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Treatment expectations and preferences and perceptions of insight-oriented and behavior therapies

C. Sue Hickey

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TREATMENT EXPECTATIONS AND PREFERENCES AND PERCEPTIONS
OF INSIGHT-ORIENTED AND BEHAVIOR THERAPIES

By

C. Sue Hickey
B.A., Antioch College, 1975

Presented in partial fulfillment of the requirements for the degree of

Master of Arts

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Treatment Expectations and Preferences and Perceptions of Insight-Oriented and Behavior Therapies (172 pp.)

Director: P. H. Bornstein

The present study examined the influence of treatment expectations and preferences on analogue subjects' perceptions of two treatment approaches: insight-oriented therapy and behavior therapy. Two primary questions were addressed. The first question was whether subjects' expectations and preferences regarding the aims, procedures, and focus of therapy would bear a direct relationship to their judgments of treatment acceptability and expectancy of therapeutic gain. The second question was whether the relationship between expectations and preferences would differentially affect subjects' perceptions of each of these treatment approaches. This investigation also provided information concerning the relative appeal and credibility of these contrasting forms of treatment. Subjects first completed a questionnaire designed to measure their expectations and preferences regarding theoretical and procedural aspects of psychotherapy. On the basis of median splits on these scale scores, subjects' expectations and preferences were each classified as either behavioral or insight-oriented, creating four expectation X preference groups. Subjects were then presented with a case description and written transcripts illustrating insight-oriented and behavior therapy. Transcript ratings generated by subjects were submitted to 2 X 2 X 2 X 2 split-plot repeated-measures analyses of variance (expectation type X preference type X order of transcript presentation X transcript type). Results most strongly supported differential effects for the two therapy transcripts. The behavior therapy transcript was judged to be significantly more effective and acceptable than the insight therapy transcript. Little support was found for the effects of the expectation and preference variables, either separately or in interaction. Results were discussed in light of methodological difficulties, including moderately correlated measures of expectations and preferences, possible subject response sets, and difficulties in subject assignment. It was concluded that future attempts to evaluate the influence of expectations and preferences on treatment perceptions discover means of assessing these subject variables which do not result in the positive correlation obtained with the present scale. Additionally, it was suggested that providing clients with a range of treatment alternatives might prove a more profitable line of inquiry than attempting to isolate subject variables such as expectations or preferences in hopes of predicting acceptance of or response to treatment.
ACKNOWLEDGMENTS

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CHAPTER I

INTRODUCTION

Frank (1961, 1973) has argued that psychotherapeutic change is primarily a function of factors common to all treatment approaches and that any form of intervention may be successful if the client has sufficient belief in its effectiveness. Frank and others (e.g., Goldstein, 1962a, b; Rosenthal & Frank, 1956) have asserted that such nonspecific factors significantly affect the course of most, if not all, forms of psychotherapy.

One frequently cited nonspecific factor is a helping relationship with a therapist (Bergin & Lambert, 1978; Strupp, 1973). Adherence to some organized system of therapeutic beliefs is another important factor common to all treatment approaches (Frank, 1961, 1973; Rosenzweig, 1936). The chief function of this belief system is to provide a rationale for treatment. More specifically, it provides an explanation of the cause of a client's psychological difficulties and a theoretical justification for some explicit procedure to relieve the client's distress. While the theoretical constructs and associated techniques may vary across treatment approaches, provided they appear reasonable and credible, they are believed to serve common morale-building functions (Frank, 1973). Most importantly, they are seen as enhancing the client's expectations of being positively influenced by treatment.

Several authors (Frank, 1961, 1973; Goldstein, 1962a, b; Krause, 1967; Rosenthal & Frank, 1956) have suggested that the patient's
expectations of improvement may influence the results of treatment. Rosenthal and Frank (1956), for example, suggested that the efficacy of any set of therapeutic procedures stems from their enhancing the patient's and therapist's belief that something useful is being done. More recently, Bednar (1970) has claimed that the success of therapy "is not a result of the validity of specific counseling procedures; rather it is because of the actual irrelevance of the specific counseling methods employed (p. 651)." He described improvement as occurring "as long as each counseling system successfully imparts to the client the expectation that he should be improving as a result of the expert treatment he is receiving (pp. 651-652)." Such an assertion naturally raises questions concerning whether various treatment approaches do indeed generate equivalent expectancy for improvement. Two primary bodies of literature have focused on the expectancy for improvement associated with various treatment approaches and procedures. The first area includes investigations of expectancy states and of the credibility of various behavioral treatment procedures and control conditions (Bernstein & Nietzel, 1977; Kazdin & Wilcoxon, 1976; Rosen, 1976; Wilkins, 1973). The second area is composed of investigations of the acceptability and perceived effectiveness of contrasting theoretical approaches, such as behavioral and insight-oriented therapies (e.g., Fancher & Gutkin, 1971; Holen & Kinsey, 1975). Both bodies of literature, to be reviewed in considerable detail, have suggested differential expectancy for improvement across various treatment approaches and procedures.
Often cited in support of Frank's view of the importance of nonspecific effects in psychotherapy is the "tie-score effect" indicated by recent reviews of comparative studies of psychotherapy (e.g., Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971; Luborsky, Singer, & Luborsky, 1975). These reviews have shown comparable success rates across divergent forms of treatment, with no single type of treatment emerging as clearly superior to the others. This tie-score effect has often been interpreted as reflecting the influence of nonspecific factors common to a variety of schools of treatment. Luborsky et al. (1975), for example, concluded that the most potent explanation of these results related to the existence of the patient-therapist relationship common to all forms of psychotherapy. Strupp (1973) has argued that a helping relationship is an essential condition for change in psychotherapy, creating a power base from which the therapist influences the patient through various treatment techniques. In a reply to Strupp, Garfield (1973) has taken exception with Strupp's primary emphasis upon common or nonspecific factors and his relative neglect of specific, "active" treatment ingredients. Garfield argued that common factors may account for some or even much, but likely not all, of behavior change in psychotherapy. Despite such disagreements, basic ingredients or common, nonspecific factors in psychotherapy are receiving increasingly greater emphasis. As Bergin and Lambert (1978) have written:

This is not to say that techniques are irrelevant but that their power for change pales when compared to that of personal influence. Technique is crucial to the extent that it provides a believable rationale and congenial modus operandi for the change agent and the client. (p. 180)
Of relevance to this discussion of the operation of relationship factors and other nonspecific influences in psychotherapy are three reports of patients' treatment experiences (Ryan & Gizynski, 1971; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975; Strupp, Wallach, & Wogan, 1964). Based on retrospective accounts of their experiences, both insight-oriented therapy patients (Strupp et al., 1964) and behavior therapy patients (Ryan & Gizynski, 1971) were found to attach a great deal of importance to aspects of the therapeutic relationship, such as the therapist's warmth and understanding. For example, Ryan and Gizynski found that successful outcome was associated with the patient's liking for his behavior therapist, the therapist's perceived efforts to facilitate positive patient expectations, and the patient's perception of the therapist as confident, persuasive, and satisfied with the outcome of treatment. Further, patients in both studies rarely mentioned the specific treatment techniques that had been employed and did not seem to find them very important contributors to behavior change.

Comparing both psychotherapy and behavior therapy patients within a single study, Sloane et al. (1975) obtained results consonant with the findings of Strupp et al. (1964) and Ryan and Gizynski (1971). At one to two years post-treatment, self-described "successful" psychotherapy and behavior therapy patients were asked to rate statements describing which factors had contributed to the effectiveness of treatment. Their responses revealed the importance of factors common to both forms of therapy, such as the skill of the therapist or the therapist's confidence that the patient would improve (Marks & Gelder,
1966), rather than the importance of any particular theoretical orientation or technique. However, all four of the self-described behavior therapy "failures" reported having encountered therapeutic goals, orientations, and relationships which were different from their expectations. All four had sought further therapy with an analytically oriented therapist; three reported feeling pleased with the change.

Of additional interest in the Sloane et al. study are the two categories of patients' responses to open-ended questions concerning what they had learned in treatment about various aspects of their lives. The first category contained descriptions of how past events influence current feelings and behaviors, while the second category contained descriptions of performing new, constructive behaviors in the present. Consistent with the theories of the two treatment approaches, insight therapy patients made twice as many statements falling within the first category as category two statements, while the reverse was true of behavior therapy patients. Thus, while successful patients did not spontaneously target particular techniques or theoretical formulations as important contributors to treatment outcome, they did seem cognizant of the basic rationale of the particular form of therapy they had received.

While of considerable interest concerning the operation of relationship factors and other nonspecific influences in behavior therapy as well as traditional psychotherapy, these three retrospective accounts do not unequivocally demonstrate that such factors actually accounted for behavior change. Further, "successful" patients' positive retrospective descriptions of their therapists were likely
influenced by their successful outcome. Additionally, finding that techniques did not seem very salient to the patients should be viewed with caution. If clients are indeed able to correctly identify the conditions leading to change, research would rely solely upon client report. Patients' perceptions of therapeutic techniques and therapy rationales might better be studied by minimizing the more commonly attended to relationship factors and redirecting patients' attention to, or increasing the saliency of, the specific techniques used by their therapists. Studies of clients' expectations and preferences regarding various treatment approaches and procedures have adopted such a strategy.

A position more moderate than Frank's (1973), which recognizes that factors independent of "active" or specific treatment ingredients can cause and moderate client improvement, is reflected in the widely proposed multidimensional approach to psychotherapy research. The question central to this approach, "Which set of therapy procedures delivered by which sort of therapists are effective for which kinds of clients with which specific problems?", has been frequently proposed as a standard for conducting and evaluating outcome research (e.g., Bergin, 1971; Ford & Urban, 1967; Luborsky et al., 1971; Paul, 1967, 1969; Strupp & Bergin, 1969). This multidimensional strategy clearly provides the issue of patient-treatment fit a legitimate place in psychotherapy research.

The intuitively appealing notion that different patients find "different kinds of treatment more acceptable, do better in them, and are less likely to abandon them than others" (Baekeland & Lundwall, 1975, p. 769) has long been recognized among clinicians. For example,
Hoch (1955) observed that: Many patients form an "ideal picture" about the therapist and also about the procedure to which they would like to respond. There are for instance patients who prefer psychotherapeutic methods which use some somatic adjuncts while others are very much against it. There are some patients who would like to submit to a psychotherapeutic procedure whose theoretical foundations are in agreement with their own ideas about psychic functioning, while others do not make such demands. (p. 322)

In a similar vein, Solovey and Milechnin (1958) have pointed out that: the individual who comes to consult, usually has his own mental representation of his disease, of the recovery he hopes to achieve, and often, even of the psychotherapeutic procedure he desires to have applied in his case. (p. 1)

More recently, Kirsch (1978) has recommended investigation of the interaction between treatment rationales and subjects' preexisting beliefs:

It seems reasonable to expect, for example, that as a result of prior learning, some individuals would be more receptive to a rationale involving psychodynamic concepts, some to a rationale based on radical behaviorist notions, and others to rationales couched in religious or mystical terms. (p. 263)

Such clinical observations clearly suggest that patients' expectations and preferences regarding therapeutic approaches and procedures be considered possible variables affecting patient-treatment fit.

Client expectations regarding the actual treatment procedures to be used have received considerable attention (e.g., Begley & Lieberman, 1970; Goldstein, 1962b; Heine & Trosman, 1960; Orne &
Wender, 1968; Rotter, 1954). Further, congruence between the type of therapy expected and the type proffered has been described as a potentially important variable in psychotherapy (e.g., Baekeland & Lundwall, 1975; Wallach & Strupp, 1960). The recent differentiation between client expectations and client preferences (Duckro, Beal, & George, 1979) has directed attention to what a client wants or desires from treatment as a neglected but potentially relevant variable, which should be considered together with what a client anticipates in treatment in predicting client satisfaction and therapy process and outcome.

The present review will focus first on the evolution and application of the concept of expectancy to psychotherapy research. Both expectancy of therapeutic gain and extension of the expectancy construct to expectations regarding the therapist's role and treatment procedures will be described. A discussion of the hypothesis that disconfirmation of clients' treatment expectations is a negative influence in psychotherapy will follow. Literature relevant to this hypothesis falls within two main areas. The first area focuses on the development of clinical procedures designed to shape client treatment expectations. This literature is based on the assumption that closer alignment of clients' expectations with therapists' expectations or with the demands of particular treatment approaches should enhance treatment effects. The second area focuses on attempts to delineate clients' expectations regarding the therapist's role and the goals, procedures, and topics of therapy. Of greatest relevance to the present investigation, these
studies have found that clients may have definite treatment expectations and that these may vary both within and between client samples. Also included within this second area are studies examining the relationship between client treatment expectations and therapy process and outcome. These studies have attempted to relate client expectations to continuation in treatment and have examined the effects of disconfirmed expectations and discrepant patient-therapist expectations. A similar evaluation of client treatment preferences and their relationship to therapy process and outcome. Next, studies investigating the relative expectancy-arousing qualities of various behavioral treatment and control procedures will be described. These studies are of particular relevance to Frank's assertion that expectancy for improvement associated with treatment rationales and procedures may contribute to treatment gains, provided they appear reasonable and credible. Finally, studies examining the relative acceptability and desirability and perceived effectiveness of contrasting treatment approaches (e.g., behavioral vs. insight-oriented therapy) will be reviewed. These investigations of preferences for various treatment approaches and procedures have been primarily of an analogue nature and have rarely attempted to relate such preferences to treatment process and outcome. They have, however, suggested that different forms of therapy may vary in their desirability and perceived effectiveness.

The current investigation follows from several previous lines of theory and research. Of central importance is Frank's (1973) assertion that belief in a therapy rationale may heighten expectancy
of therapeutic gain. Additionally, the present study continues the search for variables affecting patient-treatment fit--specifically, a matching strategy involving the selection of therapy approaches or procedures on the basis of clients' treatment expectations and preferences. Of further relevance to the present study are clinical observations and research evidence suggesting that clients may enter therapy with varying treatment expectations or preferences and that these variables may affect clients' satisfaction with or ability to benefit from treatment. Taking these areas together, it appeared plausible that congruence between the type of therapy expected or preferred and the type of therapy employed might be reflected in a more positive evaluation of therapy and in increased expectancy of therapeutic gain.

The primary purpose of the present study was to examine the influence of treatment expectations and preferences on subjects' perceptions of two treatment approaches: insight-oriented therapy and behavior therapy. Two primary questions related to perceptions of these treatment approaches were addressed. The first question was whether subjects' expectations and preferences regarding the aims, procedures, and focus of treatment would bear a direct relationship to their judgments of treatment acceptability and credibility or expectancy of therapeutic gain. The second question was whether the relationship between expectations and preferences would differentially affect subjects' perceptions of each of these treatment approaches. This investigation also provided information concerning the relative appeal and credibility of these contrasting forms of treatment, disregarding the separate and interactive influence of
subjects' expectations and preferences.
CHAPTER II

REVIEW OF THE LITERATURE

Definition and Development of the Expectancy Construct

The expectancy construct emerged from pharmaceutical research on the "placebo effect" (e.g., Frank, Nash, Stone, & Imber, 1963). In medical research, the term "placebo effect" was used to describe symptom reduction resulting from procedures employing a chemically inert agent. The concept was soon extended to psychotherapy research (Cartwright & Cartwright, 1958; Rosenthal & Frank, 1956; Shapiro, 1959).

Gliedman, Nash, Imber, Stone, and Frank (1958) described the placebo effect as "a complicated combination of psychiatrist and patient expectations (p. 349)." Later, Frank (1968) asserted that "the effectiveness of the placebo depends solely on its capacity to arouse patients' favourable expectations (p. 349)." Initially, placebo effects were viewed as behavior change resulting chiefly from the arousal of an expectation or belief about being helped in therapy (Frank, 1961). As the concept evolved, however, it became much broader.

Rosenthal and Frank (1956) used several terms to describe the placebo effect as it applied to psychotherapy. These included: faith, anticipation, belief, confidence, conviction, and expectancy. The last term seems to have gained the most widespread acceptance. By the late 1950's, "expectancy" began to replace the term "placebo" and to emerge as a separate topic of study. In its most common usage in psychotherapy research, expectancy refers to a client's prediction, made near the beginning of treatment, concerning the likelihood that
therapy or a particular therapeutic procedure will bring about symptom relief. This is more precisely termed prognostic expectancy or expectancy of therapeutic gain. The term expectancy may also refer to expectations regarding which treatment procedures will be employed, the therapist's or patient's role, the length of therapy, and the like. The development of the expectancy construct and various types of expectancy will be discussed next.

Cartwright and Cartwright (1958) discussed the types of psychotherapeutic expectancy to which Rosenthal and Frank (1956) had referred in terms of four categories: (1) belief that certain changes will result, (2) belief in the techniques or procedures as a source of help, (3) belief in the therapist as a source of help, and (4) belief in therapy with the source of help unspecified. Meltzoff and Kornreich (1970) further refined the concept of therapeutic expectancy by noting that it has an object, a direction, an instrumentality, and a temporal schema. They noted that a patient's belief or faith could be placed in either the therapist, the therapy or techniques, the patient himself, or in external forces such as time or other people. Paul (1966) defined expectancy effects as "behavioral change arising from nonspecific aspects of attention, suggestion and faith (in the therapist and his techniques) that are common to most such interpersonal situations (p. 5)."

Goldstein (1962b), in a review and analysis of the early expectation research, extracted two types of expectations relevant to the study of psychotherapy. Prognostic expectancies, the first type, were defined as the therapist's and client's assessments regarding the probability of success in the therapeutic intervention. Prognostic
expectancies may refer to the amount or rate of improvement, gain, or symptom relief the patient is expected to or expects to obtain as a result of treatment. This type is also described as expectancy of therapeutic gain. Participant role expectancies, Goldstein's second type, were defined as the anticipations held by the therapist and client regarding the kinds of personal attributes or behaviors both will display in the therapeutic relationship. Several authors (e.g., Berzins, 1977; Duckro, Beal, & George, 1979) have noted that participant role expectancies are difficult to distinguish from "preferences," although the latter may include more evaluative or need-determined components. For example, role preferences would involve wanting or desiring certain roles or behaviors, while expectancies would simply involve anticipating them. The distinction between expectations and preferences on a more general level is of considerable importance to the present investigation and will be discussed in more detail later.

A trait-state distinction of the expectancy of therapeutic gain or prognostic expectancies construct has also been described (Lick & Bootzin, 1975; Wilkins, 1973). Expectancy state, experimentally induced by instructions regarding the effectiveness of treatment procedures, is of less relevance to the present discussion and will be briefly reviewed later. Most of the early expectancy research focused on expectancy as "a trait characteristic of the attitude an individual brings into the therapy situation concerning how much benefit he will receive" (Wilkins, 1973, p. 69). These early studies seem a natural extension of the belief, widespread among clinicians, that patients' expectations of benefit are predictive of therapy outcome (e.g., Frank, 1961). As will be further
discussed, however, research has yielded equivocal support for this intuitively appealing notion.

In the typical early investigation, pre-treatment ratings of anticipated treatment gain, used as measures of "expectancy trait," were correlated with outcome measures of self-reported improvement or observer ratings. Several of these investigations demonstrated a significant relationship between initial expectancy of relief and therapy outcome (Friedman, 1963; Goldstein, 1960a; Goldstein & Shipman, 1961; Lipkin, 1954). Other studies, however, failed to demonstrate this relationship (Brady, Reznikoff, & Zeller, 1960; Goldstein, 1960b). Several of these studies will be described briefly.

Goldstein and Shipman (1961) and Friedman (1963) administered a symptom intensity rating scale to psychoneurotic outpatients on three occasions: twice prior to the initial interview, under "present self" and "expected self" test-taking orientations, and once immediately after the initial interview under the "present self" orientation. The difference between the present and expected self ratings was taken as a measure of expectancy, while the difference between the two present self ratings was taken as the measure of therapeutic gain. Both of these studies showed a positive relationship between expectancy and therapeutic gain. In Friedman's (1963) study, this relationship was strongest for symptoms associated with anxiety and depression.

Goldstein (1960a), measuring both expectancy and self-reported improvement over a 7½-week period, found a significant relationship between these measures for both therapy and waiting-list control
patients. He advocated discarding the term "spontaneous remission" in favor of describing control patients' improvement as a function of expectation of improvement and nonspecific professional attention.

Brady, Reznikoff, and Zeller (1960), studying hospitalized psychiatric patients, failed to verify the influence of expectancy on improvement. Their measure of expectancy, however, was highly inferential, based on projective tests (sentence completion and a TAT-like device). Additionally, their measure of improvement, while based on therapist ratings, fused decrease in symptomatology with improvement in psychopathology. It has long been suggested that symptoms are more likely than psychopathology to be influenced by expectations of improvement (Frank, 1961; Frank et al., 1959).

Wilkins' (1973) review of the expectancy trait literature pointed to differences in outcome criteria as one factor leading to the inconsistency of these findings. Wilkins observed that in those studies which utilized patient self-report measures of both expectancy and outcome, a positive relationship between expectation of relief and outcome was obtained. However, in those studies where outcome was assessed by independent judges "blind" to patients' expectations this relationship was not supported. It should be noted, however, that several studies utilizing independent ratings of improvement have appeared since Wilkins' review and have yielded support for the expectancy trait notion (e.g., Gottschalk, 1974; Martin, Sterne, Moore, & Friedmeyer, 1976).

In his review, Wilkins (1973) also criticized the prevalent tendency to attribute causality to expectancies. He cautioned that
such an interpretation was particularly inappropriate due to the use of correlational designs and the possible correlation and confounding of expectancy with other organismic variables. Distinguishing between deterministic and actuarial usage of the term, Wilkins (1973, 1977) argued that expectancy, rather than causing improvement, may only be a prediction about improvement based on the information a client has received.

With this examination of the literature concerning expectancy of therapeutic gain complete, investigations of expectations regarding the therapist's role and the focus, aims, and procedures of therapy will now be described. These studies are concerned not with clients' predictions regarding the success of treatment, but rather with their anticipations regarding what will occur over the course of treatment or what treatment will involve.

Clients' Treatment Expectations

Interest in clients' treatment expectations has generally been based on the assumption that disconfirmation of expectations is a negative influence in psychotherapy (Duckro et al., 1979). The literature relating to this hypothesis will be discussed here in two sections. To be reviewed first are attempts to shape more positive and realistic treatment expectations through the use of preparatory and structuring techniques in psychotherapy. The second area to be reviewed includes, first, studies delineating clients' expectations regarding treatment goals and procedures and the therapist's role.
Also included are studies investigating the relationship between these expectations and therapy process or outcome. These studies are of considerable importance since, unless such a relationship is established, the existence of client treatment expectations would be of little clinical relevance.

**Shaping expectations.** Based on the assumption that client expectancy of improvement and accurate expectations concerning what will take place in therapy should facilitate the course of treatment, numerous clinical procedures have been developed to shape clients' expectations prior to the initiation of treatment. These preparatory techniques have been employed in both expressive or insight-oriented therapy (Heitler, 1976) and behavior therapy (Wilson & Evans, 1977).

