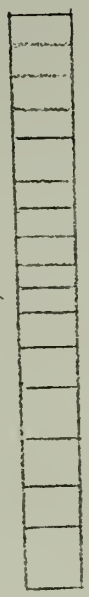
It is worse

It is the same

It is a little better

It is better

It is much better



Problem #2

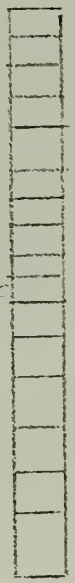
It is worse

It is the same

It is a little better

It is better

It is much better



Problem #3

It is worse

It is the same

It is a little better

It is better

It is much better

Length of treatment: _____ number of sessions.

Check nature of termination:

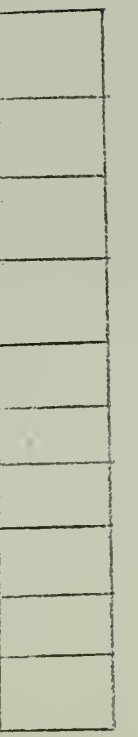
Mutual agreement between therapist and patient _____
Therapist suggested termination _____
Patient had to terminate _____
End of semester. _____
Patient cancelled last appointment _____
Patient FKA last appointment _____
Other (describe briefly) _____

Your final assessment of patient as a serious therapeutic worker: (check one)

Excellent ____
Very good ____
Average ____
Below Average ____
Poor ____

Therapist's Rating of Distress Level

This rating scale asks for your perception of how your patient's overall difficulties are incapacitating his present functioning. Only certain points along the distress continuum are defined, but you may rate your patient at any point.



Patient feels continuously incapacitated by overwhelming unpleasant affect or somatic derivatives. Such feelings as despondency, panic, or fury evidenced. He is so much in pain that he feels unable to function in his ordinary manner.

Although very intense unpleasant affect or derivatives are experienced, patient continues to function in his current environment, but with marked impairment in efficiency. Symptoms are both clearly evidenced and frequent, but not continually present.

Moderate degree of symptomatology evidenced which interferes with patient's ability to function in the sense that he is unhappy, anxious, angry of dissatisfied, but he can and does function in his ordinary manner. Symptoms are less frequent and intense but evident.

Minimal signs of distress. Vague feelings of apprehension, irritation, blues or associated minor aches and pains which make the patient uncomfortable, but he is entirely able to function in his ordinary manner.

Appendix 7

Dissertation Abstract

A STUDY OF THE EFFECTS OF PATIENT-THERAPIST EXPECTATIONS REGARDING SHORT-TERM THERAPY ON THERAPEUTIC OUTCOME

ABSTRACT

Kent POEY, Ph.D.
University of Massachusetts, 1971
Chairman: Dr. Norman Simonson

The present study proposed a unified investigation of how therapeutic outcome measures relate to prognostic expectations and two types of role expectations - those expectations concerning patients' self-reliance and those concerning therapists' directiveness. The prognostic and role expectations of 44 college outpatients and their therapists at a university mental health service were rated by questionnaire scales before, during, and after short-term therapy. Expectations of role behaviors in therapy were rated before therapy began concerning how self-reliant a patient was expected to be and how directive a therapist was expected to be in the upcoming therapy experience. The target symptom rating approach was used to obtain three target symptoms each patient wanted to work on in therapy and these were the criteria referred to by that patient and his therapist in both their expectational ratings and their ratings of outcome. Three outcome measures were obtained for each patient which consisted of the average patient-therapist improvement rating for each of the target symptoms. The design of this study

attempted to integrate the scattered and often contradictory findings of past studies by examining how outcome related to both the prognostic and role expectations of the patient, the therapist, and a measure of agreement within each patient-therapist dyad. These measures of a dyad's agreement (congruence) were the difference scores between the patient and his therapist on each of the expectancy measures.

The results indicated that patients' initial prognostic expectations are significantly higher than those of their therapists, while their outcome ratings did not show any significant differences, indicating a convergence of perceptions within the patient-therapist dyads. It was hypothesized that prognostic expectations would relate to outcome in a curvilinear fashion as previous studies had indicated. However the results demonstrated that both patients' and therapists' prognostic expectations related in a highly positive linear fashion to resultant outcome. Patients' and therapists' expectations were not significantly different in their ability to predict outcome. The hypothesized linear relationship between the level of patients' self-reliance expectations and outcome was not found. The remaining hypotheses predicted that the congruence levels of patient-therapist dyads' prognostic expectations, patient self-reliance expectations, and therapist-directiveness expectations would all relate in a positive linear fashion to outcome. The results indicated that congruence of prognostic expectations showed no significant relationship to outcome, while congruence of patient self-reliance expectations

related in a positive curvilinear fashion to outcome and congruence of therapist-directiveness expectations related in the predicted positive linear fashion. An exploratory hypothesis that predicted patients' initial distress levels concerning their three target symptoms would relate in a positive linear fashion to both prognostic expectation levels and to outcome levels was also confirmed.

These findings suggest that using the target symptom approach in the rating of patient and therapist prognostic expectations and patient distress level provides several valuable predictors of therapeutic outcome. The implications of those results were discussed in terms of the factors involved in the short-term therapeutic process, with special attention being paid to possible placebo factors. The experimental paradigm developed for this study was proposed for a future research investigation that would explore the efficacy of emphasizing the treatment of high distress, high expectation target symptoms and de-emphasizing the treatment of low distress, low expectation target symptoms.