One early shaping procedure was described by Orne and Wender (1968). Their "anticipatory socialization" or "role-induction" procedure was devised as a means of preparing patients for insight or analytically-oriented therapy. This clinical interview method was designed to serve three major purposes: (1) to clarify the treatment roles of both patient and therapist, (2) to establish a rational basis for the patient to accept psychotherapy as a means of helping him deal with his problems, and (3) to outline the course of therapy and its vicissitudes, particularly the patient's anticipated negative feelings toward therapy and the therapist. The effects of the role-induction procedure have been investigated in several studies (Hoehn-Saric, Frank, Imber, Nash, Stone, & Battle, 1964; Sloane, Cristol, Pepernik, & Staples, 1970; Strupp & Bloxom, 1973; Yalom, Houts, Newell, and Rand, 1967). With one exception (Yalom et al., 1967), these studies
have suggested a consistent, modestly positive relationship between patient preparation and patient improvement.

A number of criticisms may be levelled at these studies. First, the preparations used in several studies (e.g., Hoehn-Saric et al., 1964; Yalom et al., 1967) confounded information regarding therapy with manipulations designed to enhance expectancy of therapeutic gain. Second, treatment expectations were not directly measured in these studies; it was simply assumed that more accurate patient expectations or more congruent patient-therapist expectations had been shaped. While changes in expectations are believed to have mediated the improvement following preparation, such an association or causal relationship has not been clearly established. Additionally, these studies have failed to provide information concerning the effective ingredients of these shaping procedures. A study of preparation for a behavioral treatment approach (Parrino, 1971) has conducted such a component analysis. Parrino assessed the effects of two types of pretherapy information on the outcome of an operant shaping approach to snake phobia. The first type of pretherapy information, termed "advance organizer," involved a general exposition of the concepts and principles of reinforcement theory. The second type provided information describing how the therapist and patient would behave in therapy. Parrino found that operant therapy in combination with either theoretical or role-descriptive pretherapy information was significantly more effective in producing snake approach behavior than operant therapy with either irrelevant or no information. A combination of descriptive and theoretical information did not enhance the effect of each singly.
Another approach to shaping client expectations, differing in timing and less well researched than preparation occurring prior to therapy, has been advocated by a number of clinicians. This approach, called "structuring," attempts to modify the client's expectations once therapy has been initiated (Frank, 1961; Goldfried & Davison, 1976; Rotter, 1954; Wolberg, 1967). Like preparation techniques, structuring is intended to reduce the extent of the discrepancy between the patient's and the therapist's treatment expectations and to provide a more realistic basis for therapy. Since different schools of treatment require quite different roles for the participants, the patient's expectations about the course and duration of therapy, the behavior required of him or her, and the role of the therapist may be quite different from the demands of the treatment approach or the expectations of the therapist. As earlier reviews have noted (Goldstein, 1962b; Lennard & Bernstein, 1960), in some cases such dyssymmetry of expectations has led to premature termination and a less successful therapy outcome.

Rotter (1954), recommending "successive structuring" as a continuous process in therapy, held that the patient and therapist should discuss their roles and responsibilities, their attitudes toward the therapy, the purposes and goals of treatment, the therapist's treatment plans, and the patient's expectations. In later expositions of the same basic approach, several behavioral clinicians (Cautela & Upper, 1975; Davison, 1969; Fish, 1973; Goldfried & Davison, 1976; Goldstein, Heller, & Sechrest, 1966; Wilson & Evans, 1977; Wolpe & Lazarus, 1966) have recommended exploring clients' expectations...
regarding the goals, the theories and techniques, and the outcome of treatment. These authors have suggested providing clients, early in treatment, with an explanation of the etiology or development of their presenting problems, a rationale for and description of the treatment procedures to be employed, and a clarification of the client's responsibilities. Of interest here, Klein, Dittman, Parloff, and Dill (1969), who observed Wolpe and Lazarus over a five-day period, concluded that their use of structuring enhanced the therapeutic relationship to provide a context in which behavioral procedures could be employed most effectively.

While structuring approaches typically follow from the clinician's theoretical system, some authors (Fish, 1973; Wilson & Evans, 1977) have advocated tailoring the structuring of treatment to the client's interests, attitudes, and belief structure. As an illustration, Fish (1973) suggested that structuring for systematic desensitization might involve a conditioning interpretation for an engineer with a very mechanistic view of the world and an analogy with hypnosis or "altered states of consciousness" for a young college student. Most of these authors, however, due to their theoretical orientation, have paid special attention to clients' expectations that are at odds with a behavioral approach to treatment. For example, Cautela and Upper (1975) have reported that a client entering behavior therapy may believe that treatment will be very brief, is appropriate only for simple, circumscribed behaviors, and requires less effort and cooperation on the part of the client. Goldfried and Davison (1976) reported that for behavior therapists a client's expectation of insight rather than relearning is particularly important to determine, since the
client may feel that change is unlikely in the absence of insight into early childhood experiences or underlying conflicts.

Some of these clinicians (e.g., Cautela & Upper, 1975; Lazarus, 1971) have described using other than behavioral procedures if, after a rationale and examples of its effective use have been presented, a client remains reluctant to use a particular procedure. Others (e.g., Goldfried & Davison, 1976) have recommended initially accepting the client's view of the problem and appropriate procedures and then gradually persuading the client of the equally plausible and effective behavioral orientation. Frank (1961) suggested that therapists modify their approaches to meet patients' treatment conceptions as a means of establishing and solidifying the therapeutic relationship. From that point, he suggested, the therapist can often modify patients' expectations. Psychoanalytically oriented therapists (e.g., Alexander & French, 1946; Sullivan, 1954) had earlier advocated a similar strategy. Sullivan, for example, suggested that:

what society teaches one to expect is important. The person who comes to the interview expecting a certain pattern of events which does not materialize will probably not return; he will not say nice things about the interviewer if the latter, feeling that the things expected by his client are irrelevant or immaterial, ignores these expectations and presents the client with something much "better." In other words, what a client is taught to expect is the thing that he should get—or, at least, any variation should very clearly depart from it in a rather carefully arranged way. (p. 28)

Both preparation and structuring approaches clearly place great emphasis upon patients' perceptions and valuation of various therapeutic approaches and procedures. An alternative to these approaches,
based on a similar emphasis, has also been suggested (e.g., Lorion, 1974a). Rather than attempting to increase the patient's understanding of therapy or changing his treatment expectations, Lorion has argued that therapists consider selecting treatment procedures that more closely match the patient's anticipations. He suggested, for example, that behavioral approaches, with their focus on specific complaints and provision of an active role for the therapist, might reduce attrition rates and dissatisfaction among clients who anticipate advice and concrete guidance. Authors advocating eclectic theoretical approaches (e.g., Dimond, Havens, & Jones, 1978; Yager, 1977) have similarly suggested that therapists define patients' problems and select treatment procedures in ways that are consistent with patients' beliefs and expectations concerning their problems and appropriate treatment. While many clinicians advocate such attempts to match patients' expectations, in the absence of ways to reliably assess patients' expectations, such strategies would likely be based primarily on therapists' preconceptions, with the resultant biases in treatment assignment that have been widely noted regarding lower-income patients (e.g., Garfield, 1971; Lorion, 1974a). Additionally, unless patients' treatment expectations clearly affect treatment outcome, such matching attempts would be of little value. This review will next focus on attempts to delineate client treatment expectations and to demonstrate a functional relationship between these expectations and treatment process or outcome.

Delineating treatment expectations and the effects of disconfirmation.

Interest in the impact of client role expectations in psychotherapy has a
relatively long history. Kelly (1955) postulated that most clients enter treatment with a highly personalized conceptualization of the nature of the therapeutic relationship and of the therapist's role. Kelly believed that if the therapist ignores or rejects the client's preconceptions, particularly in the initial stage of therapy, the client will experience confusion or disappointment. Lennard and Bernstein (1960), in a similar vein, argued that dyssymmetry of therapist-client role expectations may result in disequilibrium or "strain" in therapy. Strain could be reflected in clients' breaking appointments, discontinuing treatment, or verbalizing dissatisfaction with treatment.

Several attempts have been made to discover the predominant therapist roles or behaviors envisaged by patients (e.g., Apfelbaum, 1958; Heine & Trosman, 1960). Additionally, a number of studies have investigated the relationship between congruence of therapist and patient role expectations and therapy process and outcome. These studies have been grounded in the assumption that mutuality of expectations should facilitate therapy, while widely discrepant expectations may make difficult the establishment of a therapeutic relationship.

In contrast to studies exploring clients' role expectations, several studies have attempted to delineate clients' conceptions regarding the procedures, goals, and topics of therapy. A number of investigations have compared clients' expectations of what would take place in therapy with what actually occurred, in an attempt to explain client dissatisfaction or discontinuance in treatment. If the expectation and the reality of treatment are highly discrepant, it is conceivable that the client may be dissatisfied, more inclined to terminate treatment, or less likely to show a favorable outcome.
In the classic descriptive study in the area of role expectations, Apfelbaum (1958) performed a cluster analysis of the Q sorts of outpatients at a university psychiatric clinic. Three role expectancy types were suggested: (1) the nurturant therapist (giving, protecting, and guiding), (2) the critical therapist (analytical and judgmental), and (3) the model therapist (well-adjusted, diplomatic, and permissive). Other investigators have reported a similar triad of role expectancies (Lorr, 1965; Rickers-Ovsiankina, Berzins, Geller, & Rogers, 1971). While Apfelbaum considered these types to represent stable dimensions of transference, Rickers-Ovsiankina et al. (1971) described them as situational, therapist-influenced role-definitions which might vary over the course of treatment.

Heine and Trosman (1960) investigated patients' initial expectations of psychiatric treatment using a questionnaire designed to tap several areas: patients' reasons for seeking help, their expectations regarding the type of assistance they would receive, and their degree of conviction that treatment would be helpful. Two types of expectations were identified: the guidance model and the collaboration model. The predominant expectations of this sample, clearly fitting the guidance model, were of an active, directive therapist and a passively cooperative patient. Heine and Trosman also investigated the relationship between patient expectations and continuation in treatment. The total group of 46 patients was dichotomized in terms of whether they remained in treatment or had dropped out of treatment within six weeks. Terminators' questionnaire responses reflected an emphasis on passive cooperation and receiving medicine or diagnostic information. Continuers,
in contrast, emphasized active collaboration with the therapist and receiving advice or help in changing behavior. Continuers' expectations were judged to be shared by the majority of therapists in this study, although therapists' expectations were not measured directly. Patients' degree of conviction that treatment would help was unrelated to continuation.

In another naturalistic study relating treatment expectations to continuation in therapy, Kline, Adrian, and Spevak (1974) employed a multiple-choice questionnaire to survey patients' evaluations of outpatient psychiatric services. Patients who, in the therapist's opinion, had discontinued treatment prematurely expressed dissatisfaction with their therapists' interest in them. Additionally, nearly three-fourths of the terminators described little value in self-understanding or in the specific directions they had received in therapy. Whether these areas of dissatisfaction had indeed led to termination could not be determined from this retrospective account. Such a causal relationship is questioned, however, by the finding that 36% of ongoing patients had expressed similar dissatisfaction with the value of specific directions they had received. The internal and external validity of this investigation are limited by several factors. First, it is unlikely that a representative sample of terminators was contacted. Only one-third (33 of 100) of the terminators could be contacted. Further, different procedures for questionnaire administration for continuers and terminators could have affected the responses of these two groups. While terminators were contacted by telephone, ongoing patients completed the survey in the clinic.
personnel encouraged ongoing patients to respond frankly and sought to dispel their suspicions about the survey, such procedures might not have overcome a perceived link between therapeutic services and survey responses.

Martin, Sterne, and Hunter (1976) assessed the role expectations of 144 psychiatric inpatients and 77 therapists, using an expectancy inventory devised by Lorr (1965). This inventory required different judgments of patients and therapists: patients were asked to indicate the behaviors they expected of their therapists, while therapists were asked to indicate the behaviors they expected of their patients or believed their patients would expect of them. Factor analysis generated nurturant and critical factors for both patients' and therapists' inventory responses, permitting examination of both types of expectations within patient-therapist dyads. Unfortunately, dyads were not formed on the basis of their role expectancies, but rather on the basis of usual hospital procedures. Mutuality of patient and therapist nurturant and critical role expectations, when considered singly, showed no relationship with either patient or therapist satisfaction with treatment. When both types of role expectations were considered together, however, both patients and therapists in the mutual high nurturant-low critical condition reported the greatest satisfaction with treatment. This condition included only 6% of the therapy dyads, however.

Begley and Lieberman (1970), using a modified version of a questionnaire developed by McNair and Lorr (1964), investigated which techniques as well as behaviors 65 mental health center clients
expected of their therapists. Patients' questionnaire responses were scored on the basis of three factors (analytic, impersonal, and directive) derived from therapists' responses in an earlier study (McNair & Lorr, 1964). Low inter-item correlations within these factors suggested that patients may not view therapy from this frame of reference. A cluster analysis of patients' responses was also performed. This analysis yielded two clusters, with 21 patients in the first cluster and 12 in the second. The first patient group anticipated discussion of childhood and the unconscious and an active, directive, and warm therapist. The second group expected the therapist to take a more detached, passive, and objective role. It should be noted that 32 patients, or nearly half of the sample, fit neither of these clusters. Interestingly, 87% of all patients expected exploration of their childhoods and expected to be asked to say whatever comes into their minds. While this finding may suggest some acceptance of psychoanalytic doctrine, it may also reflect a positive response bias created by Begley and Lieberman's use of a 2-point (yes-no; true-false) rating scale. Of interest is a later investigation of the construct validity of this scale using college students instructed to assume they were patients referred for psychotherapy (Lieberman & Begley, 1972). These authors found no relationship between the cluster 1 and 2 dimensions of involvement expected with a therapist and measures of locus of control, social interaction style, or self-disclosure.

Garfield and Wolpin (1963) investigated the treatment conceptions of 70 patients applying for outpatient therapy, using a 60-item multiple-choice questionnaire. Psychotherapy was seen as the treatment
of choice by 88% of the sample, while 98% believed psychotherapy would be of at least moderate help. The chief topic of discussion in therapy was considered to be one's early life by 27% of the sample and to be the more recent past by 47%. Of further interest, half the subjects indicated that the most important thing the therapist does is to help the patient understand himself better. Giving advice and guidance was considered most important by 33%, while the remainder of the sample (17%) indicated that helping the patient "get things off his chest" or to use his own resources was most important. While these responses suggest that two-thirds of the sample expected therapists to place considerable responsibility on clients to help themselves, most patients expressed a preference for advice over assistance in developing self-understanding.

Gladstein (1969) investigated the treatment expectations of high school students seen through a university counseling practicum. A content analysis was performed on these clients' responses to open-ended questions concerning what they hoped to accomplish through counseling. The primary expectation, both before and after counseling, was for vocational help. Although significantly fewer clients reported having received vocational or educational assistance than had wanted this help, satisfaction ratings were related to these expectations and discrepancies only for those subjects who indicated that they had received no benefits from treatment. While Gladstein's study is valuable in having employed an open-ended format rather than relying upon predetermined categories of expectations, the homogeneity of the client sample restricts the generalizability of these results.
Further, despite Gladstein's intent and description, the focus of this study appears to be preferences rather than expectations.

In another study of patients' expectations of treatment approaches or techniques (Hornstra, Lubin, Lewis, & Willis, 1972), standardized interviews were conducted with 611 applicants to a community mental health center. Of interest to this discussion are the clients' responses to an open-ended question: "What is the best possible treatment you could have right now?". A desire for medication was indicated by 15.5% of the clients and for "talking therapies" by 13.8% of the clients. Although 60.5% of these clients had had previous psychiatric treatment, nearly 30% of the sample were unable to state a preferred type of treatment. When the above question was posed in a multiple-choice format, however, patients were more likely to specify a treatment choice. The talking therapies were chosen by 51.7% of the clients, while 22.4% chose medication. Some authors (e.g., Lorion, 1974a) have advocated the use of open-ended interviews in the identification of patients' treatment expectations, suggesting that available questionnaires and structured interviews may limit the types or goals or treatments patients target as anticipated or desired. In addition to associated problems relating to subjectivity of scoring, the findings of Hornstra et al. suggest that patients might have difficulty expressing their treatment expectations within a purely open-ended format.

Socioeconomic status has frequently been discussed as a possible correlate of clients' expectations regarding psychotherapy (Heitler, 1976; Lorion, 1974a). Since much of the knowledge regarding clients'
treatment expectations has been drawn from investigations of social-class differences in expectations, several of these studies will be reviewed.

Two studies (Aronson & Overall, 1966; Overall & Aronson, 1963) have been widely cited as confirming the existence of social-class differences in treatment expectations. These authors devised a 35-item questionnaire tapping patient expectations of therapists' roles along five dimensions originally suggested by Hollingshead and Redlich (1958). Hollingshead and Redlich had hypothesized that lower-class patients would expect therapists to assume an active-directive and supportive role and have a medical orientation, while middle-class patients would expect therapists to assume a passive role and have a psychiatric orientation.

In the first study (Overall & Aronson, 1963), lower-class patients were found to score high on all five dimensions of expectations, including that of therapists' having a psychiatric orientation (e.g., focusing on emotional or dynamic material). No middle-class comparison group was employed in this study. Overall and Aronson acknowledged that their failure to support Hollingshead and Redlich's conceptualization may have been due to the conditions of data collection and a resultant yea-saying response set. Their expectation questionnaire was administered orally by a white, middle-class interviewer and required yes-no responses. The lower-class patients, most of whom were black, could have perceived agreement with the questions as a condition of acceptance into treatment.
Of additional interest in this first study, patients judged the therapist's behavior in the initial interview to have been less active and medically oriented than they had expected. In a further analysis, patients were grouped according to whether they returned after the first interview. Compared to returners, non-returners' expectations of the therapist's role were significantly more directive than their perceptions of the therapist's behavior in the initial interview. This study provides suggestive evidence that expectations incongruent with what actually occurs in treatment may be associated with dropping out of treatment.

In the second study, Aronson and Overall (1966) compared 40 lower-class and 40 middle-class patients' responses to their expectation questionnaire. Only 18 of the 35 items differentiated the two social classes, with most of these falling within the active-directive, supportive, and passive categories. To a greater extent than the lower-class patients, middle-class patients recognized that they would need to discuss affect-laden material and determine the direction of discussion in therapy. They also recognized that the therapist was not likely to recommend solutions to their problems. The two classes held similar expectations of therapists' medical and psychiatric roles.

Lorion (1974b) conducted a replication of Overall and Aronson's work which avoided their confounding of social class and race. A shortened version of Overall and Aronson's expectation questionnaire was administered to working-class, middle-class and unskilled or unemployed, white applicants for outpatient therapy. Subject groups
were matched for age, marital status, religion, and sex. Since no social-class differences in treatment expectations were found, Lorion recommended careful reevaluation of assumed differences in treatment expectations across socioeconomic groups.

Goin, Yamamoto, and Silverman (1965) examined 250 lower-class clients' expectations of either insight therapy or active help, such as advice or medication. These expectations were measured on the basis of a single item, which required clients to choose between the following: "I want to solve my problems by talking about my feelings and past life" and "I am here because I want to solve my problems by having the doctor do something to make me feel better." Insight therapy was desired by 52% of the sample; active held by 48%. This naturalistic study also involved a post hoc analysis of the effects of receiving therapy either congruent or incongruent with these expectations. Contrary to Overall and Aronson's (1963) results, expectations incongruent with the nature of treatment received did not relate to earlier termination. A relationship to client satisfaction was noted, however. Of those clients who expected advice and received it, 72% expressed satisfaction with treatment. This figure contrasted with only 57% of those who expected advice and did not receive it. Therapist ratings of improvement did not differ across these two groups.

Lazare, Cohen, Jacobson, Williams, Mignone, and Zisook (1973) conducted a survey of patient treatment requests. These authors differentiated patient requests from expectations, describing the former as representing hopes or desires and the latter as representing
anticipations of roles, techniques, the duration of treatment, and outcome. This distinction parallels the preference-expectation differentiation others have recently made (e.g., Dreman, 1977; Duckro et al., 1979). Based on interviews with 200 patients at a psychiatric walk-in clinic, Lazare et al. evolved 14 categories of patient requests, which seemed to fall within three groupings: (1) wanting the therapist to be a supportive person, supplying advice and succorance and permitting ventilation; (2) to be a physician, providing medical information, social interventions, or administrative functions; and (3) to be a psychotherapist, providing clarification and insight. Lazare et al. recommended discussing these requests with the patient in deciding upon a course of treatment, conceptualizing the patient role as that of a customer whose requests are usually legitimate.

Frank, Eisenthale, and Lazare (1976) employed an 84-item self-rated patient request questionnaire based on the categories Lazare et al. (1972) had described. Responses of 278 patients at a psychiatric walk-in clinic revealed no social-class differences for 8 of the 14 request categories: clarification, ventilation, control, confession, psychodynamic insight, reality contact, advice, and medical advice. Compared to patients from classes I through IV, however, class V patients requested more psychological expertise, succorance, community triage, social intervention, and administrative help. For all classes, the most frequently endorsed requests tended to be clarification, ventilation, psychological expertise, and psychodynamic insight.
Frank et al. (1976) agreed with the conclusion of previous reviews (Garfield, 1971; Lorion, 1974a) that social-class differences in treatment disposition and outcome may reflect therapists' stereotyped notions about class-linked treatment conceptions, so that neither lower- nor higher-class patients receive the type of treatment they might want. Garfield (1971) suggested that all social groups share misconceptions about treatment equally. For example, Hill (1969) found that middle-class patients most frequently endorsed insight in combination with advice as their desired treatment, while their therapists endorsed insight alone. Clients in another study (Bent, Putnam, Kiesler, & Nowicki, 1975), whose median educational level was two years of college, expected to receive advice and medicine "quickly" and to show some improvement "very soon." Frank et al. (1976) found that higher-class patients wanted as much control, advice, and medical help as the lower-class patients.

Thus, the literature concerning social-class differences in client expectations and treatment preferences is, at best, mixed. There appears to date to be no conclusive evidence that lower-class patients expect or want anything different from their higher-class counterparts. Of greater pertinence to the present investigation, however, is the general finding that clients may have definite treatment expectations and that differences in treatment expectations may exist both between and within client samples.

The literature concerning client treatment expectations, while delineating definite expectations and variations in these among clients,
does not provide strong support for the hypothesis that disconfirmation of expectations is a negative influence in psychotherapy. Several reviewers have concluded that congruence between client and therapist expectations or between client expectations and what actually occurs in treatment does facilitate continuance in therapy (e.g., Baekeland & Lundwall, 1975; Berzins, 1977; Parloff, Waskow, & Wolfe, 1978). These reviewers have, however, described virtually no relationship between incongruent or disconfirmed treatment expectations and client improvement. This failure parallels that described earlier regarding the relationship between expectancy of therapeutic gain and client improvement (Wilkins, 1973).

Duckro et al. (1979), reviewing primarily the literature on disconfirmed client role expectations, concluded that studies supporting and failing to support the disconfirmation hypothesis are equally divided, across a variety of dependent variables, including outcome, satisfaction, therapy process, and duration of stay. These authors concluded that only the role-induction strategy (e.g., Hoehn-Saric et al., 1964) has generated a predominance of studies in favor of the expectation hypothesis. Even here, interpretations are confounded by failure to assess clients' treatment expectations or to separate the effects of extra personal attention from presumed changes in expectations.

Duckro et al. criticized several earlier reviewers (Baekeland & Lundwall, 1975; Heitler, 1976; Lorion, 1974a) for having accepted the validity of the disconfirmed expectations-negative consequences hypothesis on the basis of very little empirical support. Baekeland and Lundwall, for example, concluded after examining only six studies
that discrepant expectations regarding the goals and methods of therapy were associated with dropping out of treatment. Even the review by Duckro et al., however, included only from 5 to 11 studies within each of the categories of dependent variables. Clearly, while the disconfirmation hypothesis has not been established with certainty, neither has it been tested adequately.

Several methodological and conceptual criticisms may be levelled at the existing literature regarding treatment expectations. First, few reports have included precise definitions of the form of therapy offered to clients. The different samples of clients and therapists employed across studies have been inadequately described, making it difficult to evaluate the appropriateness of client expectations in view of their presenting problems and therapists' treatment orientations. Procedures for assessing expectations also vary, in format and adequacy of construction and administration, across studies. Several studies (e.g., Goin et al., 1965) have relied upon single items to assess treatment expectations, raising questions concerning the reliability of measurement. Some multiple-item questionnaires may be criticized on grounds of questionable validity, associated with either a positive response bias due to simple "yes-no" response formats (e.g., Betley & Lieberman, 1970) or the conditions of data collection, with clients possibly perceiving a link between their questionnaire responses and the availability of therapeutic services (e.g., Kline et al., 1974; Overall & Aronson, 1963). Additionally, some questionnaires have
tapped clients' expectations regarding treatment techniques or therapist behaviors together with their expectations regarding such global variables as therapist personality (e.g., Begley & Lieberman, 1970). When expectations regarding solely the aims and procedures of treatment are assessed, these too are defined rather broadly. Two illustrations are the distinction between expectations or receiving advice or active help and insight therapy (e.g., Garfield & Wolpin, 1963) and between talking and receiving medication (Hornstra et al., 1972). Finally, different procedures for assessing outcome and continuation in therapy have been employed. For example, in one study premature terminators were so labeled on the basis of therapist opinion (Kline et al., 1974). Heine and Trosman (1960) classified treatment dropouts using six weeks as a cut-off, while Overall and Aronson (1963) used one interview as a cut-off. Such methodological variations clearly suggest caution in generalizing across studies and in evaluating the disconfirmation hypothesis on the basis of box-score summaries of results (e.g., Duckro et al., 1979).

Duckro et al. (1979) suggested that a major problem in this research area has been the ambiguous definition of the term "expectation." They delineated two competing definitions of expectation: one which adheres to the original use of the term (Apfelbaum, 1958; Goldstein, 1962b; Kelly, 1955) as the anticipation of some event, and a second which involves a desire or preference that some event should occur. Duckro et al. suggested that researchers' confusing these
contrasting usages of the term expectation may be a primary cause of the inconsistency of experimental findings. Some of the studies reviewed here have clearly employed the "anticipation" concept (e.g., Begley & Lieberman, 1970). Others, unknowingly, have utilized the "preference" concept (e.g., Gladstein, 1969; Goin et al., 1965; Hornstra et al., 1972). Relatively few authors have made the anticipation or expectation-preference distinction (Berzins, 1977; Dreman, 1977; Frank et al., 1976; Garfield & Wolpin, 1963; Pohlman, 1961). Pohlman (1961), for example, observed that client expectations may change or become more accurate over the course of therapy, without concomitant change in client preferences. Lazare et al. (1972), and, later, Frank et al. (1978) suggested that clients' preferences are likely of greater clinical relevancy and validity concerning a client's orientation to and probable suitability for a particular treatment than are expectations.

In addition to describing these definitional problems and distinctions, Duckro et al. (1979) discussed their implications for research in this area. They suggested modifying the major assumption and conceptualization of the effects of disconfirmed client expectations to include accounting for the preference variable. Drawing from Helson's (1959) adaptation-level theory, they speculated that expectation and preference may be hierarchically related, with preference a more basic variable underlying response to disconfirmation of an expectation. This hypothesis predicts that if an event that actually occurs is more highly preferred than an expected event, positive affect and approach motivation will result. If, on the other hand, an actual event is
less preferred than an expected event, negative affect and avoidance motivation will result. The intensity of positive or negative reactions is predicted to increase with greater discrepancies in desirability between the actual and the expected event. The effects of disconfirmation of an expectation are thus considered to be a function of both the direction and the intensity of the discrepancy.

This bipolar theory contrasts with the unidimensional position developed by McClelland, Atkinson, Clark, and Lowell (1953) which implicitly or explicitly underlies most research in the area. The latter theory holds that effects of disconfirmation arise solely as a function of the extent of the discrepancy between the actual event and the expected event. A small discrepancy is said to be associated with positive affect and approach motivation, while larger discrepancies are associated with more negative reactions. Block (1964) compared the unidimensional and bipolar positions in a study of client role expectations. Segments from actual therapy sessions were transcribed and rated independently by five judges "blind" to the hypotheses under investigation. Segments were dichotomously categorized along three dimensions: discrepancy (high-low), affect (positive-negative), and motivation (approach-avoidance). In support of Helson's bipolar theory, affective responses and motives were found to vary with the direction (more or less preferred), not the size, of the discrepancy. On the basis of Helson's theory and the preliminary support provided by Block, Duckro et al. (1979) suggested that future research not only address the question of whether a client's expectations are confirmed or disconfirmed, but
also ask whether the client wanted or did not want what he or she 
expected. Since the relationship between expectations and preferences 
is one focus of the present study, literature relating to treatment 
preferences will now be reviewed. As will be shown, studies of 
preference to date have continued to utilize the unidimensional 
hypothesis to explain the effects of failure to meet client preferences.

**Treatment Preferences**

While studies concerning client treatment expectations are some­
what limited in number, even fewer studies have attempted to delineate 
treatment preferences and to investigate the effects of unmet preferences 
on therapy process and outcome.

Dreman (1977) investigated the relationship between treatment 
preferences and expectations among 100 clients at a university 
counseling center and in comparison with nonclients. A 30-item 
questionnaire, consisting of 15 items prefaced by both "Do you want?" 
and "Do you think?" (for preferences and expectations, respectively), 
tapped a number of areas of counselor behavior. In comparison to 
nonclients, clients had significantly greater expectations of the 
counselor to help the client acquire insight and to analyze and 
interpret the client's emotional problems. Differences between pre­
ferences and expectations generally suggested that both clients and 
nonclients wanted or preferred more counselor activity than they 
expected to receive. For example, clients expressed a stronger 
preference for than expectation of counselor activity in the following 
areas: eliminating symptoms, explaining and interpreting the client's
problems, helping the client solve his problems and acquire insight, telling the client how to behave in different situations, and helping the client to be independent. Of further interest, while significant discrepancies between preferences and expectations were noted on 11 of the 15 comparisons in the nonclient population, only the above six significant discrepancies were noted in the client population. This finding of higher congruence between clients' preferences and expectations should be noted by investigators employing analogue populations.

Venzor, Gillis, and Beal (1976) employed Apfelbaum's (1958) three role expectancy types (nurturant, critical, and model therapist) in an adjective checklist format. Clients and nonclient undergraduate volunteers were asked to check those characteristics they would find desirable in a counselor. Subjects then read four scripts of a person with academic difficulties talking to a friend who responded in either an empathic, expository, interrogative, or competitive (assertive, challenging) style. Of interest here are subjects' responses to an item asking whether they would like a therapist to respond similarly to the friend in the script. On this quasi-behavioral index, neither clients nor nonclients demonstrated differential preference among the empathic, interrogative, and expository styles, suggesting a diversity of acceptable treatment tactics. All of these styles, however, were preferred to the competitive style. While generally Venzor et al. found little correspondence between the adjective checklist of preferred therapist characteristics and the quasi-behavioral index of preferred response styles, significant
correlations were found between valuing of nurturant characteristics and preferences for empathic and questioning response styles. Venzor et al. suggested that future studies employ measures of expectancy regarding actual therapist behaviors, using video, audio, or written samples of the behavior in question, and abandon measures of expectancy regarding global therapist characteristics.

Relatively few studies have tested the hypothesis that failure to meet clients' preferences regarding counselor behaviors or therapeutic procedures will result in a less desirable therapy process or outcome. Pohlman (1961) investigated the preferences regarding counselor behavior of 38 clients drawn from a university "how-to-study" course. Prior to counseling and again after a maximum of eight sessions, clients were asked to rate how often they would like 30 types of counselor behavior to occur. Comparisons of client preferences at the end of counseling and client estimates of how often each counselor activity had actually occurred revealed some interesting findings. Compared to the number of clients wanting them less, a significantly larger number of clients wanted more of 18 of the 30 counselor behaviors than they believed had occurred. These activities included giving advice and approval and discussing study habits, goals of living, and religious or moral questions. In contrast, more clients preferred less of the following activities: repeating what the client had just said, having the client do the talking and introduce new topics, and answering the client's questions by asking what the client thinks. It should be noted that the therapists employed in this study were beginning counselors, enrolled
in a university counseling practicum. Counselors' levels of experience may have affected preference ratings, with clients responding from a general set of wanting "more" from their counselors. While this study clearly demonstrated that client preferences regarding different counselor activities may vary, it did not evaluate the impact of these preferences on counseling outcome. This evaluation was, however, completed in a follow-up study. Pohlman (1964) found that perceived adherence of counselor behavior to client preferences bore no relationship to clients', counselors', or supervisors' judgments of the success of counseling.

A later study by Duckro and George (1979) similarly failed to support the unmet preferences hypothesis. These authors employed as subjects undergraduate students reporting some problem they wished to discuss with a counselor. The 24 highest and 24 lowest scorers on a measure of preference regarding counselor directiveness were randomly assigned to either a high- or a low-directive therapist. The therapists, doctoral students "blind" to subjects' preferences, conducted 30-minute interviews focusing on subjects' presenting problems. Neither process measures nor client satisfaction ratings reflected significant adverse effects of failure to meet subjects' preferences. Regardless of their expressed preferences, clients of high-directive therapists reported greater satisfaction with the therapeutic relationship than clients of low-directive therapists. The judged competence of low- and high-directive therapists did not differ.
Ziemelis (1974) investigated the effects of client preference and expectancy regarding counselor physical and personality characteristics on the process of an initial 30-minute interview. After stating their preference for one of two counselors, 60 rehabilitation clients were randomly assigned to their more or less preferred counselor and to one of three expectancy-manipulation conditions. Findings regarding preferences were mixed. Client and counselor self-report ratings of the therapeutic relationship revealed no effects of assignment to a more or less preferred counselor. Significant effects were found, however, on independent observers' ratings of the depth of interaction in the session. Interestingly, after the initial interview all clients reported stronger preferences for the counselor they had seen. This effect was most striking for those clients assigned to their less preferred counselor. Effects of the expectancy manipulation were revealed only on client self-report ratings. The negative-expectancy manipulation (i.e., telling clients they would not be assigned to their preferred counselor) resulted in clients' reporting a less favorable view of the therapeutic relationship. As Ziemelis noted, however, this finding may have been due to demand associated with the negative-expectancy manipulation, since expectancy effects were not reflected in counselor or observer ratings.

Only one study (Devine & Fernald, 1973) has demonstrated the adverse effects of unmet preferences on outcome, and that study is of an analogue nature. Devine and Fernald found that snake-phobic subjects who had received their preferred treatment showed significantly greater snake approach behavior than subjects randomly
assigned across treatments or subjects assigned to their nonpreferred treatment. Inspection of this main effect revealed that these preference effects held in the encounter and rational-emotive treatment conditions, but not in the systematic desensitization or modeling-behavioral rehearsal conditions.

As the descriptive studies reviewed above suggest, clients undeniably enter therapy with certain preferences regarding therapist behavior and treatment approaches. While studies to date have not provided strong support for the unmet preferences-negative effects hypothesis, the available evidence is clearly too scant to warrant a conclusion that the hypothesis has been adequately tested. Additionally, studies have typically involved limited therapeutic contact, often of the nature of an intake interview (e.g., Duckro & George, 1979; Ziemelis, 1974). Further, clients' presenting problems have been either clearly circumscribed, such as study problems (Pohlman, 1961, 1964), or analogue in nature (Devine & Fernald, 1973; Duckro & George, 1979).

**Expectancy of Gain Associated with Behavioral Treatment Procedures**

Several reviews have recently appeared concerning the operation of nonspecific factors in behavioral approaches to treatment (Bernstein & Nietzel, 1977; Borkovec, 1973; Borkovec & O'Brien, 1976; Davison & Wilson, 1973; Kazdin & Wilcoxon, 1976; Lick & Bootzin, 1975; Rosen, 1976; Wilkins, 1971, 1973). Consideration of the role of nonspecific factors in behavioral treatment approaches has received major impetus from analogue research investigating behavioral fear-reduction
techniques, particularly systematic desensitization. These investigations have focused chiefly on one nonspecific factor, subjects' expectancy of therapeutic gain, since this has frequently been proposed as an alternative to "active" change mechanisms used to explain the effects of desensitization (e.g., counterconditioning or extinction).

As Lick and Bootzin (1975) have noted, two basic strategies have been employed in behavioral investigations of expectancy of therapeutic gain. In the first category, systematic desensitization and other treatment procedures are contrasted with placebo manipulations which are considered inert from the perspective of counterconditioning theory. These studies, of greater relevance to the present review, will be considered in more detail later. In the second category, investigations have attempted to induce different expectations of outcome for the same technique. This strategy, involving the manipulation of expectancy state, was adopted in an attempt to circumvent the interpretive difficulties inherent in expectancy trait notions (Wilkins, 1973, 1977). In most of these studies, expectancy state is manipulated through information presented to subjects about the effectiveness of therapeutic procedures to which they will be exposed. Subjects are told, for example, that a technique has been demonstrated to be either effective (a positive-expectancy manipulation) or ineffective (a negative-expectancy manipulation). In other studies, the expectancy manipulation involves presenting subjects with information disguising
the therapeutic intent of treatment procedures. For example, subjects are led to believe that they are participating in a study of physiological reactions to feared stimuli.

These studies have in general failed to demonstrate a significant relationship between expectancy state and outcome (Rosen, 1976). Wilkins' (1973) review listed six studies that showed a significant positive effect of expectancy manipulations on behavioral measures of fear, eight that did not, and one that showed both positive and negative effects. In an attempt to explain the inconsistency of these findings, Wilkins argued that expectancy effects could be a function of experimenter bias. He observed that in the few studies with positive findings, the therapists were not blind to the experimental manipulations, while therapists were blind in those studies failing to demonstrate expectancy effects. A recent experiment by Rosen (1974), however, appears to discount Wilkins' argument. Therapists in this study were blind to the experimental manipulations, and an expectancy effect was still obtained. Hamilton (1977), however, has criticized Rosen's study on several grounds: its apparent use of low-to-moderate fear subjects, reliance on recruited rather than volunteer subjects, and the apparent weakness of the expectancy manipulation since the outcome of the therapeutically oriented group differed significantly only from the no-treatment group, not from the experimentally oriented group. Hamilton concluded that, because of these methodological problems, Rosen's study does not provide adequate evidence to dismiss Wilkins' experimenter bias explanation of divergent findings.
An additional criticism of the research manipulating expectancy state is that all of the studies reviewed by Wilkins (1973) inferred from outcome measures that a state of expectancy had been induced. None validated its existence independent of outcome or assessed the experiential impact of the instructions to determine whether they had in fact changed subjects' beliefs or generated differential expectancy for the treatment procedures. One notable exception to this confounding of measures of outcome with measures of expectancy and to the contamination of expectancy manipulations by cues and feedback in the treatment setting has appeared since Wilkins' review. Lott and Murray (1975) validated their expectancy manipulations for systematic desensitization with one group of snake phobic subjects and tested for behavioral effects of the manipulations with another group of subjects, employing experimentally blind raters. Subjects' verbal predictions of outcome on a behavioral avoidance checklist comprised the validation check. The positive expectancy manipulation group was found to predict significantly greater snake approach behavior than both the neutral expectancy and no-manipulation groups. Similar significant effects of the expectancy manipulations on actual snake approach behavior were later demonstrated by the target group of subjects.

Several recent reviews (Bernstein & Nietzel, 1977; Kazdín & Wilcoxon, 1976; Mathews, 1978; O'Leary & Borkovec, 1978) have concluded that standard means of controlling for nonspecific treatment factors, such as "pseudotherapy" (Lang, Lazovík, & Reynolds, 1965) and "attention-placebo" control groups (Paul, 1966) may be inadequate. This conclusion
was based on several investigations which found that treatment and control conditions may differ in credibility, i.e., in the extent that they generate client expectancy for improvement. As Rosenthal and Frank (1956, 1958) and, more recently, Baker and Kahn (1972) have argued, only when control procedures generate expectancy for improvement equivalent to that generated by "active" treatment procedures can behavior change be attributed to the active or specific ingredients of a treatment procedure. Therefore, finding differential credibility raises doubt concerning whether systematic desensitization includes a specific ingredient over and above expectancy effects.

Several recent investigations, employing the first research strategy described by Lick and Bootzin (1975), bear on this issue. These investigations of the expectancy-inducing qualities of systematic desensitization and other fear-reduction and placebo control procedures will be reviewed in considerable detail. These studies typically employ analogue subject populations, generally students recruited from undergraduate psychology classes and reporting some type of fear (e.g., snake phobia, test anxiety). These subjects are first exposed to written or audiotaped descriptions of treatment and control rationales and procedures or to videotaped excerpts of treatment. After this exposure, credibility or expectancy for improvement is assessed. Borkovec and Nau (1972) originated a now widely used self-report measure of credibility, involving five 10-point expectancy-for-improvement scales. These items involve rating the extent to which treatment and control descriptions seem logical, are likely to be successful in eliminating the particular fear under
study and a different fear, would be recommended to a friend, and would be undergone personally. Expectancy for improvement has also been measured by having subjects role-play or simulate performance on therapy outcome measures, such as the behavioral avoidance test (e.g., Lick & Bootzin, 1970; Nau, Caputo, & Borkovec, 1974). This behavioral measure of expectancy was originally described by Orne (1969).

Both self-report and simulation measures of expectancy have been criticized recently. Kazdin and Wilcoxon (1976) noted that self-report ratings of expectancy for improvement may appear relatively transparent to subjects, so that subjects may be responding to demand characteristics associated with the administration of the questionnaire. Simulation techniques share with behavioral avoidance tests a vulnerability to demand within the testing situation (Bernstein, 1973; Bernstein & Paul, 1971; Bernstein & Nietzel, 1973). McReynolds and Tori (1972), attempting to circumvent these difficulties, used an unobtrusive measure to assess treatment credibility. Subjects in this study of "blood and wound-related fears" were asked to cross out numbers on a sheet of paper, a bogus measure of fear actually relating to the nontarget response of frustration-tolerance. In this study, expectancy effects in the desensitization group were reflected on this bogus measure as well as on a behavioral measure of the target fear. Kazdin and Wilcoxon (1976) recommended that any single study employ both self-report, simulation, and unobtrusive measures in order to provide converging evidence regarding treatment credibility and client expectancy for improvement.
In the seminal study in this area, Borkovec and Nau (1972), using the self-report scales described earlier, had 450 unselected college students rate the credibility of one of six written placebo and treatment rationales and procedural descriptions. These descriptions were applied to the target problem of speech anxiety. The rationales of systematic desensitization were found to generate greater self-reported expectancy for improvement than all four placebo rationales. Interestingly, the rationale for Paul's (1966) attention-placebo group received the lowest credibility rating.

Osarchuk and Goldfried (1975), in an extension of Borkovec and Nau's research targeting test anxiety, failed to demonstrate differences in credibility among six therapy and placebo rationales. Even the least credible rationales in their investigation received equal or higher credibility ratings than the most credible rationales employed by Borkovec and Nau. These authors suggested that varying credibility ratings may be a function of the nature of the target behavior in question and/or of the subject population studied. Supporting the latter interpretation, Kirsch and Henry (1977) found significantly higher credibility ratings for speech-anxious undergraduates receiving treatment than for pretest pilot subjects who knew they would not be receiving treatment. In this study, oral descriptions of systematic desensitization, a non-extinction control, and a placebo condition were found to be equal in credibility. No significant between-group differences in outcome were found after five hours of treatment. Of additional interest, rated credibility was found to have a greater impact on self-report than on behavioral measures of speech anxiety.
In an extension of Borkovec and Nau's rating approach from phobias to the target problem of smoking, Hynd, Stratton, and Severson (1978) reported differential expectancies for improvement among various treatment and placebo control conditions. Subjects in this study, undergraduate self-reported cigarette smokers, read descriptions of five smoking control strategies: rapid smoking, covert sensitization, a combination of these two approaches, satiation, and relaxation. The relaxation technique was judged to be significantly more credible than the satiation technique. The other strategies' rated credibility did not differ significantly from that of relaxation or satiation.

Improving upon Borkovec and Nau's (1972) subject-selection procedure, McGlynn and McDonell (1974) studied only those female undergraduates judged to be snake-phobic on the basis of a behavioral avoidance test. Subjects listened to tape-recorded excerpts of both desensitization and a commonly used "pseudotherapy," relaxation with visualization of affectively neutral scenes. Forced-choice credibility ratings, based on Borkovec and Nau's five items, were employed. Subjects showed a significant preference for the desensitization tape on three items. They chose desensitization as more logical and potentially more successful in eliminating fears of snakes and rated themselves as more confident recommending it than pseudotherapy to a friend who was fearful of snakes.

McGlynn and Walls (1976) modified the design of McGlynn and McDonell's study by grouping subjects on the basis of initial level of snake fear, in order to investigate Borkovec's (1973) hypothesis
that intensity of fear may interact with demand characteristics to confound treatment effects. Further, since McGlynn and Walls exposed subjects to only one rationale, direct ratings rather than binary preferences or forced-choice ratings of credibility were obtained. While "mildly" avoidant subjects rated desensitization as relatively more credible than pseudotherapy (though not significantly so), "moderately" avoidant subjects did not. These differences are in line with Borkovec's (1973) suggestion that analogue subjects with less intense fears may be more responsive to demand cues for improvement.

Nau, Caputo, and Borkovec (1974) employed Borkovec and Nau's research strategy with self-described snake-fearful college students. Simulation, a behavioral measure of credibility suggested by Orne (1969), was employed in addition to a verbal self-report measure. This measure required that subjects role-play the effects of five weeks of treatment. Significant positive correlations were obtained between simulated improvement and subsequent verbal credibility ratings across all conditions. In the first experiment in this series, which utilized audiotaped procedural descriptions, implosive therapy and a relaxation-plus-recall component control received the highest verbal credibility ratings. Role-played improvement, however, was not significantly greater in the treatment than the control conditions. In the third experiment, subjects were presented with verbal descriptions as well as videotaped excerpts of treatment and control procedures, information deemed more analogous to that actually presented in therapy. In this experiment, simulated treatment response and verbal credibility ratings
were equivalent across all treatment and control conditions.

Findings in this area are contradictory and plagued with interpretive difficulties. Some studies (e.g., Borkovec & Nau, 1972; McGlynn & McDonell, 1974) have demonstrated that treatment and control rationales generate differential expectancies for improvement. Other studies (e.g., Nau et al., 1974; Osarchuk & Goldfried, 1975) have not. As a whole, however, these studies do support Rosenthal and Frank's (1956) suggestion that psychotherapy outcome researchers take measures to ensure equivalency of nonspecific influences across treatment and control conditions. Further, while these studies do not unequivocally demonstrate that differential expectancies alone account for outcome differences between treatment and control groups, nonspecific effects are supported as one plausible rival interpretation of such differences.

One serious limit to the external validity of these studies, as Lick and Bootzin (1975) have noted, is that credibility ratings of therapy rationales or subjects' simulated responses to treatments they have not received may not correspond to expectancy ratings of clients undergoing treatment. Actual exposure to treatment procedures and the feedback experienced while receiving treatment likely affect expectancy and may even alter initial expectancy of clients. Further, serious doubts exist regarding the appropriateness of generalizing from experimental analogue populations to phobic clinical populations (Bernstein & Paul, 1971; Borkovec, 1973; Rosen, 1975). Most of these studies have recruited and employed mildly phobic subjects who are likely less strongly motivated for treatment than self-referred clients. Another criticism of these studies involves the vulnerability to demand
and poor reliability associated with a self-report scale or behavioral avoidance test administered on a single occasion. While circumvention of these methodological difficulties and extension of this research strategy to clinical populations are sorely needed, studies to date do provide suggestive evidence concerning the relative expectancy-inducing qualities of treatment and control procedures.

Though applauding beginning research efforts, Bernstein and Nietzel (1977) have stressed the need for further operationalization of nonspecific factors associated with behavioral interventions and for more precise equation of the stimulus values of various treatment and control conditions. They called for continued investigation of the relationship between descriptions of to-be-administered treatments and subjects' subsequent verbal and nonverbal behavior on treatment-relevant dimensions. Accepting O'Leary and Borkovec's (1978) argument that analogue therapy and psychotherapy may be viewed as ends of a continuum rather than as dichotomous forms of intervention, an analogue approach to Bernstein and Nietzel's questions may still offer valuable information concerning theoretical and methodological issues in expectancy research. In closing, it should be noted that these investigations have chiefly been conducted to assess the credibility of placebo manipulations in order to devise adequate, maximally convincing control conditions for psychotherapy research. Of greater relevance to the present investigation, however, are their findings of differential credibility between active treatment procedures. For example, Borkovec and Nau (1972) found that descriptions of implosive therapy and desensitization generated equivalent expectancy for
improvement. Further, as Borkovec's (1973) review suggested, more credible treatments have been shown to lead to greater therapeutic gain across a variety of behavioral procedures, including desensitization, implosive therapy, and operant shaping. This review will next consider research assessing subjects' perceptions and expectations of a wider range of treatment approaches, particularly studies comparing behavioral and insight-oriented approaches.

Preferences and Expectations Regarding Contrasting Treatment Approaches

A limited but growing body of research has investigated the desirability and perceived effectiveness of the theoretical rationales and techniques associated with different therapeutic approaches. These investigations differ in intent from studies described earlier which compared the credibility of behavioral fear-reduction techniques and control procedures. The credibility studies were aimed at selecting or developing credible control conditions, in order to permit clearer demonstration of the specific effects of systematic desensitization in therapy outcome research. The studies to be reviewed next are directed at determining preferences for a wider range of treatment approaches. These studies typically present subjects with written descriptions or filmed or audiotaped demonstrations of a number of therapeutic approaches (e.g., psychoanalytic, client-centered, and behavior therapy). Subjects are then asked to complete preference or perceived effectiveness ratings. These studies will be discussed in considerable detail.

Fancher and Gutkin (1971) hypothesized that attitude toward science would moderate attitudes toward specific therapies. After
measuring undergraduate students' general attitude toward science, these authors presented subjects with written statements describing two insight therapies (psychoanalytic and client-centered therapy) and two behavior therapies (Wolpe's reciprocal inhibition and implosive therapy). Each description included information concerning the therapy's philosophical framework, goals, conceptions of behavior disorder, and specific therapeutic procedures. Descriptions were not directed specifically to any type of psychological problem. Subjects were then asked to rank order the four therapies along the following dimensions: general preference (how personally appealing), the likelihood of seeking each therapy for help with a mild and severe behavior disorder, and how scientific each seemed. Although the behavior therapies were rated as more scientific than the insight therapies, subjects' general attitudes toward science did not correlate with their therapy preferences. Preference ratings clearly favored the insight therapies. While psychoanalytic and client-centered therapy received almost identical general preference ratings, client-centered therapy was most preferred for "mild" disorders and psychoanalysis for "severe" disorders. Whether such preferences would hold with patients receiving such treatments, rather than simply being presented descriptions of them, cannot of course be determined from this study. In a later study, Boudewyns and Borkovec (1974), employing descriptions of the same two insight and two behavioral therapies, also found a preference for the insight therapies.

Results contradictory to those of Fancher and Gutkin (1971) were obtained by Holen and Kinsey (1975). These investigators had college
students listen to three demonstration tapes (Shostrom, 1966), unidentified but illustrative of behavioral, client-centered, and psychoanalytic therapies. Therapists were nationally recognized proponents of their treatment approaches. Each worked with the same client and same presenting problem, recurrent headaches. After listening to each tape, subjects rated their preference and the believed effectiveness of each. The behavior therapy was more highly preferred and believed more effective than both the client-centered and psychoanalytic tapes. Though important in demonstrating that subjects' acceptance and confidence do vary across treatment approaches, the design of this study confounds therapists and techniques and therefore does not permit a conclusion that this variance in preference is due solely to aspects of theories or techniques. Further, these preferences are specific to a particular presenting problem.

Knudson and Carskadon (1978) classified 140 college students into four conceptual or belief systems, varying along the dimension of concreteness-abstractness. Subjects were then presented with written descriptions of client-centered therapy and behavior therapy and asked to indicate, apparently on a single forced-choice item, their preference between the two therapies. Two weeks later, half the subjects observed a demonstration tape (Shostrom, 1966) of their preferred therapy, while half viewed their nonpreferred therapy. Afterwards, subjects again stated their therapy preferences. Only 10.7% had changed from their initial preference, so that exposure to either a preferred or non-preferred tape did not seem to have modified expressed preferences. Subjects in all four conceptual systems showed an overall preference
for client-centered therapy over behavior therapy (76.4% to 23.6%). Individuals in the more concrete conceptual systems, however, showed relatively stronger preferences for the behavioral approach, while those in the more abstract conceptual systems showed greater preferences for the client-centered approach. Subjects' preference for client-centered therapy is a finding consistent with that of the Fancher and Gutkin (1971) study. Surprisingly, however, Holen and Kinsey (1975), using the same demonstration tapes, found a preference for the behavior therapy tape. One possible explanation of this discrepancy is that the written descriptions initially presented to subjects in the Knudson and Carskadon study may have interacted with the demonstration tape to increase preference for client-centered therapy. Further, subjects in the Knudson and Carskadon study were asked to state a preference for one form of therapy before viewing the demonstration tapes. This commitment or a desire to appear consistent may have made subjects unwilling to report a change of preference, even if the behavioral tape had had such an impact.

Slaney (1977), in contrast to previous studies' investigations of relative preference for a number of treatment approaches, had subjects rate only one of two transcripts. Students in an adult education program were presented with a written transcript composed of nine client-counselor interactions. This transcript represented an excerpt from a counseling session and provided information summarizing the previous three sessions of treatment. Subjects were asked to put themselves in the role of the male client, who was experiencing
difficulties at work, home, and in social situations and who was anxious, unassertive, and unsure of himself. In one form of the transcript, the counselor made nine facilitative responses (designed on the basis of Carkhuff's (1969) Empathy Scale). In a second form, the counselor's ninth response was a suggestion of assertiveness training. Subjects, after reading the transcripts, rated the counselor's expertness, understanding, and appeal and estimated the eventual outcome of treatment. The counselor suggesting assertiveness training was perceived as significantly more expert and appealing than the counselor employing solely the facilitative conditions, and his treatment was estimated as potentially more effective. Sex differences appeared on two ratings: females rated counselors as more expert and rated the facilitative conditions treatment as more effective than did males. The generalizability and usefulness of these findings with actual clients cannot be estimated. Additionally, this study does not permit a clear comparison between a client-centered and a behavioral form of treatment, since the counselor suggesting assertiveness training also utilized the facilitative conditions. Further, subjects' more favorable perceptions of assertiveness training may be specific to this particular client problem (a lack of assertiveness).

Stuehm, Cashen, and Johnson (1977) presented introductory psychology students 15-minute videotapes of simulated first counseling sessions, illustrative of humanistic, psychoanalytic, and behavioral approaches. Each approach was demonstrated by the same counselor with the same client and same (unspecified) presenting concern. Subjects' responses to a single question concerning which taped segment they had preferred
indicated a strong preference for the behavioral approach (by 65 of 94 subjects, with 20 preferring humanistic and 9 psychoanalytic). Subjects' responses to an open-ended question concerning why they preferred a particular approach suggested that the "structure" of the behavioral treatment (i.e., the appearance that something was being accomplished) was important in subjects' preferences. Limitations of this study include the use of a single question to determine preference, which raises questions concerning reliability of measurement, and the use of a single therapist to demonstrate all three treatment approaches. Potential biases of the therapist in favor of one approach or greater facility with one treatment were not discussed in this report. The composition of the subject pool also limits the generalizability of these findings. Since a primary (and unsupported) hypothesis of this study was that therapy preference might vary with locus of control orientation, the sample was limited to high "external" and high "internal" subjects.

Wollersheim, McFall, Hamilton, Hickey, and Bordewick (in press) examined the effects of therapy rationale and type of psychological problem on attitudes concerning the treatment, problem, and counselor. Subjects from an introductory psychology class first read a case history of a female college freshman experiencing either snake phobia, test anxiety, depression, or schizophrenia. They were then presented with both an audiotaped and a written description of one of the following treatment rationales: classical psychoanalysis, behavior therapy, rational-emotive therapy, or no rationale. These rationales were general, not problem-specific. No differences were observed on items assessing
how logical the treatment seemed, confidence in its success, or confidence in recommending it to a friend experiencing a similar problem. However, subjects' reported willingness to personally undergo their respective treatments suggested greater willingness to undergo behavior therapy for test anxiety, rational-emotive therapy for depression, and psychoanalysis for schizophrenia. These results suggest that clients' differential preferences for various therapeutic approaches may vary according to the nature of the presenting problem.

In the only investigation employing a clinical population, Helweg and Gaines (1977) compared hospitalized psychiatric patients' and normal college undergraduates' preferences for client-centered therapy and rational-emotive therapy. Subjects viewed films (Shostrom, 1966) of both Albert Ellis and Carl Rogers interviewing the same female client. Preference was measured simply by asking subjects which therapist they would choose to work with in therapy. Preferred therapists received higher ratings of empathic understanding, unconditional regard, and congruence, suggesting that preference for a particular treatment or therapist may contribute to an enhanced initial therapeutic relationship. Helweg and Gaines also investigated a number of personality and demographic variables associated with preferences for one of the two therapists or presentations. In both clinical and normal subjects, preference for the Ellis presentation was associated with greater dogmatism and an external locus of control orientation. Preference for the Rogers presentation, on the other hand, was associated with being younger and with valuing independence.
Trait anxiety was related to therapy preference only for the clinical subjects, with the more anxious patients preferring the Ellis presentation. Of further interest, multivariate analyses of personality and demographic variables suggested that individuals could be reliably classified into therapist-preference groups. Of the student group, 90% of those preferring Ellis and 88% of those preferring Rogers were successfully classified (86% and 80%, respectively, in the patient group).

Kowitt and Garske (1978) selected a sample of 40 college undergraduates scoring high or low on a self-disclosure questionnaire. Subjects listened to 10-minute audiotapes of excerpts from simulated therapy sessions—one depicting client-centered therapy and the other systematic desensitization. Both sessions were conducted by the same male therapist, with a female client complaining of interpersonal difficulties. Client-centered therapy was perceived as providing a greater opportunity for self-exploration and was preferred by males and high self-disclosure subjects. Systematic desensitization, however, was perceived as more effective. It was preferred by females and low self-disclosure subjects. The results suggested that high self-disclosers were attracted to a therapeutic modality that matched their preference to reveal themselves, while low self-disclosers preferred a modality with structure and direction. It appears likely, however, that the self-disclosure questionnaire and requests for ratings of opportunity for self-exploration made the hypotheses of this study relatively transparent. The generalizability of these results is restricted by the use of extreme groups of self-disclosers.
Gordon (1976) investigated the effects of volunteering and responsibility concerning the choice of treatment on the perceived value and effectiveness of relaxation training. This analogue study compared the ratings of two groups of subjects: one composed of undergraduates who volunteered for a session of relaxation training (volunteers) and one composed of subjects who signed up after having been told that they could receive extra credit for their participation (nonvolunteers). Subjects received a 20-minute relaxation treatment in pairs, with one member of each pair choosing between a "neuro-glandular" and a "cardiovascular" training tape. These tapes were actually the same systematic relaxation treatment, with different labels. Volunteer subjects given a choice of treatment reported significant pre- to posttest increases in degree of relaxation and a significantly greater valuation of treatment than volunteers not given a choice of treatment. Volunteers who were denied choice were the only subjects reporting no significant effects from treatment. Regardless of choice condition, volunteer subjects were significantly more interested in attending another treatment session than were nonvolunteers. Gordon suggested that a client's feelings of responsibility for treatment might increase his valuation of treatment and perhaps influence the outcome of therapy.

Devine and Fernald (1973) showed 32 undergraduate students, who had been deemed snake-phobic on the basis of self-report fear ratings and a behavioral avoidance test, a 40-minute videotape of four therapists. One therapist employed systematic desensitization, one an encounter approach, one rational-emotive therapy, and one a
modeling-behavioral rehearsal procedure. Each therapist explained the techniques for 5 minutes, then demonstrated their use with a group of subjects for 5 minutes. Subjects were interviewed after having completed 5-point Likert-type preference ratings, in order to insure that they had expressed their preferences accurately. Half of these subjects were then assigned to a preferred treatment and half to a non-preferred treatment. Sixteen control subjects, who did not see the videotape or indicate their preferences, were randomly assigned across the four therapy approaches. Each group of 12 subjects met for two 1-hour sessions. One week later, the behavioral avoidance test was readministered. Subjects who had received their preferred treatment showed significantly greater improvement than both the randomly assigned and the non-preferred groups. For encounter and rational-emotive treatments, subjects receiving their preferred treatment showed significantly less avoidance behavior than randomly assigned or non-preferred subjects. There was a nonsignificant difference between subject groups in the systematic desensitization and modeling-behavioral rehearsal conditions. Thus, the effect of preference on outcome seemed to hold for some treatment approaches but not for others. Devine and Fernald proposed three possible explanations of their findings: (1) that expectation/preference may be the single most important determinant of therapy outcome, (2) that the subject accurately identifies in his preference ratings the most effective therapy for him, or (3) that the subject given a preferred treatment demonstrates increased improvement in order to justify his stated preference. A post hoc
determination of randomly assigned subjects' treatment preferences and improvement rates across preferred and non-preferred treatments could have provided suggestive evidence concerning these three possible explanations.

In summary, while these studies suggest that different forms of therapy may vary in their desirability and perceived effectiveness, they do not demonstrate a clear preference for any particular therapeutic approach. Some studies (Boudewyns & Borkovec, 1974; Fancher & Gutkin, 1971; Knudson & Carskadon, 1978) suggest that insight therapies (client-centered or psychoanalytic) are considered more appealing than behavioral therapies. Other studies, however, have found that behavioral therapies are preferred (Holen & Kinsey, 1975; Kowitt & Garske, 1978; Slaney, 1977; Stuehm et al., 1977).

Several factors may help account for the inconsistency of these findings. First, stimulus materials chosen to illustrate treatment approaches vary across studies. Several investigations have employed the Shostrom (1966) films (Helweg & Gaines, 1977; Holen & Kinsey, 1975; Knudson & Carskadon, 1978) or other filmed demonstrations (Stuehm et al., 1977). The videotape used by Devine and Fernald (1973) included both a demonstration and an explanation of techniques. Audiotapes have been employed in several studies (Gordon, 1976; Kowitt & Garske, 1978; Wollersheim et al., in press). Fancher and Gutkin (1971) used only written theoretical and procedural descriptions, while Slaney (1977) presented subjects with written transcripts of therapy sessions. While studies employing demonstration films supply subjects with information
more analogous to that provided to actual clients, this form of presentation confounds therapist styles or characteristics with technique factors. In such studies, and in those employing different therapists for different approaches, preference ratings reflect therapist-treatment preference. They do not solely reflect preference for a particular therapy rationale or procedure. While some studies (Kowitt & Garske, 1978; Stuehm et al., 1977) had one therapist demonstrate all counseling approaches, this strategy would equate therapist factors across tapes only if the therapist were equally skilled and confident in all the approaches. Additionally, while some materials have labeled the therapeutic approach described (e.g., Knudson & Carskadon, 1978; Wollersheim et al., in press), others have not (e.g., Holen & Kinsey, 1975). That different labels may affect subjects' perceptions of therapeutic approaches has been suggested by Woolfolk, Woolfolk, and Wilson (1977). The negative valence attached to a behavior therapy label may help explain the contradictory results obtained by Holen and Kinsey (1975) and Knudson and Carskadon (1978). The latter study, in contrast to the former, clearly identified the behavior therapy approach. Despite the wide variation in type and format of stimulus materials employed, no comparisons of the effects of different forms of presentation on preference ratings have been conducted. The findings of Nau et al. (1974), however, suggest that as materials employed parallel an actual therapy session more closely, procedures' expectancy-arousing qualities may become more equivalent.

In addition to the prevalent therapist-technique confounding described above, studies have imprecisely defined or not clearly
differentiated the treatment approaches being compared. Typically, the therapist's professed orientation has been the single defining feature of a particular treatment approach (e.g., Holen & Kinsey, 1975). Additionally, there exists across studies considerable variability of therapist style within treatment approaches. For example, Stuehm et al. (1977) chose Ellis' rational-emotive therapy to represent behavior therapy, while Fancher and Cutkin (1971) employed Wolpe's reciprocal inhibition and Stampfl's implosive therapy. Within-orientation variability must be considered in making generalizations about preferences for treatment approaches, especially about those based on therapist-treatment pairings. Clearly, more rigorous delineation of the theoretical assumptions, rationales, and techniques central to particular therapeutic approaches is required. The stipulative definitions drawn up by Sloane et al. (1975) for their comparative outcome study, specifying common and contrasting elements of behavior therapy and analytically oriented therapy, represent an admirable attempt along these lines. Furthermore, since differences between therapeutic approaches may be greater in theory than in practice, Sundland (1977), in his review of the theoretical orientations of psychotherapists, has suggested relating professed orientation to actual therapist behaviors in clinical interactions. In the Sloane et al. (1975) study, therapists' behaviors were quite consistent with what one would predict from their theoretical orientations. For example, behavior therapists were more active, directive, and talkative and defined therapeutic goals and treatment strategies more focally than dynamically oriented therapists. Dynamically oriented therapists,
on the other hand, were more interested in childhood memories, explained symptoms symbolically, and interpreted resistance more frequently. A behaviorally based differentiation of various treatment approaches could prove valuable in studies of clients' treatment preferences.

The design of most of these studies has involved presenting all descriptions or demonstrations of treatment to all subjects (Fancher & Gutkin, 1971; Helweg & Gaines, 1977; Holen & Kinsey, 1975; Kowitt & Garske, 1978; Stuehm et al., 1977). Slaney (1977) and Wollersheim et al. (in press), in contrast, presented each subject with only description. The design of the former group of studies, assessing relative preference rather than preference ratings for the single form of treatment offered, does not create an experimental situation analogous to that of persons actually presenting for therapy. In clinical settings, despite the common assumption that clients may have preexisting notions concerning their preferred form(s) of treatment, clients are typically not provided a set of options for treatment. Interestingly, some studies of alcohol treatment have shown that the greater the number of treatment options offered a patient, the better the outcome (Kissin, Platz, & Su, 1970, 1971). Additionally, Devine and Fernald (1973) found that subjects assigned to the form of therapy preferred among a set of options showed greater improvement.

Another factor which might account for inconsistency in this literature involves the type of psychological problem to which a therapy rationale or procedure is applied. Presenting problems of clients in demonstration tapes have included recurrent headaches
(e.g., Holen & Kinsey, 1975), anxiety and lack of assertiveness (Slaney, 1977), and interpersonal difficulties (Kowitt & Garske, 1978). In other studies the presenting problem is unspecified (Stuehlm et al., 1978), or the approaches are described in general terms, independent of a target problem (Fancher & Gutkin, 1971). That preferences for therapeutic approaches may vary as a function of the type and severity of presenting problem is suggested by Fancher and Gutkin (1971) and by Wollersheim et al. (in press).

Measures of preference employed also vary across these studies. For example, Helweg and Gaines (1977) simply asked subjects which therapist they would choose to work with in therapy. Fancher and Gutkin (1971) asked subjects to rank the descriptions in terms of how "personally appealing" they were. Despite such variations in the wording and format of these items, all are considered measures of preference, and most studies have employed only a single item. The questionable reliability and validity of such a measure was considered in only one study. Devine and Fernald (1973), rather than relying upon a single item, interviewed subjects to help insure the accuracy of initial preference ratings. Straightforward verbal self-report measures of preference have unfortunately not been used together with more behavioral or less obtrusive measures made outside the experimental setting. Preference could be assessed, for example, by assessing subjects' actual treatment recommendations or descriptions of therapy to family or friends.

In a related vein, these studies may be criticized for a measure that is typically lacking. Despite Frank's (1961) suggestion that any
system of therapy may be successful if the client has sufficient belief in its efficacy, data on perceived effectiveness as well as preference have seldom been collected. Of the four studies that have requested ratings of judged effectiveness, three (Holen & Kinsey, 1975; Kowitt & Garske, 1978; Slaney, 1977) found greater perceived effectiveness for behavioral approaches. The fourth study (Wollersheim et al., in press) found no differential estimates of success across therapy approaches.

An additional criticism of these studies relates to their typical reliance on nonclinical subject samples. Most have employed undergraduate students who were not presenting with psychological problems or requesting treatment. Devine and Fernald (1973) studied an analogue population of snake-phobic undergraduates. These subjects, however, were likely only mildly phobic since they were apparently screened on a behavioral avoidance test under low-demand-for-approach conditions. Even these subjects were solicited for inclusion in the study. Only one study (Helweg & Gaines, 1977) employed a clinical population, hospitalized psychiatric patients. Generalizing from the preferences of undergraduates to those of persons experiencing psychological problems and voluntarily seeking treatment would be hasty and unwise. Only future research can establish whether the treatment preferences of experimental or analogue populations parallel those of clinical populations. Research comparing the credibility of behavioral fear-reduction and control procedures, however, suggests that expectation of therapeutic gain may vary across subject populations (Kirsch & Henry, 1977; Osarchuk & Goldfried, 1975).
Similar comparisons of preferences for treatment approaches and techniques across subject populations and extension of this research strategy to clinical groups are sorely needed.

The greatest potential value in assessing preference for or judged effectiveness of various therapeutic approaches lies in developing sound methods for assigning patients to particular forms of psychotherapy. A. Rosen (1967), in a brief review of the literature on clients' preferences regarding counselors' characteristics and procedures, suggested that such preferences might determine whether a client seeks and is satisfied with counseling, as well as the process, duration, and outcome of treatment. Despite this suggestion, there have been few attempts to relate preferences for treatment approaches to such measures. Suggestive evidence exists (Helweg & Gaines, 1977) that the use of certain therapeutic approaches may enhance the initial therapeutic relationship. Only two investigations, both of which were analogue studies (Devine & Fernald, 1973; Gordon, 1976) have attempted to relate preference or choice of treatment to outcome measures. Both studies demonstrated a relationship between these measures.

Until more standardized and reliable means of assessing both preferences and expectations for various therapeutic approaches have been devised, the assignment of clients to various forms of treatment will likely remain relatively haphazard, so that clear demonstration of a relationship between either preferences or expectations and client satisfaction or treatment process and outcome would be unlikely. Aids to the development of such measures are not provided by the existing
literature, since single or forced-choice items are so widely employed. Although measures of expectations of therapists' roles and behaviors exist (e.g., Apfelbaum, 1958; Rickers-Ovsiankina et al., 1971), similar measures strictly assessing clients' expectations and preferences for particular therapy rationales and techniques have not been devised. Additionally, measures of therapists' theoretical orientations, including therapists' behavior, attitudes, techniques, and treatment goals (McNair & Lorr, 1964; Sundland & Barker, 1962; Wallach & Strupp, 1964), have in only one instance been modified for use with clients. Scales measuring attitudes toward particular treatment approaches have been described in two reports (Dubno, Hillborn, Robinson, Sandler, Trani, & Weingarten, 1978; Musgrove, 1974), both designed to measure attitudes toward behavior modification. Unfortunately, these scales focused on general favorableness of attitude toward behavior modification, not on attitudes toward particular techniques or theoretical formulations.

One possible approach to determining the dimensions relating to attitudes toward various modes of psychotherapy was suggested by Stuehm et al. (1977). They suggested investigating whether subjects' expectations influence their attitudes toward particular treatment approaches. More recently, Duckro et al. (1979) have suggested that both expectations and preferences be considered. One focus of the present study was the development of a measure of expectations and preferences regarding psychotherapy. An additional focus was the relationship between expectations and preferences and perceptions of two contrasting treatment approaches: insight-oriented therapy and behavior therapy.
CHAPTER III

Method

Design

A 2 X 2 X 2.2 split-plot repeated-measures design (Kirk, 1968) was employed. The first two factors, both between-subjects variables, represented treatment expectation (behavioral or insight) and treatment preference (behavioral or insight). The third factor represented the between-subjects variable of order of presentation of the therapy transcripts, with the behavioral transcript followed by the insight transcript (AB) or vice versa (BA). The repeated-measures factor represented exposure to transcripts illustrating two treatment approaches: behavior therapy and insight-oriented therapy.

Subjects

Subjects were 117 (53 male, 64 female) volunteers from a University of Montana introductory psychology course who participated in partial fulfillment of course requirements. Questionnaires from three additional subjects reporting previous personal experience in psychotherapy were excluded. Of the 117 subjects, 22 (12 male, 10 female) participated only in a portion of the study investigating the test-retest reliability of the independent measures. Ninety-five subjects completed all aspects of the experimental procedures. In order to obtain equal numbers of subjects in each of the experimental conditions, seven subjects were randomly selected from each of the eight conditions. Thus, data from only 56 (23 male, 33 female) of the 95
subjects were employed in testing the experimental hypotheses.

Materials

Treatment Expectations and Preferences Scale. A scale designed to measure treatment expectations and preferences was devised for use in the present study. Items were written to tap various dimensions of insight-oriented and behavior therapy, including the focus of treatment, etiological conceptions, treatment aims or goals, and the procedures or techniques employed. Features providing a contrast between these two treatment approaches were derived from a number of theoretical expositions (Frank, 1973; Frey & Raming, 1977; London, 1964; Marks & Gelder, 1966; Patterson, 1966; Prochaska, 1979; Sloane et al., 1975). Generally, insight therapy was taken to involve tracing symptoms back to their origins or to underlying ideas, feelings, or impulses, with an emphasis on increased insight or self-understanding. Behavior therapy, in contrast, was taken to involve identifying the manner in which problem behaviors are learned and how they are maintained by current environmental conditions, with an emphasis on overt behavior change or direct symptom removal. Items were written in layman's terms in accordance with these general and other more specific distinguishing features. In addition, several items representative of these treatment approaches were taken from previous measures of treatment expectations (Begley & Lieberman, 1970; McNair & Lorr, 1964).

An initial pool of 46 items was developed, with 22 items designed to characterize behavior therapy and 24 to characterize insight therapy. A questionnaire listing these 46 items in random order was
presented to graduate students in clinical psychology (see Appendix A). Students were asked to rate how descriptive each item seemed to be of insight-oriented and behavior therapy. A 7-point scale was employed, with ratings ranging from -3 to +3. Positive anchor points on the rating scale characterized behavior therapy ("highly," "moderately," and "slightly descriptive"), while negative points characterized insight-oriented therapy. The midpoint (0) on the rating scale typified items judged not to differentiate the two treatment approaches.

Mean item ratings were computed for the 17 (of 38) questionnaires completed and returned in the initial validation sample, and for the 10 questionnaires completed by a separate group of graduate students two months later. A mean absolute value of 2.0 or greater had been set as a cutoff point for an item's inclusion in the final scale. This cutoff point required that all items retained be judged as at least "moderately descriptive" of insight-oriented or behavior therapy. The same 30 items met this criterion in each sample of raters -- 15 descriptive of insight-oriented therapy and 15 descriptive of behavior therapy. The mean rating for each of the 30 items in each of the groups of raters is presented in Table 1.

Insert Table 1 about here

The Treatment Expectations and Preferences Scale included these 30 items in a random order of presentation. Two sets of test-taking instructions and two 7-point rating scales were developed for use with these 30 items, in order to arouse expectation and preference
test-taking orientations and to elicit judgments from subjects corresponding to these two dimensions (see Appendix B). The "expectation" instructions involved a short paragraph asking subjects to answer the items in terms of what they would expect, anticipate, or predict to be involved in therapy. The "preference" instructions, in contrast, asked subjects to respond in terms of what they would prefer, want, desire, or hope to be involved in therapy. Subjects were required to complete both an expectation rating and a preference rating for each of the 30 items. Two forms of the Treatment Expectations and Preferences Scale were developed, in order to permit counterbalancing and control for possible order effects. One form (EP) presented the expectation instructions followed by the preference instructions and required subjects to complete the expectation rating followed by the preference rating. The second form (PE) involved the reverse order of both instructions and ratings. Both forms asked subjects to answer items in terms of what they would expect or prefer if they were experiencing some type of personal problem and considering seeking psychological help.

The rating scale employed to measure expectations included the following seven anchor points: (+3) will definitely be involved in therapy, (+2) will probably be involved in therapy, (+1) somewhat likely to be involved in therapy, (0) may or may not be involved in therapy, (-1) somewhat unlikely to be involved in therapy, (-2) will probably not be involved in therapy, and (-3) will definitely not be involved in therapy. The preference rating scale included seven different anchor points: (+3) strong desire that this be involved in therapy, (+2) moderate desire that this be involved in therapy, (+1)
mild desire that this be involved, (0) indifferent about this being involved, (-1) mild desire that this not be involved, (-2) moderate desire that this not be involved, and (-3) strong desire that this not be involved in therapy.

On both the expectation and preference scales, responses indicating that a subject did not expect or prefer a component of behavior therapy were assumed to reflect an expectation or preference in the insight direction. Conversely, responses indicating that a subject did not expect or prefer a component of insight-oriented therapy were assumed to reflect an expectation or preference in the behavioral direction. A scoring key was devised which converted ratings across behavioral and insight items, so that positive item scores were taken to reflect an insight expectation or preference, and negative scores were taken to reflect a behavioral expectation or preference. Thus, responses indicating an expectation of or preference for behavior therapy (or contrary to insight therapy) were scored in the negative direction, while those responses indicating an expectation of or preference for insight therapy (or contrary to behavior therapy) were scored in the positive direction. Total scores on each dimension, summed across all 30 items for both expectations and preferences, had a possible range of +90 to -90.

The total expectation score and the total preference score derived from the Treatment Expectations and Preferences Scale served as the two primary independent variables in this study. Via separate median splits on the expectation and preference total scores, subjects could be assigned to "behavioral expectation"
or "insight expectation" groups and to "behavioral preference" or "insight preference" groups. Pilot testing with 23 subjects from an undergraduate psychology class suggested that scale scores showed sufficient range and variability to justify median splits (see Table 2). Frequency distributions of the total expectation and total preference scores for the 95 subjects tested in the current investigation suggested that both are unimodal, positively skewed distributions. As can be seen in Table 2, the ranges and standard deviations for the pilot sample greatly exceeded those for the current sample.

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Insert Table 2 about here

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For the current sample, the median expectation score was 7.67, while the median preference score was 3.38. Simultaneous classification of the 95 subjects across both dimensions resulted in 33 subjects' being classified as insight preference X insight expectation (total preference score > 3.38, total expectation score > 7.67), 16 as behavioral preference X insight expectation (preference < 3.38, expectation > 7.67), 14 as insight preference X behavioral expectation (preference > 3.38, expectation < 7.67), and 32 as behavioral preference X behavioral expectation (preference < 3.38, expectation < 7.67). Counterbalancing the order of presentation of the therapy transcripts further complicated the unequal cell sizes created by the preference X expectation classification. To obtain equal numbers of subjects in each cell of the 2 X 2 X 2 design, seven subjects were randomly selected from each of the
eight groups, resulting in a final experimental sample of 56 subjects.

Case description. All subjects were provided with the same, approximately 500-word description of a fictitious client (see Appendix C). This description included some brief social history and background information and depicted a female college student who encounters psychological difficulties during her freshman year. The case description was written to reflect a variety of problems with which college students could be assumed to be familiar, rather than a particular diagnostic category. The client was described as undecided about her educational goals, doubting that she should remain in college, fearful of failure and criticism, unassertive, and as exhibiting symptoms of depression and anxiety.

Transcripts of therapy. Subjects received a 4-page script of a behavior therapy session and a 4-page script of an insight-oriented therapy session (see Appendices D and E). These were simply labeled as "Transcript A" and "Transcript B," not as behavioral or insight-oriented therapy. Transcripts were designed to convey no information about the client's satisfaction with treatment or likelihood of improving as a result of treatment. The behavior therapy session was written to include specific descriptions of problem behaviors, suggestions for new behaviors, a reference to systematic desensitization and relaxation, role-playing, and encouragement to practice the new behaviors. The transcript was derived in part from previously reported illustrations of behavior therapy (Lazarus, 1971; Loew, Grayson & Loew, 1975; Neuman, 1969; Wolpe, 1969, 1976)
and adapted to suit the presenting problems outlined in the case description. The insight-oriented therapy session included reflections of client feeling, dream analysis, use of a metaphor, and several interpretations. This transcript was adapted from several sources (Barton, 1974; Langs, 1973; Loew et al., 1975; Rogers, 1977).

In order to insure that the transcripts devised were representative of insight-oriented therapy and behavior therapy, four clinical psychologists on the faculty of the University of Montana who identified themselves as insight-oriented or behavioral in orientation reviewed the transcripts and provided a written narrative account of their impressions. Comments provided by the reviewers of the insight-oriented therapy transcript suggested that both client-centered and analytic procedures were employed. In all cases, illustrations were considered to be accurate representations of these two treatment approaches and appropriate to the presenting problems outlined in the case description.

Dependent Measures

The primary dependent measures employed in this study were 16 6-point Likert-type scales on which subjects rated their attitudes regarding the treatment approaches illustrated (see Appendix F). Several of these items were based on those previously employed in investigations of subjects' perceptions of treatment rationales (Borkovec & Nau, 1972; Wollersheim et al., in press). Ratings were made on the primary dimensions of the acceptability of the treatment approach (items 1, 2, 5, 6, 9, 11, 13, and 14) and its perceived effectiveness (items 3, 8, 10, 12, and 15). The
three remaining items (4, 7, and 16) assessed subjects' perceptions of the therapist's understanding and experience and their own familiarity with the treatment approach illustrated. Several of these items asked subjects to place themselves in the role of the client in the case description and transcript and to respond in terms of how they would react if experiencing similar problems and receiving that form of treatment.

Procedure

The measures involved in this study were administered in large classrooms to groups of 20-30 subjects. After subjects had gathered, volunteers were solicited who would be willing to fulfill their participation in the study by completing one hour at that time and an additional hour one week later. These subjects were taken to an adjoining room, where they completed only the Treatment Expectations and Preferences Scale. Of 30 volunteers, 22 returned the following week and again completed the scale. Data from these 22 subjects provided information concerning the stability of this scale over time.

Subjects in the experimental group received packets of materials containing the following items: (a) a cover sheet on which to provide demographic information (age, sex, year in college, coursework in psychology, and psychotherapy experience); (b) Treatment Expectations and Preferences Scale; (c) the case description; (d) illustrations of behavioral and insight-oriented therapy sessions; (e) the transcript rating scales, and (f) a post-experimental questionnaire. This questionnaire (see Appendix G) contained items designed to assess experimental demand and awareness of the
experimental hypotheses, the realism of the case description and therapy transcripts, ease of role-taking in reading the materials and completing the questionnaires, general favorableness of attitude toward psychotherapy and its judged effectiveness, and familiarity with and judged effectiveness of psychoanalytic, behavior, and client-centered therapy. Packets were collated in order to randomize across subjects the order of presentation of the two forms of the Treatment Expectations and Preferences Scale and of the insight and behavior therapy transcripts.

Subjects in the experimental group were asked to provide the demographic information requested on the cover sheet of their test booklets and then to complete the Treatment Expectations and Preferences Scale. They next read the case description, followed by one treatment transcript. Subjects were asked to place themselves in the role of the client as they read the transcript. After completing the 16-item transcript rating scale, subjects read the second transcript and completed 16 ratings of it. After supplying information requested in the post-experimental questionnaire, subjects were debriefed concerning the purposes of the study and thanked for their participation. All subjects were given an opportunity to ask questions about the nature of the study, and those wishing to be informed of the results were asked to leave their names and addresses.
CHAPTER IV

Results

Demographic Data

Subjects ranged in age from 18 to 31, with a mean age of 19 years, and had completed a mean of 1.18 years of college (1-3 year range). Coursework in psychology was, for all subjects, limited to the introductory class in which they were enrolled at the time of the study, so that background in psychology did not differ across groups. A chi-square analysis revealed no significant differences in the number of males and females across the four expectation X preference groups ($\chi^2=4.126$, df=3, $p>.20$). Additionally, separate 2 X 2 X 2 analyses of variance (insight/behavioral preference X insight/behavioral expectation X insight/behavioral-behavioral-insight order of transcript presentation) showed no significant differences across groups for the variables of age or year in college (all $p$s>.05). A marginally significant expectation X preference interaction, however, was obtained for the age variable, $F(1,48)=2.877$, $p=.09$. Tukey's comparisons of the means in this interaction revealed that the insight preference X behavioral expectation group was significantly older than the behavioral preference X behavioral expectation group (Ms=20.07 and 18.43). With the exception of this age difference, groups did not differ significantly of any of the demographic variables (sex, coursework, or year in college).
**Treatment Expectations and Preferences Scale**

The two scores derived from this scale, a total expectation score and a total preference score, were employed as the basis of classification of subjects into four expectation X preference groups.

**Measures of stability and internal consistency.** Coefficients of stability, or test-retest reliability coefficients, were computed for the total expectation and total preference scores for the sample of 22 subjects tested over a one-week interval. The obtained test-retest reliability coefficient was .84 for the total expectation score and .65 for the total preference score. For the 8 subjects who completed form EP of the Treatment Expectations and Preferences Scale, a value of .79 was obtained for the expectation score. This value was also .79 for the 14 subjects completing form PE. The preference score test-retest reliabilities were .53 for form EP and .69 for form PE. For the total group of 22 subjects, the mean expectation scores at pre- and posttesting were 9.9 and 10.0, while the mean preference scores were 3.6 and 7.1. *t* tests for paired samples indicated that neither expectation nor preference mean scores differed significantly from pre- to post-testing, $t_E(21) = -.07, p > .50$ and $t_P(21) = -.29, p > .50$.

Internal consistency estimates for the expectation and preference scores of all 95 subjects were computed using Cronbach's coefficient alpha. For these total scores, the obtained values were .419 for expectations and .473 for preferences. These values seem to reflect the two separate content domains tapped in the scale, i.e., the behavioral and insight therapy components.
Values for coefficient alpha were next computed separately for the 15 behavior therapy items and the 15 insight therapy items for both independent variables. Values were .771 for the 15 behavioral expectation items, .738 for the 15 insight expectation items, .722 for the 15 behavioral preference items, and .768 for the 15 insight preference items. These levels of alpha suggest that the behavioral and insight items each sampled a common domain of content in a fairly adequate manner, across both the expectation and preference dimensions.

**Total expectation and total preference scores.** The relationship between total expectation and total preference scores, across both forms of the Treatment Expectations and Preferences Scale, was determined by means of Pearson's product moment correlation. For the total group of 95 subjects, a significant, moderately positive relationship was found between these two variables ($r = .61$, $df = 93$, $p < .005$). The relationship between expectations and preferences was also significant for the subsample of 56 experimental subjects ($r = .47$, $df = 54$, $p < .005$).

Expectation-preference correlations were not significantly different across the EP ($r = .57$, $df = 46$, $p < .005$) and the PE ($r = .66$, $df = 45$, $p < .005$) forms of the scale ($z = .73$, two-tailed, $p = .46$). Further, no significant difference was found between the mean total preference scores across the two forms of the scale ($p > .40$). Mean total expectation scores, however, were significantly higher for the EP form than the PE form ($p < .005$), reflecting a greater expectation of insight therapy. Means and standard deviations for preference and expectation scores obtained from these two forms and $t$ values for these comparisons
are presented in Table 3.

Despite the significant correlation between expectations and preferences, t tests for paired samples revealed a number of significant differences between expectation and preference ratings of the 30 scale items. These differences were, for 8 of the 13 significant comparisons, in the direction of subjects' preferring a less insight-oriented treatment than they expected. Mean item ratings and t values for the total sample of 95 subjects are presented in Table 4.

Subject classification. In order to assess the effects of the expectation X preference classification of subjects across the eight experimental groups, total expectation and total preference scores for the 56 experimental subjects were submitted to separate 2 X 2 X 2 split-plot analyses of variance (insight/behavioral preference X insight/behavioral expectation X insight-behavioral/behavioral-insight order of transcript presentation). Mean total expectation and total preference scores across the eight experimental groups are presented in Table 5. This table also contains those mean scores for the four expectation X preference groups.
Similar analyses of variance were performed on scores summed across the 15 behavioral and 15 insight items, for both the expectation and the preference ratings. Table 6 presents these mean scores for the four expectation X preference groups.

Insert Table 6 about here

For total expectation scores, main effects were obtained for both the preference factor, $F(1, 48) = 13.4, p = .0009$, and the expectation factor, $F(1, 48) = 65.6, p < .00001$. As would be expected from the median-split classification of subjects on this variable, the mean expectation scores were significantly different across the expectation groups, with the insight expectation group mean greater than that of the behavioral expectation group ($M_s = 15.1$ and 2.5, respectively). However, the mean expectation scores also differed significantly across the insight and behavioral preference groups ($M_s = 11.7$ and 6.0). This difference, which would not be expected to result from the median-split subject classification, seems to reflect the significant positive relationship between the expectation and preference variables.

For total preference scores, a similar pattern of results was obtained. Mean preference scores differed significantly, as expected, between the insight preference ($M = 13.1$) and behavioral preference groups ($M = -6.4$), $F(1, 48) = 113.5, p < .00001$. However, mean preference scores also differed significantly across the insight ($M = 6.7$) and the behavioral ($M = -.03$) expectation groups, $F(1, 48) =$
13.4, \( p = .0009 \). Again, this main effect for the preference factor across the expectation factor seems to reflect the significant positive correlation between these two variables.

Analyses of variance of scores summed across the 15 insight items and across the 15 behavioral items of the Treatment Expectations and Preferences Scale were performed in order to more closely examine the components of the total expectation and total preference scores. No significant main effects or interactions were obtained for expectation ratings of the 15 insight items (all \( p_s > .05 \)). The mean for these 15 items was 25.0 in the insight expectation group and 27.9 in the behavioral expectation group. Scores across the 15 behavioral items' expectation ratings were significantly influenced by both the preference factor, \( F (1, 48) = 7.8, \ p = .007 \), and the expectation factor, \( F (1, 48) = 34.3, \ p = .00001 \). The behavioral expectation group's mean across these 15 items (\( \bar{M} = -22.5 \)) reflected a significantly more behavioral expectation than the mean for the insight expectation group (\( \bar{M} = -9.3 \)). Thus, it appeared that subjects were classified into the insight or behavioral expectation group primarily on the basis of their responses to the 15 behavioral items.

Analysis of scores across the preference ratings of the 15 insight items revealed only a main effect for the preference factor, \( F (1, 48) = 13.3, \ p = .0009 \), as expected from the subject classification scheme employed. The mean score across these items in the insight preference group (23.3) was significantly greater than that in the behavioral preference group (12.7).
In the analysis of preference ratings across the 15 behavioral items, significant main effects were obtained for both the preference, $F (1, 48) = 14.6, p = .0006$, and the expectation factors, $F (1, 48) = 10.1, p = .002$. The mean score across these 15 items was -9.7 in the insight preference group and -19.2 in the behavioral preference group. The relationship of these scores to the expectation factor again seems to reflect the significant positive correlation between the two primary independent variables.

Pearson product moment correlations were employed to assess the relationship between subjects' ratings of the 15 insight and 15 behavioral items for expectations and preferences. Significant negative correlations were obtained across these groups of items for both the expectation ($r = -.55, df=54, p <.005$) and the preference ratings ($r = -.39, df=54, p <.005$). For both expectation and preference ratings, as subjects' endorsements of insight items increased in magnitude, their endorsements of behavioral items also increased in magnitude. Thus, both theoretical dimensions were endorsed by subjects to a similar degree.

**Dependent Measures**

Each of the 16 dependent measures was analyzed by a $2 \times 2 \times 2 \times 2$ split-plot repeated-measures analysis of variance. The between-subjects variables were: treatment preference (insight or behavioral), treatment expectation (insight or behavioral), and order of transcript presentation (behavioral-insight (AB) or insight-behavioral (BA)). The within-subjects variable represented repeated exposure to a therapy transcript, illustrating either behavior therapy or insight therapy.
Since the assumption of homogeneity of variance and covariance is often questionable with split-plot repeated-measures designs, so that a positive bias in the $F$ test may result, a chi-square test for symmetry of the variance-covariance matrix (Kirk, 1968) was performed for each of the 16 analyses. Since no obtained value of chi-square exceeded the critical value, the conventional degrees of freedom were employed in all $F$ tests. Tukey's test, appropriate for split-plot repeated-measures designs (Kirk, 1968), was used for comparisons among means in significant interaction effects.

**Treatment effectiveness ratings.** Five of the dependent measures (items 3, 8, 10, 12, and 15) were designed to assess subjects' beliefs concerning the effectiveness of treatment, or expectancy of therapeutic gain. A significant main effect was obtained on all five items for the repeated-measures or transcript factor. Means and summaries of the analyses of variance for this factor are presented in Table 7. The pattern of this main effect

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Insert Table 7 about here

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was identical for all five items: the rated effectiveness of the behavior therapy transcript surpassed that of the insight therapy transcript. Behavior therapy was rated as likely to be a more helpful treatment than insight therapy (item 3), as leading to greater client improvement (item 10), and as of potentially greater benefit to subjects if they were experiencing a similar problem and receiving this type of therapy (item 15). Additionally, compared to
the insight transcript, the behavioral transcript elicited stronger expressions of confidence that the therapist would be helpful with other problems experienced by college students (item 8) and that the treatment would eliminate the client's presenting problems (item 12).

A significant main effect for order of presentation of the two transcripts was obtained for item 15, $F(1, 48) = 5.17, p = .025$. Subjects receiving the insight transcript followed by the behavioral transcript rated the treatments as of potentially greater benefit to themselves, if they were receiving therapy, than did those subjects receiving the alternate order of presentation ($M_s = 4.38$ and $3.89$, respectively). A marginally significant preference X expectation interaction effect was also obtained for this item, $F(1, 48) = 3.75, p = .055$, with the insight preference X insight expectation group ($M = 4.50$) indicating greater potential benefit than the insight preference X behavioral expectation group ($M = 3.78$). Moreover, whereas in the insight preference group the insight expectation group's mean surpassed that of the behavioral expectation group ($M_s = 4.50$ and $4.07$), the opposite pattern was obtained in the behavioral preference group ($M_s = 3.78$ and $4.18$). Tukey's test, however, failed to support a significant difference between the means of groups in this interaction ($p_s > .05$).

Analysis of item 12 also revealed a marginally significant preference X expectation interaction, $F(1, 48) = 3.52, p = .06$, with the insight preference X insight expectation group expressing greater confidence that treatment would eliminate the client's presenting problems ($M = 4.68$) than the insight preference X behavioral expectation group ($M = 4.07$) and the behavioral preference X insight
expectation group ($M = 4.07$). Tukey's ratios again fell short of statistical significance, however. The conventional level of significance was also approached for the expectation X order interaction for item 12, $F(1, 48) = 2.88, p = .09$. Mean comparisons failed to demonstrate the significance of a trend for the insight expectation group presented with the insight transcript first to express greater confidence than the insight expectation group presented with the behavioral transcript first ($M_s = 4.68$ and $4.07$). The behavioral expectation groups' ratings showed less differences across these orders of presentation ($M_s = 4.18$ and $4.11$).

Only one additional analysis of the treatment effectiveness items yielded even a marginally significant $F$ ratio. The main effect for the expectation variable approached significance on item 10, $F(1, 48) = 2.94, p = .089$), with the insight expectation group ($M = 2.69$) estimating greater improvement for the client than the behavioral expectation group ($M = 3.07$).

Appeal/acceptability ratings. Several of the dependent measures focused on the acceptability of the two treatment illustrations (items 1, 5, 6, 9, 11, 13, and 14). Three of these questions (items 5, 6, and 9) required judgments concerning the treatment conceptions and procedures selected and their appropriateness for the client portrayed in the case description. Significance of the main effect for the transcript factor was approached on items 5 and 9 ($ps = .068$ and .059). Both suggested relatively stronger acceptance of the behavioral treatment. Subjects expressed stronger agreement with the behavior therapist's conceptualization
of the client's problems (item 5) and rated the behavioral treatment as more logical than the insight approach (item 9). These means and F ratios are presented in Table 7. A marginally significant expectation X order interaction was also obtained for item 9, F(1, 48) = 3.23, p = .08. This interaction evidently resulted because the insight expectation X AB order and behavioral expectation X BA order groups endorsed equivalent ratings of the logicalness of the treatments (Ms = 4.46 and 4.50), whereas the insight expectation X BA group gave significantly higher ratings than the behavioral expectation X AB group (Ms = 5.21 and 4.53) (p < .05).

A significant repeated-measures effect was obtained for item 6, F(1, 48) = 9.87, p = .003. Subjects expressed stronger agreement with the procedures employed in the behavior therapy session (M = 4.62) than with those used in the insight therapy session (M = 4.28). Significance of the preference X expectation interaction was approached in the analysis of this item, F(1, 48) = 3.32, p = .07. The insight expectation X insight preference group mean (4.68) surpassed that of both the insight expectation X behavioral preference group (4.14) and the insight preference X behavioral expectation group (4.17), reflecting greater agreement with treatment procedures, though not of a significant degree (ps > .05).

The remaining items pertaining to subjects' acceptance of the treatment approaches consisted of one general satisfaction measure (item 13) and four quasi-behavioral measures (items 1, 2, 11, and 14). The F test for the repeated-measures or transcript factor
approached significance for the general satisfaction ratings of item 13 ($p = .068$). This main effect reflected greater reported satisfaction with behavior therapy than insight-oriented therapy ($Ms = 4.46$ and $4.05$). A marginal preference X order interaction was also obtained for this item, $F(1, 48) = 3.16$, $p = .078$. The behavioral preference X insight-behavioral (BA) transcript order group estimated greater satisfaction if offered these treatments than the behavioral preference group receiving the transcripts in the reverse order ($Ms = 4.46$ and $3.82$). The insight preference groups' ratings showed an opposite pattern ($Ms = 4.10$ and $4.25$). The differences among means in this interaction failed to reach significance in Tukey's test, however ($p > .05$).

Turning now to the four quasi-behavioral items, no significant main effects for the transcript factor were obtained for item 1, reflecting no significant differences in subjects' confidence recommending the two treatment approaches to a friend. Main effects for this factor did reach significance, however, on items 2, 11, and 14 (see Table 7). The pattern of this effect was the same across all three items, revealing greater acceptability of the behavioral treatment. Subjects showed greater willingness (item 2) to undergo the behavioral treatment than the insight treatment. Further, the number of sessions subjects reported that they would be willing to attend (item 11) and the amount they would be willing to pay per session (item 14) were significantly higher for the behavioral than the insight-oriented treatment.

Marginal significance was obtained for a main effect for preference on item 2, $F(1, 48) = 2.86$, $p = .09$. The insight pre-
ference group expressed greater willingness to personally undergo these treatments than did the behavioral preference group ($M_s = 4.41$ and 3.94). For item 14, a marginally significant preference X transcript interaction was obtained, $F(1, 48) = 2.82, p = .09$. While Tukey's tests revealed no significant differences between means in this interaction, both the insight and the behavioral preference groups reported lesser amounts they would be willing to pay for the insight than the behavioral treatment. Moreover, this pattern of differences was stronger in the behavioral preference group ($M_s = 1.75$ and 2.39) than in the insight preference group ($M_s = 2.36$ and 2.54).

**Perceptions of the therapist and familiarity with the treatment approaches.** Responses to item 4, measuring subjects' perceptions of the therapist's understanding of the client's difficulties, were significantly influenced by the transcript factor, $F(1, 48) = 4.06, p = .047$, with a better understanding attributed to the behavioral than the insight-oriented therapist. The expectation X order interaction was also significant for item 4, $F(1, 48) = 4.05, p = .047$. Comparisons of the means in this interaction revealed no significant differences (all $ps > .05$). However, the insight expectation group receiving the insight transcript first judged the therapist to have a better understanding of the client's difficulties than the insight expectation group receiving the insight transcript second ($M_s = 4.89$ and 4.62). The pattern of these means was reversed for the two behavioral expectation groups ($M_s = 4.25$ and 4.75).

Significant main effects for transcript were obtained on item 7,
assessing subjects' estimates of the therapist's experience treating clients with problems similar to those presented in the case description, $F(1, 48) = 5.05, p = .027$. The behavior therapist was considered to have greater experience than the insight therapist ($M_s = 2.16$ and $2.58$). No other significant main effects or interactions were observed for this item.

The main effect for transcript approached significance on item 16, $F(1, 48) = 2.94, p = .089$, with subjects reporting less familiarity with the insight than with the behavioral treatment ($M_s = 3.68$ and $3.41$). The expectation X transcript interaction also approached significance for this measure, $F(1, 48) = 2.94, p = .089$. No means in this interaction differed significantly (all $ps > .05$). However, while the behavioral expectation group reported equal familiarity with the two types of treatment (both $M_s = 3.57$), the insight expectation group reported greater familiarity with the behavioral than the insight-oriented treatment ($M_s = 3.25$ and $3.78$).

**Post-Experimental Questionnaire**

Items 1 and 2 were open-ended questions designed to assess subjects' awareness of the experimental hypotheses and perceptions of experimental demand. Responses to these items were independently classified by two raters who had been provided with simple classification criteria. For item 1, subjects were termed aware of the experimental hypotheses if they described the study as investigating their perceptions of treatments that meet or fail to meet their stated expectations and preferences. For item 2, subjects were
termed aware of experimental demand if they described the experimenter as hoping that subjects would rate the transcripts differentially, according to their stated expectations or preferences. Both raters judged only two of the subjects to be aware of the experimental hypotheses and of experimental demand. Both of these subjects were in the behavioral preference group. Of further interest, four subjects (three in the insight preference X insight expectation group and one in the insight preference X behavioral expectation group) described the experimenter as hoping they would prefer the behavioral treatment. All four of these subjects termed the treatment "behavioral," despite the fact that the transcripts were not labeled as reflecting any theoretical orientation.

Chi-square analyses were performed on the dichotomous ratings required in item 4. This question asked whether subjects felt that their expectations, preferences, or views about psychotherapy had been influenced by the study in any way. Of 56 subjects, 27 reported change, while 29 reported none. While the proportions of "yes" and "no" responses to this question did not vary significantly across the four expectation X preference groups ($\chi^2 = 2.5$, df=3, $p > .20$), they did vary across the two orders of transcript presentation ($\chi^2 = 3.5$, df=1, $p < .10$). A larger proportion of subjects in the insight-behavioral (BA) group reported change (17/28), while a larger proportion of subjects in the behavioral-insight (AB) group reported no change (18/28). Chi-square analyses failed to reach significance for the four expectation X order groups ($\chi^2 = 4.2$, df=3, $p > .20$) and for the four preference X order groups ($\chi^2 = 5.4$, df=3, $p < .20$).
In the latter analysis, the behavioral preference X AB group tended to report no change (10/14) and the behavioral preference X BA group tended to report change (10/14), while the proportions varied less in the insight preference groups.

Separate 2 X 2 X 2 split-plot analyses of variance were conducted on the remaining 15 post-experimental questionnaire items (items 3a and 3b and items 5 through 13c), with Tukey's test used for comparisons of the means in significant interaction effects. The three between-subjects factors were preferences (insight or behavioral), expectations (insight or behavioral) and transcript order (behavioral-insight (AB) or insight-behavioral (BA)). Overall mean ratings for these 15 items, the sources of variance in main effects and interactions surpassing the conventional (.05) level of significance, and significant F ratios are presented in Table 8.

Analyzes of items 3a and 3b yielded no significant main effects or interactions (all ps > .05), which indicated equivalent perceptions of the realism of the two therapy transcripts across all subject groups. That the therapy transcripts were labeled as "Transcript A" (behavioral) and "Transcript B" (insight) across both orders of presentation (AB and BA) may have contributed to the equivalence of these ratings. Comments in several of the BA test booklets suggested that subjects may have disregarded the actual transcript labels and termed the insight transcript "Transcript A" based on its appearing first in their test booklets. The realism of the case description

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Insert Table 8 about here
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(item 5) was also judged to be equivalent by all subject groups (all ps > .05). The overall mean ratings of the two transcripts' and of the case description's realism were all above the midpoint of the 7-point scale, as can be seen in Table 8.

Four questions (items 6 through 9) were designed to measure subjects' ease of role-taking and involvement in the experimental procedures. A preference X transcript order interaction was significant in the analysis of item 6, subjects' ratings of their ability to picture the client portrayed in the case description. For the behavioral preference group, greater ability to picture the client was reported when the insight transcript was presented first than when the behavioral transcript was presented first ($M_s = 6.07$ and 4.78), whereas the reverse was true for the insight preference group ($M_s = 5.50$ and 6.00). Moreover, for the AB (behavioral-insight) order of presentation, the insight preference group's ratings surpassed those of the behavioral preference group, while the reverse was true for the BA order of presentation. Tukey's test revealed that the mean ratings of both the behavioral preference X BA group and the insight preference X AB group exceeded that of the behavioral preference X AB group ($ps < .05$).

Subjects' ratings of their ability to take the role of a potential client while completing the Treatment Expectations and Preferences Scale (item 9) were found to be significantly influenced by the expectation variable ($p = .02$). Subjects in the insight expectation group reported being better able to imagine themselves in this role than subjects in the behavioral expectation group ($M_s = 4.93$ and 4.03). Groups did not differ in their reported
ability to place themselves in the client's role while reading the therapy transcripts (item 7) or in reporting that they had experienced similar problems in their own lives (item 8) (all ps > .05). As Table 8 presents, mean ratings across groups for these four items were all above the midpoint of the 7-point scales, suggesting relative ease of role-taking and involvement with the experimental procedures.

Analyses of items 10 and 11, questions assessing favorableness of attitude toward psychotherapy and the believed effectiveness of therapy in general, yielded only a single main effect surpassing the conventional level of significance. Ratings of the effectiveness of psychotherapy (item 11) were significantly influenced by the preference factor, \( F (1, 48) = 8.8, p = .004 \), with greater judged effectiveness by the insight preference group than the behavioral preference group (Ms = 5.32 and 4.53, respectively). The preference X order interaction approached significance in the analysis of item 10, \( F (1, 48) = 3.87, p = .052 \). Tukey's test revealed that the insight preference X BA order group reported a significantly more favorable attitude toward psychotherapy than the behavioral preference X AB order group (Ms = 5.36 and 4.21). Further, while the insight preference group's ratings were uniformly high across both orders of transcript presentation (\( M_{AB} = 5.57, M_{BA} = 5.36 \)), the behavioral preference group's ratings showed a wider range (\( M_{AB} = 4.21, M_{BA} = 5.50 \)). While a main effect for preference failed to reach significance in the analysis of item 10, \( F (1, 48) = 2.535, p = .11 \), the insight preference group tended to report a more favorable attitude toward
psychotherapy than the behavioral preference group (Ms = 5.46 and 4.86).

Items 12 and 13 were designed to measure subjects' knowledge and believed effectiveness of psychoanalytic, behavioral, and client-centered therapies. A main effect for transcript order approached significance for item 12a, $F(1, 48) = 3.61, p = .06$, and for item 12b, $F(1, 48) = 2.71, p = .10$. Subjects who received the insight transcript first reported greater knowledge of psychoanalytic therapy than those who received the behavioral transcript first (Ms = 3.43 and 2.71). Ratings of knowledge of behavior therapy followed the same pattern (Ms = 3.79 and 3.10). Significant main effects for expectation, preference, and transcript order were obtained for item 12c, assessing subjects' knowledge of client-centered therapy. The insight preference group reported greater knowledge of client-centered therapy than the behavioral preference group (Ms = 3.85 and 3.03), while the behavioral expectation group reported greater knowledge than the insight expectation group (Ms = 3.85 and 3.03). Further, subjects receiving the behavioral transcript first reported greater knowledge of client-centered therapy than those receiving the insight transcript first (Ms = 4.03 and 2.86). Across all groups, subjects reported equal familiarity with behavior therapy and client-centered therapy (Ms = 3.45) and less familiarity with psychoanalytic therapy (M = 3.07). The absolute level of these ratings indicated that, on the average, subjects reported knowing less than "a moderate amount" about any of these forms of treatment.

No significant mean effects or interactions were obtained for item 13, assessing the believed effectiveness of psychoanalytic,
behavioral, and client-centered therapies (all ps > .05). However, mean ratings across groups showed psychoanalytic therapy (M = 4.09) to be judged as less effective than behavior therapy (M = 4.48) and client-centered therapy (M = 4.82). Interestingly, psychotherapy in general (item 11) received a higher mean effectiveness rating (4.93) than did any of the specific treatment approaches.
CHAPTER V
DISCUSSION

The present study addressed two primary questions related to perceptions of behavioral and insight-oriented treatment approaches. The first question was whether subjects' expectations or preferences regarding the aims, procedures, and focus of therapy would influence their perceptions of these treatment approaches. The second question addressed whether treatment expectations and preferences, considered in interaction, would differentially affect subjects' perceptions of each of these treatment approaches. The study also provided evidence concerning behavioral and insight-oriented treatments' judged acceptability and credibility.

The strongest and most consistent effects obtained in this investigation were solely a function of the therapy transcripts presented to subjects, with all effects for the transcript factor indicating a more favorable view of behavior therapy than insight-oriented therapy. First, the illustration of behavior therapy was judged to be significantly more effective than the insight therapy illustration. This pattern was obtained on all five measures of treatment effectiveness. This finding of greater expectancy of therapeutic gain associated with a behavioral treatment approach corroborates previous research findings (Holen & Kinsey, 1975;
Kowitt & Garske, 1978; Slaney, 1977). Second, the more positive evaluation of the behavioral than the insight treatment was also reflected on measures of treatment acceptability. Analyses of the main effect for transcript surpassed the conventional level of significance on four of the eight acceptability items and approached significance on three additional items. Subjects expressed greater willingness to personally undergo the behavioral treatment, for more sessions and at a higher cost, than the insight treatment (all \( ps < .05 \)). The behavioral transcript also evoked more favorable ratings of the logicality of the treatment (\( p = .059 \)) and the appropriateness of the procedures selected (\( p = .003 \)), greater agreement with the therapist's conceptualization of the client's problems (\( p = .068 \)), and higher general satisfaction (\( p = .068 \)). Additionally, the behavior therapist, in comparison to the insight-oriented therapist, was judged to have significantly greater understanding of the client's difficulties and greater experience treating clients with problems similar to those outlined in the case description (\( ps < .05 \)).

The greater acceptance of behavior therapy and more positive perceptions of the behavior therapist are consistent with findings obtained in a number of previous studies (Holen & Kinsey, 1975; Slaney, 1977; Stuehm et al., 1977). It should be noted, however, that an equal number of previous studies found greater acceptance of insight therapies (Boudewyns & Borkovec, 1974; Fancher & Gutkin, 1971; Knudson & Carskadon, 1978).
The differential credibility and acceptability of the behavioral and insight transcripts demonstrated in the present study clearly support Frank's (1961) assertion that treatments which appear more reasonable to subjects may also enhance their expectations of being positively influenced by treatment. These findings also lend credence to suggestions that comparative studies of psychotherapy control for variations in such nonspecific factors as credibility and acceptability in order to more firmly establish that differential improvement across treatments is a function of "active" treatment ingredients (Baker & Kahn, 1972; Rosenthal & Frank, 1956).

In comparison to the strong effects exerted on credibility and acceptability ratings by the transcripts, the effects of the expectation and preference variables were minimal. No main effects, two-factor interactions (expectation X preference), or three-factor interactions (expectation X preference X transcript) surpassed the conventional level of significance. Thus, the results failed to provide clear support for the hypotheses that subjects' treatment expectations and preferences, either separately or in interaction, would influence their perceptions of the therapy transcripts.

Several main and interaction effects involving these two variables did approach significance, however. Of 16 separate analyses of variance of the transcript ratings, marginal effects were obtained once for the expectation variable (item 10, $p = .089$), once for the preference variable (item 2, $p = .093$), and three times
for the expectation X preference interaction (item 6, \( p = .07 \); item 12, \( p = .06 \); and item 15, \( p = .07 \)). While the single instance each of a main effect for preference and for expectation could reflect chance findings, or Type I errors, the occurrence of the expectation X preference effect on 3 of the 16 analyses cannot be as readily dismissed on those grounds and may provide tentative support for the interactive influence of these two variables. Adding to the meaningfulness of this interaction is the fact that its pattern was the same in all three cases. All showed the tendency, though nonsignificant in terms of mean comparisons, for the insight preference X insight expectation group to give higher transcript ratings than the other three preference X expectation groups. This group's ratings were particularly higher than those of the behavioral preference X insight expectation group. Further, this pattern seemed to result because the insight preference X insight expectation group made the highest ratings of both transcripts, while the behavioral preference X insight expectation group tended to show a large discrepancy between the two transcript ratings, due to low ratings of the insight transcript. While this pattern could reflect a more favorable general attitude toward psychotherapy in the insight preference X insight expectation group, responses to the post-experimental item (item 10) assessing this attitude failed to support this explanation. No significant expectation X preference interaction was obtained in the analysis of this item. The high ratings of both transcripts could also reflect a response set
similar to an acquiescence set in the insight preference X insight expectation group. Supporting this interpretation, this group not only rated the transcripts more favorably than other subjects, but also endorsed a greater number of components of therapy, and more strongly, when completing the Treatment Expectations and Preferences Scale.

Other marginal effects for the preference and expectation variables included one preference X order interaction (item 13, $p = .078$) and one preference X transcript interaction (item 14, $p = .09$). In the first case, the behavioral preference group tended to express greater satisfaction with treatment when receiving transcripts in the insight-behavioral order than in the reverse order. In the second case, the behavioral preference group reported they would be willing to pay less for the insight than the behavioral treatment, while the insight preference group showed less extreme differences between the two transcript ratings.

More consistent findings were reflected in the one significant (item 4, $p = .047$) and two marginally significant (item 9, $p = .08$; item 12, $p = .09$) expectation X order interaction effects. Again, while mean comparisons failed to reach significance, a similar pattern of results was obtained for all three items. In each case, the insight expectation group receiving the transcripts in the insight-behavioral (BA) order made the most favorable transcript ratings. They rated the greatest therapist understanding of the client's difficulties (item 4), the greatest logicality of the treatment (item 9), and the greatest confidence that treatment would be successful in eliminating the client's problems (item 12).
This finding seemed to stem from this group's giving the highest ratings of both the insight and the behavioral transcripts. For two of these three items (items 9 and 12), the two insight expectation X order groups (AB and BA) showed the greatest difference between their ratings of the two transcripts, while the two behavioral expectation X order groups showed the least difference. Apparently, for the insight expectation group, being presented first with the expected form of treatment seemed to result in more positive ratings of both treatments. This could suggest that the insight expectation group, in comparison to the behavioral expectation group, is more susceptible to attempts to influence expectations once expectations are met. Such a tendency seems to provide tentative support for the notion discussed by several clinicians (e.g., Frank, 1961; Goldfried & Davison, 1976) that when structuring treatment it is important to first meet a client's expectations and only later to change approaches or select alternative procedures deemed more appropriate by the therapist. Such a strategy, if the alternative treatment is in fact more appealing or credible than the treatment the client expects, may further enhance the alternative treatment's appeal and credibility. In view of the increasing emphasis on offering clients a choice among treatment options (e.g., Lorion, 1974a), further consideration of subjects' treatment expectations could aid the development of effective treatment selection or "structuring" strategies (Rotter, 1954; Orne & Wender, 1968).

The tendency for the insight expectation X BA order group to make consistently higher ratings of the therapy transcripts than
other subject groups, while the insight expectation X AB order group did not, may suggest that receiving the behavioral transcript first changed the expectations or preferences of the latter subject group. However, reported change in expectations, preferences, or views about psychotherapy (post-experimental item 10) did not differ across the two insight expectation X order groups and would not appear to support this explanation. Relevant to this argument concerning the influenceability of expectation scores is the obtained one-week stability coefficient of .84. This relatively high correlation suggests that expectation scores are not readily influenced by intervening events or situational factors. While no data concerning the stability of expectations or preferences as a result of exposure to the transcripts were collected in the present study, a previous study would suggest that minimal change occurred. Knudson and Carskadon (1978) found that initial preferences changed after exposure to a preferred or nonpreferred therapy tape for only 10% of their sample.

Another plausible explanation of the three expectation X order interactions is that the insight expectation group rated the insight transcript highly when presented with it first in order to justify their Treatment Expectations and Preferences Scale ratings or to achieve consistency between those and their transcript ratings. Receiving the insight transcript first might have made more salient the comparison between these two sets of ratings. Those subjects might then have adjusted their behavioral transcript ratings upward in order to reflect that transcript's
generally perceived greater credibility and acceptability. An alternative explanation of the high behavioral transcript ratings among these subjects stems from the fact that three subjects in the insight expectation group described experimental demand as involving the experimenter's hope that subjects would prefer the behavioral treatment. The insight expectation group may have been the most acquiescent to this perceived experimental demand, responding with more positive evaluations of the behavioral transcript.

The general failure of the present study to provide strong and consistent support for the separate or interactive effects of treatment expectations and preferences may relate, on a more basic level, to problems in the measurement of these variables. Several aspects of subjects' scores on the Treatment Expectations and Preferences Scale reflected these measurement problems. First was the significant positive correlation between expectations and preferences. This correlation, though corroborating previous research findings (Dreman, 1977; Dreman & Dolev, 1976), posed serious difficulties for subject classification. One difficulty was the unequal distribution of subjects across the four expectation X preference groups. Approximately twice as many subjects were classified as having expectations and preferences similar in orientation (both behavioral or both insight-oriented) as having them different in orientation. To obtain equal numbers of subjects in each group, the size of the subject sample was decreased
by approximately 41%, reducing the power of the analysis and potentially the representativeness of the sample. The second difficulty resulting from the positive expectation-preference correlation involved regression effects, so that subjects whose expectations and preferences differed in orientation had more moderate expectation and preference scores than subjects whose expectations and preferences were similar in orientation. Since the behavioral and insight-oriented transcripts would vary less from moderate scorers' than from extreme scorers' expectations and preferences, the extent of confirmation or disconfirmation would be reduced in the groups whose expectations and preferences differed in orientation.

Other characteristics of subjects' ratings on the Treatment Expectations and Preferences Scale may help to explain the failure to obtain findings in support of the disconfirmed expectations and preferences hypotheses. The first characteristic of interest is the significant negative correlation between subjects' scores on the 15 insight therapy items and their scores on the 15 behavior therapy items. This relationship, which held for both expectation and preference ratings, reflected increasing endorsement of components of insight therapy with increasing endorsement of components of behavior therapy. While this simultaneous endorsement of both treatment orientations to a similar degree may reflect a yea-saying response set evoked by scale properties, it may also accurately indicate that subjects do not adhere strongly to a single theoretical orientation. Other studies have found such simultaneous
endorsement of contrasting treatment components, even among client
groups. For example, Begley and Lieberman (1970) characterized
one client group as anticipating both an active, directive therapist
and discussion of childhood and the unconscious, features that would
not both fit within an analytic mold. Hill (1969) found that
clients most frequently endorsed insight in combination with advice
as their desired treatment. While subjects in the current study
may not have held expectations and preferences that conform closely
to one or another school of therapy, they may have held conceptions
that could be accurately classified as eclectic in orientation. Such
an orientation is becoming increasingly prominent among therapists.
For example, Garfield and Kurtz (1974) found that the majority (53%)
of the clinical psychologists in their sample labeled themselves as
eclectic. Thus, while subjects' eclecticism would clearly be expected
to mitigate disconfirmation effects, it may not reflect an unrealistic
view of therapy.

The simultaneous endorsement of insight and behavioral treatment
components may also reflect the fact that subjects had been exposed
to material concerning both treatment approaches in their intro-
ductive psychology class. Since subjects were aware that different
therapists may conduct therapy in different modes, when asked what
they expected therapy to involve, they accurately endorsed both
approaches. If Treatment Expectations and Preferences Scale
ratings reflected subjects' knowledge that a variety of contrasting
treatment approaches exist, rather than their own personalized
conceptions of psychotherapy, disconfirmation effects would not
have occurred. While the same argument does not apply as strongly
to the preference variable, the correlation between expectations
and preferences suggests that subjects might not have made clear
distinctions between these variables.

Another finding concerning subjects' ratings of the 15
insight and 15 behavioral items is of interest. While expectation
ratings of the 15 insight items showed no significant variation
across the insight and behavioral expectation groups, expectation
ratings of the 15 behavioral items did show significant variation
across these groups. Thus, since the two groups held similarly
high insight expectations, the insight expectation group differed
from the behavioral expectation group primarily in having a less
prominent behavioral expectation. Groups' equivalent insight
expectations could explain the failure to obtain differential
credibility and acceptability ratings of the insight transcripts.
Since both the insight and the behavioral expectation groups
"received" an expected form of treatment when presented with the
insight transcript, their expectations would not likely be differen-
tially confirmed or disconfirmed by this transcript. Presentation
of the behavioral transcript to these two expectation groups, in
contrast, would seem more likely to result in confirmation of
expectations in the behavioral expectation group and disconfirmation
in the insight expectation group. The failure to obtain a significant
expectation X transcript interaction effect on any of the 16 dependent
measures suggests either that the behavioral transcript was not
perceived as meeting or failing to meet subjects' expectations or
that expectations were in fact disconfirmed in the insight expectation group but failed to adversely affect those subjects' transcript ratings. Devine and Fernald's (1973) findings of adverse effects on outcome as a result of unmet preferences for some forms of treatment (encounter and rational-emotive treatments) but not for others (systematic desensitization and modeling-behavioral rehearsal) may be relevant to the current study. It could be that, while the rated acceptability and effectiveness were statistically greater for the behavioral than the insight transcript, the insight transcript was still viewed as sufficiently acceptable and effective. In support of this interpretation, the greatest difference between the mean ratings of these two transcripts on the 16 dependent measures was only .55 on a 6-point scale.

The limited range of scores on the Treatment Expectations and Preferences Scale provides another possible explanation for the limited influence of expectations and preferences on transcript ratings. Of a possible range of 180 points for the total scores, subjects' expectation scores actually ranged only 46 points, and their preference scores ranged only 57 points. For the 15 insight and 15 behavioral items, with a possible range of 90 points, subjects' actual insight expectation ratings ranged 31 points, their behavioral expectation ratings 42 points, their insight preference ratings 59 points, and their behavioral preference ratings 50 points. The more extreme variability of these ratings in the pilot sample suggests that this restricted range may be more a characteristic of the current subject sample than of the instrument. With the limited variability
in the current sample's scores, it seems plausible that subjects' expectations and preferences were not sufficiently extreme for the transcripts to be seen as either highly discrepant or highly concordant with subjects' stated expectations or preferences. As Duckro et al. (1979) described the unidimensional disconfirmation hypothesis, the extent of the discrepancy between an actual and an expected or preferred event determines the extent of the positive or negative reaction to the discrepancy. The bipolar position, based on Helson's adaptation-level theory (1959, 1964), holds that discrepancies in desirability between the actual and expected event also influence the degree of positive or negative reaction to the event. These discrepancies may not have been sufficiently great in the present study to evoke either a detectable positive or negative reaction.

Subjects may also have failed to perceive discrepancies between their stated expectations and preferences and the treatments illustrated due to the design of this study. While both the behavioral and insight items of the Treatment Expectations and Preferences Scale and the two therapy transcripts had been judged to adequately reflect these two treatment orientations, no data were collected to determine whether the dimensions tapped by the scale were reflected in the transcripts. Neither independent raters, nor, more importantly, the subjects themselves were asked to rate the extent to which the transcripts' procedures, goals, and foci paralleled the dimensions measured by the Treatment Expectations and Preferences Scale. In designing the study, an attempt was
made to employ transcripts not written specifically in line with
the scale dimensions, since it was felt that with one presentation
more general and theoretical and the other more practical and
applied, subjects would be less likely to perceive experimental
demand or to deliberately attempt to respond consistently across
the scale and transcript ratings. Subjects' general failure to
recognize experimental demand or any relationship between their
scale and transcript ratings as being of interest to the exper­
menter suggests that this strategy was effective. However, this
strategy may also have made less salient the discrepancies between
the general theoretical and procedural dimensions of these treat­
ments and their appearance in practice. Of relevance to this line
of argument, subjects were told at the beginning of the study that
they would be reading and rating two therapy transcripts. It
seems plausible that, rather than highlighting the distinctions
between these two approaches and the discrepancies between the
approaches and expectations or preferences, this information led
subjects to expect disconfirmation. This awareness may have
moderated the negative effects of disconfirmation. As a limited
number of studies have suggested, making available a greater range
of treatments or even giving an illusion of choice may result in
greater valuation of treatment (Gordon, 1976; Kissin, Platz, & Su,

The analogue nature of this study may have further reduced
the saliency of those discrepancies which were perceived between
stated expectations or preferences and the treatments offered in
the transcripts. Perhaps in a clinical population, where the
treatment assigned or offered a client has clear impact and deter­
mines a future course of action, such discrepancies are more
salient and play a more critical role in evaluating the treatment.

In summary, the present study found that treatment expectations
and preferences bore little relationship, either singly or in inter­
action, to the perceived credibility and acceptability of illustra­
tions of insight-oriented and behavior therapy. The limited impact
of these subject variables, together with the strong effects
obtained for the transcript factor, suggests either than expecta­
tions and preferences were confirmed or disconfirmed by the transcripts
but failed to affect subjects' judgments of the treatments or that
these judgments were made independently of the theoretical and
procedural dimensions reported as expected or preferred by subjects.
The behavioral transcript's generally greater appeal may have
stemmed from variations along dimensions not manipulated in the
present study. These dimensions might have included such factors
as the perceived warmth or personal attractiveness of the therapist.
While written therapy transcripts were employed to minimize the
impact of relationship factors, subjects may nonetheless have
formulated conceptions of the therapist or the therapeutic rela­
tionship and used them as a basis for evaluating the two treatment
approaches. Exploratory study is suggested in order to determine
which of the variety of factors operating in psychotherapy (e.g.,
the therapeutic relationship, treatment procedures, therapy rationale)
are most salient to subjects and which bear the strongest relationship to their evaluations or acceptance of treatment. It is also recommended that future therapy rationale or credibility studies attempt to equate treatment illustrations along such relationship dimensions.

The present study failed to provide support for the suggestion of Duckro et al. (1979) that both expectations and preferences be considered in assessing the effects of disconfirmation. The study also failed to demonstrate a greater influence of treatment preferences than expectations on transcript ratings, and thus failed to support several authors' suggestions that preferences should have greater impact on perceptions of psychological treatments (Duckro et al., 1979; Frank et al., 1978; Lazare et al., 1972). In the present study, these two variables were apparently not sufficiently distinct, as measured, to permit a clear test of their differential or interactive predictive power. Future attempts to investigate these suggestions will clearly need to discover means or assessing expectations and preferences that do not result in the positive correlation obtained between these variables with the present scale. Alternately, investigators will need to determine whether, despite this correlation, expectations and preferences are sufficiently distinct constructs to be considered jointly in predicting the appeal or credibility of treatment.

It should be noted that expectations and preferences in the present study were measured for the theoretical and procedural aspects of treatment. It seems plausible that these two
variables may be correlated for such dimensions but not for other aspects of treatment, such as therapist behavior or the client role.

In previous studies, measures of expectations and preferences for treatment approaches also included measures regarding such global variables as therapist personality (Begley & Lieberman, 1970) or, when measured solely regarding the aims and procedures of treatment, were measured much more broadly than in the present study. For example, Hornstra et al. (1972) compared expectations of talk versus medication, while Goin et al. (1965) and Garfield and Wolpin (1963) compared expectations of active help or advice versus insight. Some studies have suggested that, even in clinical populations, subjects may not have a priori beliefs or desires concerning the treatment approach to be employed. For example, nearly 30% of the clients in one study (Hornstra et al., 1972) were unable to state a preferred mode of treatment in response to an open-ended question. This was true despite the fact that nearly two-thirds had received previous psychiatric treatment. If, as these studies suggest, clients do not always hold specific, a priori conceptions concerning the expected or desired mode of treatment, it may be unreasonable to expect that nonclients would hold such conceptions and use them as a basis for evaluating various treatment approaches.

Attempts were made in this study to create materials and experimental manipulations that would be involving for subjects and analogous to aspects of the clinical situation. These
attempts included: employing a case description which portrayed problems within the experience of college students, illustrating the two treatment approaches by means of therapy transcripts rather than general theoretical descriptions, and asking subjects to complete the Treatment Expectations and Preferences Scale from the role of a prospective client and to imagine themselves in the client's role as they read the therapy transcripts. These attempts seemed to be effective, as evidenced by subjects' reporting relative ease of role-taking, involvement with the experimental procedures, and perception of the client's problems as similar to those they had experienced in their own lives. Still, subjects were not selected on the basis of experiencing the types of problems portrayed in the case description and transcripts. Neither were they necessarily considering seeking psychological treatment.

Whether the absolute level and direction of results obtained in the present study would hold for client populations judging similar illustrations of treatment or, more importantly, for clients actually receiving these treatments, awaits further research. As Kazdin (1978) has argued, the use of nonclinical or analogue populations may in some instances provide a more conservative test of a treatment's credibility, since these populations may be more critical in appraising treatments than clients in distress and desperate for relief. Supporting this argument, Kirsch and Henry (1977) found that behavioral treatment procedures were rated significantly higher in credibility by speech-anxious subjects receiving treatment than
by pretest pilot subjects who knew they would not be receiving treatment. Furthermore, differential treatment credibility and acceptability have been found within nonclinical populations, even with comparable materials employed to illustrate the treatments of interest. For example, Holen and Kinsey (1975) and Knudson and Carskadon (1978), utilizing the same filmed demonstrations of client-centered and behavior therapy, obtained contradictory results.

In previous studies employing college populations, factors associated with differential acceptability and credibility have included: labeling the illustrations' theoretical orientations (Woolfolk et al., 1977), increasing the stimulus materials' resemblance to aspects of the clinical situation (Nau et al., 1974), and variations in the types of presenting problems to which treatments are applied (Osarchuk & Goldfried, 1975; Wollersheim et al., in press). Another factor potentially influencing these ratings is suggested by the current study: subjects' familiarity with various psychotherapeutic approaches. The differential familiarity with behavioral and insight-oriented approaches reported by the current sample may have resulted from differential exposure to these approaches in their introductory psychology class. More speculatively, their course instructor's interest and expertise in learning theory, which is generally reputed to form the basis of behavioral treatment approaches, may have led to subjects' greater familiarity with behavior therapy and
to their more favorable ratings of the behavioral treatment. Subjects' knowledge of various approaches to psychotherapy may well prove an important variable in extensions of the research strategy used in the present study to clinical populations.

The present findings and research to date have failed to establish with certainty that disconfirmed treatment expectations and preferences inevitably lead to negative effects on client satisfaction or on treatment process and outcome (Duckro et al., 1979). Since the accumulated findings have revealed divided support for the influence of treatment expectations and preferences, it is difficult to predict the fruitfulness of further research in this area. The more consistent demonstration of differential acceptability and credibility across treatments in a number of studies (e.g., Borkovec & Nau, 1972; Holen & Kinsey, 1975; McGlynn & McDonell, 1974; Stuehm et al., 1977), including the present one, suggests that providing clients with a range of treatment options might prove a more profitable line of inquiry than attempting to isolate subject variables such as expectations or preferences in hopes of predicting response to treatment.
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APPENDIX A

Rating Scale for Items' Descriptiveness of Insight-oriented Therapy and Behavior Therapy

The following is a list of items designed to tap various dimensions of two treatment approaches: insight-oriented therapy and behavior therapy. These dimensions include the focus of treatment, its aims or goals, and the procedures employed. Using the following scale, please rate each item in terms of how descriptive or characteristic of insight-oriented or behavior therapy you consider each to be. Items descriptive of insight-oriented therapy receive negative scores, those descriptive of behavior therapy receive positive scores, while those not clearly differentiating the two approaches receive scores of 0. Write in one number to the left of each item, as follows:

-3: Highly descriptive of insight-oriented therapy
-2: Moderately descriptive of insight-oriented therapy
-1: Mildly descriptive of insight-oriented therapy
  0: Does not differentiate insight-oriented and behavior therapy
+1: Mildly descriptive of behavior therapy
+2: Moderately descriptive of behavior therapy
+3: Highly descriptive of behavior therapy

1. Getting help changing the consequences of my behavior, so I get rewarded for behaving in new ways.
2. Teaching me new behaviors I can start practicing right now.
3. Having the therapist suggest new ways I can act in difficult situations.
4. Learning how to reward myself for doing things differently.
5. Emphasizing that my behavior will change automatically as I understand myself better.
6. Emphasizing that my problems are caused by current conditions in my life, not by my childhood or personality.
7. Not just getting rid of my sympoms, but understanding how and why they developed.
8. Having the therapist help me choose specific behaviors I need to change.
9. Getting help changing my personality.
10. Having the therapist structure and plan out therapy sessions in advance.
11. Learning to recognize current sources of stress in my environment.
12. Being shown that my problem behaviors developed through learning and can be changed by relearning.

13. Concentrating only on behaviors that are problems for me in the here and now.

14. Seeing that my behavior is caused by certain feelings, needs, or ideas I'm not aware of.

15. Being told to try out and practice new ways of behaving in situations that are hard for me.

16. Learning to be less afraid by staying relaxed while I imagine and am exposed to things that upset me.

17. Having the therapist ask a lot about my childhood memories.

18. Helping me understand how the different parts of my personality conflict with each other.

19. Getting trained to relax in situations that upset me.

20. Having therapy focus on ways to get rid of my symptoms, not on their underlying causes.

21. Getting help discovering parts of myself that have been too painful to accept.

22. Having the therapist demonstrate and practice with me the new behaviors I should learn.

23. Discussing my feelings about the therapist with him or her as therapy progresses.

24. Bouncing my ideas off the therapist to become more aware of unrecognized motives and thoughts.

25. Having the therapist point out that some of my reactions and attitudes are rooted in the past and don't apply now.

26. Helping me understand how I am avoiding the solutions to my problems.

27. Saying anything that comes into my mind.

28. Letting go and getting my feelings off my chest in the therapy sessions.

29. Being helped to rework the way I see the past.

30. Learning that I relate to the therapist in the same way that causes me trouble outside of therapy.

31. Getting some painful feelings out of my system.

32. Having the therapist take the lead in deciding what we'll talk about.

33. Understanding why I relate to the therapist the way I do.

34. Learning how childhood events are at the root of my feelings and behavior.

35. Getting practical experience relating to other people in new ways, rather than insights into my personality.

36. Getting help understanding my dreams and fantasies.

37. Teaching me how to express my needs and feelings to others in a more open and direct fashion.
38. Having the therapist suggest specific ways to change situations that cause me to react the way I do.
39. Being trained in specific skills in areas in which I'm lacking.
40. Exploring how my feelings about my parents relate to current experiences.
41. Finding the hidden causes of my behavior and feelings.
42. Having the therapist explain the meaning of silences, gestures, and shifts in my posture.
43. Deliberate attempts' being made to stop behavior that makes me anxious.
44. Having the therapist frequently give me advice on how I should act.
45. Coming to know and accept my true feelings and acting upon them.
46. Helping me relive traumatic experiences.
APPENDIX B

Treatment Expectations and Preferences Scale

Form EP

For each of the following 30 items, you will be asked to make two ratings: (1) what you expect or predict would be involved in therapy if you were going for help, and (2) what you would want or prefer to be involved in therapy if you were going for help. You likely have certain anticipations concerning what would or would not occur in therapy, as well as certain preferences about what you'd find desirable or undesirable. As you answer each item, keep in mind: (1) your estimates about what is likely or unlikely to be a part of therapy, and (2) your desires about what you hope would or would not be a part of therapy.

Use the following two scales to answer these items. Numbers on both scales range from -3 to +3. Positive numbers on the expectation scale are for items you expect or predict are likely to be involved in therapy, while positive numbers on the preference scale are for items you want or prefer to be involved. Negative numbers on the expectation scale are for items you expect or predict are unlikely to be involved in therapy, while negative numbers on the preference scale are for items you want or prefer not to be involved.

For each of the 30 items, write in the number that comes closest to your expectation in the space on the left. Write in the number that comes closest to your preference in the space on the right. Be sure to make both ratings for all 30 items.

**EXPECTATION**
+3 = Will definitely be involved in therapy
+2 = Will probably be involved in therapy
+1 = Somewhat likely to be involved in therapy
0 = May or may not be involved in therapy
-1 = Somewhat unlikely to be involved in therapy
-2 = Will probably not be involved in therapy
-3 = Will definitely not be involved in therapy

**PREFERENCE**
+3 = Strong desire that this be involved in therapy
+2 = Moderate desire that this be involved in therapy
+1 = Mild desire that this be involved in therapy
0 = Indifferent about this being involved in therapy
-1 = Mild desire that this not be involved in therapy
-2 = Moderate desire that this not be involved in therapy
-3 = Strong desire that this not be involved in therapy
1. Helping me understand how the different parts of my personality conflict with each other.

2. Having the therapist demonstrate and practice with me the new behaviors I should learn.

3. Getting help understanding my dreams and fantasies.

4. Getting practical experience relating to other people in new ways, rather than insights into my personality.

5. Learning to reward myself for doing things differently.

6. Learning to be less afraid by staying relaxed while I imagine and am exposed to things that upset me.

7. Exploring how my feelings about my parents relate to current experiences.

8. Seeing that my behavior is caused by certain feelings, needs, or ideas I'm not aware of.

9. Getting trained to relax in situations that upset me.

10. Getting help discovering parts of myself that have been too painful to accept.

11. Discussing my feelings about the therapist with him or her as therapy progresses.

12. Deliberate attempts' being made to stop behavior that makes me anxious.

13. Learning how childhood events are at the root of my feelings and behavior.

14. Having the therapist frequently give me advice on how I should act.

15. Being helped to rework the way I see the past.

16. Saying anything that comes into my mind.

17. Being shown how my problem behaviors developed through learning and can be changed by relearning.

18. Having the therapist suggest specific ways to change situations that cause me to react the way I do.

19. Being told to try out and practice new ways of behaving in situations that are hard for me.

20. Having the therapist ask a lot about my childhood memories.

21. Finding the hidden causes of my behavior and feelings.

22. Having the therapist suggest new ways I can act in difficult situations.

23. Helping me relive traumatic experiences.

24. Bouncing my ideas off the therapist to become more aware of unrecognized motives and thoughts.

25. Having therapy emphasize that my behavior will change automatically as I understand myself better.

26. Getting help changing the consequences of my behavior, so I get rewarded for behaving in new ways.

27. Being trained in specific skills in areas in which I'm lacking.

28. Having therapy focus on ways to get rid of my symptoms, not on their underlying causes.
29. Teaching me new behaviors I can start practicing right now.
30. Having therapy not just focus on getting rid of my symptoms, but on helping me understand how and why they developed.
Treatment Expectations and Preferences Scale
Form PE

For each of the following 30 items, you will be asked to make two ratings: (1) what you would want or prefer to be involved in therapy if you were going for help, and (2) what you expect or predict would be involved in therapy if you were going for help. You likely have certain preferences about what you'd find desirable or undesirable in therapy, as well as certain anticipations concerning what would or would not occur. As you answer each item, keep in mind: (1) your desires about what you hope would or would not be a part of therapy, and (2) your estimates about what is likely or unlikely to be a part of therapy.

Use the following two scales to answer these items. Numbers on both scales range from -3 to +3. Positive numbers on the preference scale are for items you want or prefer to be involved in therapy, while positive numbers on the expectation scale are for items you expect or predict are likely to be involved. Negative numbers on the preference scale are for items you want or prefer not to be involved in therapy, while negative numbers on the expectation scale are for items you expect or predict are unlikely to be involved.

For each of the 30 items, write in the number that comes closest to your preference in the space on the left. Write in the number that comes closest to your expectation in the space on the right. Be sure to make both ratings for all 30 items.

<table>
<thead>
<tr>
<th>PREFERENCE</th>
<th>EXPECTATION</th>
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<tbody>
<tr>
<td>+3 = Strong desire that this be involved in therapy</td>
<td>+3 = Will definitely be involved in therapy</td>
</tr>
<tr>
<td>+2 = Moderate desire that this be involved in therapy</td>
<td>+2 = Will probably be involved in therapy</td>
</tr>
<tr>
<td>+1 = Mild desire that this be involved in therapy</td>
<td>+1 = Somewhat likely to be involved in therapy</td>
</tr>
<tr>
<td>0 = Indifferent about this being involved in therapy</td>
<td>0 = May or may not be involved in therapy</td>
</tr>
<tr>
<td>-1 = Mild desire that this not be involved in therapy</td>
<td>-1 = Somewhat unlikely to be involved in therapy</td>
</tr>
<tr>
<td>-2 = Moderate desire that this not be involved in therapy</td>
<td>-2 = Will probably not be involved in therapy</td>
</tr>
<tr>
<td>-3 = Strong desire that this not be involved in therapy</td>
<td>-3 = Will definitely not be involved in therapy</td>
</tr>
</tbody>
</table>
1. Helping me understand how the different parts of my personality conflict with each other.
2. Having the therapist demonstrate and practice with me the new behaviors I should learn.
3. Getting help understanding my dreams and fantasies.
4. Getting practical experience relating to other people in new ways, rather than insights into my personality.
5. Learning to reward myself for doing things differently.
6. Learning to be less afraid by staying relaxed while I imagine and am exposed to things that upset me.
7. Exploring how my feelings about my parents relate to current experiences.
8. Seeing that my behavior is caused by certain feelings, needs, or ideas I'm not aware of.
9. Getting trained to relax in situations that upset me.
10. Getting help discovering parts of myself that have been too painful to accept.
11. Discussing my feelings about the therapist with him or her as therapy progresses.
12. Deliberate attempts' being made to stop behavior that makes me anxious.
13. Learning how childhood events are at the root of my feelings and behavior.
14. Having the therapist frequently give me advice on how I should act.
15. Being helped to rework the way I see the past.
16. Saying anything that comes into my mind.
17. Being shown how my problem behaviors developed through learning and can be changed by relearning.
18. Having the therapist suggest specific ways to change situations that cause me to react the way I do.
19. Being told to try out and practice new ways of behaving in situations that are hard for me.
20. Having the therapist ask a lot about my childhood memories.
21. Finding the hidden causes of my behavior and feelings.
22. Having the therapist suggest new ways I can act in difficult situations.
23. Helping me relive traumatic experiences.
24. Bouncing my ideas off the therapist to become more aware of unrecognized motives and thoughts.
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27. Being trained in specific skills in areas in which I'm lacking.
28. Having therapy focus on ways to get rid of my symptoms, not on their underlying causes.
29. Teaching me new behaviors I can start practicing right now.
30. Having therapy not just focus on getting rid of my symptoms, but on helping me understand how and why they developed.
Mary, age 19, is presently enrolled as a freshman at a large state university. She came to college from a town some distance away, where her parents are respected members of the community. Her family is middle-class. Her father is a businessman, and her mother is a housewife. Mary is the second of three children. As the middle child, she felt compelled to compete for her parents' affection.

When entering elementary school, Mary seemed to have a hard time breaking away from home. She cried at the bus stop the first few mornings but gradually seemed to accept the routine. Throughout elementary and high school, Mary received above-average grades in all of her classes. While active in several clubs in high school, Mary seemed to prefer the company of a few close friends. She began dating as a junior in high school, but she did not become involved in a steady relationship. Although she wanted to take a year off after graduating from high school, her parents finally convinced her to attend college. She enrolled at the state university with a number of her classmates.

Upon her arrival at college, Mary took a general course of studies, since she had not decided upon a major. By the middle of her first quarter, despite spending many hours studying each day, she began to lose confidence in her abilities. She feared doing poorly or flunking out of school and letting her family down. Studying became increasingly difficult for her. She could concentrate for only a short while before becoming lost in thought. She lay awake at night worrying about whether she was cut out for college. Though she was generally an easygoing person who tried hard to get along with everyone, she noticed herself becoming jittery, moody, and short-tempered. Whenever she talked with her family or friends back home, she came away feeling that they were unhappy with her—for being away from her hometown or for not doing as well as they expected her to.

Mary felt that many of her friends at school used her and gave little in return. They'd borrow her class notes or car and study with her, but they were never around when she felt bad and needed someone to talk to. Mary was dating a guy she had met shortly after her arrival in town, but she felt he was bossy and very critical of her, so that she still felt homesick and lonely. Often after spending time with acquaintances on campus or at parties, she would go back to her room and cry, wondering whether she just wasn't attractive or friendly enough and why she always clammed up around people and couldn't enjoy herself anymore like everyone else seemed to. Mary began spending more and more time alone, discouraged with herself and overwhelmed with her coursework. The harder she tried to pull herself out of this mood and situation, the worse they seemed to get. It was at this point that she decided to seek psychological treatment.
Mary: I haven't been feeling very happy lately. I don't know what's the matter. Nothing seems right. I've been wondering a lot why I'm in college...maybe I don't belong here.

Therapist: So you've been feeling discouraged and are questioning being in school. How long have you been feeling this way?

Mary: I'd say it started about two months ago.

Therapist: Since then, is it a constant feeling, or does it come and go?

Mary: I haven't thought about that much...I guess the general feeling is unhappiness, but I get worried, tense, and anxious, too. Those feelings come and go.

Therapist: What was happening two months ago when you started having these feelings?

Mary: Well, I'd just started college...it's my first time living away from home. --And I met a guy, Jim. He's the first guy I've ever cared this much about, but he's so bossy and critical sometimes that I just can't relax and be myself when I'm with him. Sometimes I just clam up!

Therapist: Could you be a little more specific? What types of criticisms from Jim upset you?

Mary: All types! Any criticism from him makes me upset, even if I know he's wrong. I can't talk back. I get all choked up and feel tense and like I'm going to cry.

Therapist: What might he say that would affect you this way?

Mary: Oh...that I'm too quiet at parties or saying, "Why'd you come if you won't enjoy yourself?" I don't like being such a stick in the mud!

Therapist: Are there other situations or people that trigger these same feelings?

Mary: Talking with my family seems to make it worse. Then I really feel tense and anxious--more so than usual! I can't study...I don't want to be around people--not even my boyfriend.
Therapist: What do your parents say when you talk with them?

Mary: Well, they always ask how I'm doing in my classes—and I just can't tell them I'm having trouble studying. I start thinking of how much trouble they went to so I could come to college, and I feel like I'm letting them down.

Therapist: So you feel upset as soon as they ask how you're doing in your classes.

Mary: Yes, then...and also when they ask if I've chosen a major yet. I know they want me to go into business, because my father has connections and can help me get a good job back home when I graduate. I'm not sure that's right for me, though.

Therapist: You see those questions as pressuring you to do well in school and to decide on a major, and that upsets you.

Mary: A lot! I'm afraid they're disappointed in me...(crying)

Therapist: You worry they're displeased with you. You fear their disapproval and feel very tense and anxious in the face of that. Often there are a number of events that seem to trigger such feelings...

Mary: Actually, it's a lot like the way I feel when I turn in my papers for courses. I never think they're good enough.

Therapist: What makes them good enough?

Mary: Well...whether my professors will approve of them. I know what they want, and if I don't do just that, I'm upset with myself.

Therapist: So it does depend on their evaluation.

Mary: Yes, I'd say I'm too concerned about other peoples' opinions.

Therapist: All of the things you've told me so far have to do with being evaluated in some way and fearing others' disapproval. That's a good start at discovering what your response of anxiety has been learned to. Over the next week, I'd like you to keep a log of other times you feel anxious, tense, or unhappy. Just write down what things happen before you have those feelings and what your reaction is afterwards. Once we've found what triggers those feelings, we have ways to change the anxiety that seems to occur automatically. You need to learn to combat the anxiety. One way is muscle relaxation. You've probably never learned that, have you?
Mary: No, I haven't.

Therapist: Next time I'll start to show you. We'll draw up a list of all the situations that make you anxious and work to replace that reaction with relaxation. Another way to combat anxiety is to start taking action, to start standing up for yourself.

Mary: How do I do that?

Therapist: Essentially start speaking out and expressing the annoyance you feel. It's very hard at first, but if you make a special point of doing it, you find it gets easier and easier.

Mary: But I've tried that. The words just don't come out sometimes.

Therapist: That's because of the fear you have of disapproval or criticism. Let's try something! Suppose you were standing in line and someone cut in front of you. How would you feel, and what would you do?

Mary: I'd feel ready to explode, and I might say something then. I'd be pretty sure I was right.

Therapist: Good! Now let's try another situation. I want you to pretend that I'm your mother. I'll say the sorts of things she might say to you, and let's see how well you handle them in this situation. --"Mary, if you're going to ask us to pay for your schooling, you'd better start doing better! You don't even know what you want to do!"

Mary: I know I should be doing better, Mom, but...I'm not sure I want to be in school right now.

Therapist: --"Don't want to be in school? After all we've done for you! Of course you should be in school! Are you questioning our judgment?"

Mary: Oh, no! Of course not, Mom...

Therapist: But you are! If you deny it, you're not getting your point across to her. Now let's reverse our parts. I'll be you, and you be your mother.

Mary: Okay, here goes! --"Mary, why can't you do better and stay in school? It would make us so happy!"

Therapist: "Look, Mom, by the time a person reaches my age, she has to make some decisions for herself. You and Dad have done the best for me, and if you don't approve of what I do, try to see it as my bad luck, not as your failure." What do you think she'd say if you tried that?
Mary: She'd probably say something like, "But, Mary, you know we love you and want what's best for you...but are you sure you want to leave school?"

Therapist: Then you could say, "No, I'm not sure I want to leave school, but I am sure I want to make that decision for myself."

Mary: You know, that might work. I'm not sure where to start, though, and trying to talk like that could be pretty frightening. I'm not sure I'm up to it...

Therapist: The only way to know is to try. As you begin to practice speaking up for yourself, you'll start feeling more comfortable with it. If you learn to relax and face what upsets you and practice standing up for yourself, maybe this fear of disapproval won't be so strong.
APPENDIX E

Transcript B

Mary: I haven't been feeling very happy lately. I don't know what's the matter. Nothing seems right. I've been wondering a lot why I'm in college...maybe I don't belong here.

Therapist: You've been feeling discouraged lately.

Mary: Yes, I'm just not certain of anything! Sometimes I want to be in school, and other times I just want to leave...maybe go home for a while and decide what I really want out of life. --But I'm afraid I'd be letting my parents down. They've given up a lot so I could go to school. They're very important to me; sometimes it seems like I've always just lived for their pat on the back. I get tired, though, of everyone else telling me what's best for me.

Therapist: So you've always tried to please your parents, to live up to what they wanted for you. And now you're starting to wonder what you want for yourself.

Mary: Yes, sometimes I think my parents have done too much for me. They never developed their own interests...my mother especially. She never let me learn to stand on my own two feet.

Therapist: You feel sort of angry with them about that.

Mary: Mm-hmm...and guilty, too, because they did so much for me, and I don't always appreciate it.

Therapist: You let them do a great deal for you. Maybe it felt good to them, but it doesn't always feel good to you.

Mary: My sister's different, though. She can stand up to them. She told them to let her live her own life.

Therapist: But up to this point you haven't felt it was right for you to stand up to them that way.

Mary: No! Somehow I believe they must know what's best for me. They're trying, anyway, and I trust them.

Therapist: You can trust others and believe they know what's right for you, but sometimes belief in yourself seems just impossible.
Mary: Yes, even a little child loves to stand on his own two feet!

Therapist: And you're wondering where you lost that confidence in yourself.

Mary: Oh my! (crying) Here comes the rainstorm... I feel like I fail in everything I do. Everybody expects so much of me, and I try so hard to please them, but I always let them down. I guess I expect a lot of myself, too. I don't feel I'm a brilliant person, but I'm not as stupid as my grades indicate. The grades don't really reflect what I can do, though. I go blank lately whenever I try to study. The friends I have here don't really seem that close to me, and with my boyfriend I'm always worried I'm saying or doing the wrong thing. I look around, and all the girls I know seem ready to get serious with someone. I just don't think I'm ready yet... I don't know what's wrong with me.

Therapist: Right now you feel different from others, and you don't see how you can fix that.

Mary: I just wonder what the next step should be. I realize it all began a long time ago...

Therapist: You realize the roots must go a long way back, and at some point you'll have to start reworking what went wrong.

Mary: My mother was always correcting me and yelling at me. Once I went to a dance when she didn't want me to. She was really angry, but I went anyway. Then I got real sick and had to come home before it was over. I remember I pretended to be sick longer than I was. I just stayed in bed, having Mom take care of me.

Therapist: You felt somehow that by doing things your own way you risked losing her love...that it was scary to get angry or be on your own and easier to cling to people and try to please them.

Mary: It must be! I always tried to be such a good kid, and if I did get angry about it, my mother got even angrier with me.

Therapist: And you're still trying to be a good kid, but now it doesn't seem to be working for you.

Mary: No. I can't get by being a good kid anymore--I don't want to! I'm supposed to start making it on my own...I'm not sure where to start, though, and the idea is pretty frightening.

Therapist: You're wondering what will happen if you start doing what you want and stand up for yourself.
Mary: Whenever I get an urge to be so agreeable, I could try to stop myself and think, "Okay, here's Mom telling me to be a good little girl again!" Maybe that way I could stop and decide what I want to do.

Therapist: You wouldn't have to go ahead automatically...and maybe you could start developing some respect for yourself. You'll need that on a pretty fundamental basis in order to have any achievements in any area.

Mary: You know, I had this dream last night. I don't know what made me remember it. I'm walking up a hill toward a park bench, and there's a beggar with a tin cup sitting there. Just as I'm about to drop some money in his cup, I notice there's already a tremendous amount of money there. I'm really surprised to see it!

Therapist: Perhaps you see yourself as both the poor beggar and the generous giver...like you've never discovered for yourself all the money in your tin cup. You thought it was empty, and so you gave and gave, hoping to get something in return.

Mary: Mmm...if I start believing that I have something to offer, I can give without thinking I have to...and start asking for what I want from other people.

Therapist: Going back to your relationship with your mother, you've always felt you had to do what she thought was best for you?

Mary: Yes, always!

Therapist: Do you feel some parallel of that with your boyfriend?

Mary: Yes, I told him once I feel he treats me like a child.

Therapist: And that makes you angry?

Mary: No...more hopeless...

Therapist: I wonder whether this hopelessness isn't a way of dealing with your anger... Any person in your position must feel angry, always trying to mold yourself to suit others.

Mary: I guess I do get fed up with having to be so agreeable all the time.

Therapist: And how might this relate to your coursework?

Mary: Sometimes I'm just afraid I can't do it, that I'm not cut out for school.

Therapist: And that keeps you from even trying. You feel whipped before you start.
Mary: I sit with my books and stare at the pages, and it all turns into a blur. My mind just goes blank.

Therapist: Maybe the blurring is a way of pushing something out of your mind you don't want there, something you're afraid of...

Mary: But why am I afraid, and of what?

Therapist: What comes to mind?

Mary: Well...maybe if I do well in school I'll be that much closer to being on my own.

Therapist: So this way you hold yourself back. You avoid taking chances and risking failure, and you keep yourself from becoming independent...just like your parents have tried to keep you from it.

Mary: Do you think I'm able to make it on my own? I wonder sometimes...

Therapist: If you gain more confidence in yourself, you can begin to decide. Every success you have will make you feel more confident. If you come to understand how your feelings of anger about what people expect of you developed, accept those feelings, and express them instead of burying them deep inside, maybe they won't come out as this need to be the good little girl.
APPENDIX F

Transcript Rating

Instructions: Please read each of the following questions carefully and circle the number which best represents your answer. In answering consider the case description of Mary that you read and the transcript just presented illustrating this type of therapy. Be sure to circle the number that best describes your opinion for each of the 16 items.

1. How confident would you be in recommending this type of treatment to a friend experiencing problems similar to Mary's?

1 2 3 4 5 6

Not at all Little Slight Some Good Extremely
Confident if any Lack of Confidence Amount of Confident
Confidence Confidence Confidence

2. If you were experiencing problems similar to those in the case description, would you be willing to undergo this type of treatment?

1 2 3 4 5 6

Definitely Probably Possibly Possibly Probably Definitely
Not Not Not

3. How effective do you believe that the treatment the therapist outlined will be?

1 2 3 4 5 6

No Help Little Minimally Moderately Very Completely
Whatever if any Helpful Helpful Helpful Helpful Help

4. How good an understanding do you feel the therapist had of the client's difficulties?

1 2 3 4 5 6

No Understanding Very little Some, but Fair Good Excellent
Understanding Under- inadequate Under- Under- Under-
standing Standing Standing Standing Standing
5. How much do you agree that the therapist's conceptualization of the client's behavior fits the problems outlined in the case description?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely</td>
<td>Strongly</td>
<td>Mildly</td>
<td>Mildly</td>
<td>Strongly</td>
<td>Completely</td>
</tr>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Agree</td>
<td>Agree</td>
</tr>
</tbody>
</table>

6. How much do you agree with the procedures the therapist was using to help the client with her problems?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely</td>
<td>Strongly</td>
<td>Mildly</td>
<td>Mildly</td>
<td>Strongly</td>
<td>Completely</td>
</tr>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Agree</td>
<td>Agree</td>
</tr>
</tbody>
</table>

7. How much experience do you feel the therapist has in treating clients with problems similar to these?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extensive</td>
<td>Good</td>
<td>Some</td>
<td>A Little</td>
<td>Very</td>
<td>No</td>
</tr>
<tr>
<td>Experience</td>
<td>Amount</td>
<td>Experience</td>
<td>Little</td>
<td>Experience</td>
<td>Experience</td>
</tr>
<tr>
<td>of Experience</td>
<td>ience</td>
<td>eience</td>
<td>ience</td>
<td>eience</td>
<td>eience</td>
</tr>
</tbody>
</table>

8. How confident are you that the therapist would be helpful with other types of problems experienced by college students?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very</td>
<td>Moderately</td>
<td>Slightly</td>
<td>Slightly</td>
<td>Moderately</td>
<td>Very</td>
</tr>
<tr>
<td>Confident</td>
<td>Confident</td>
<td>Confident</td>
<td>Doubtful</td>
<td>Doubtful</td>
<td>Doubtful</td>
</tr>
</tbody>
</table>

9. In light of the problems described in the case description, how logical does this type of therapy seem to you?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Moderately</td>
<td>Somewhat</td>
<td>Somewhat</td>
<td>Moderately</td>
<td>Very</td>
</tr>
<tr>
<td>Logical</td>
<td>Illogical</td>
<td>Illogical</td>
<td>Logical</td>
<td>Logical</td>
<td>Logical</td>
</tr>
</tbody>
</table>

10. How much do you believe Mary would improve with this type of therapy?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete</td>
<td>Major</td>
<td>Some</td>
<td>Slight</td>
<td>Little if</td>
<td>No</td>
</tr>
<tr>
<td>Improvement</td>
<td>Improvement</td>
<td>Improvement</td>
<td>Improvement</td>
<td>Improvement</td>
<td>Improvement</td>
</tr>
</tbody>
</table>
11. If you were experiencing similar problems, how many sessions of this form of therapy would you be willing to undergo?

1 2 3 4 5 6

1-5 6-10 11-15 16-20 21-25 26 or more

12. How confident are you that this treatment would be successful in eliminating the problems described in the case description?

1 2 3 4 5 6

Not at all Little Slight Some Good Extremely Confident

If any Lack of Confidence Amount of Confident Confidence

13. How satisfied would you be if you were offered this type of therapy?

1 2 3 4 5 6

Completely Very Slightly Slightly Very Completely

Dissatisfied Dis- Dis- Satisfied Satisfied Satisfied satisfied

14. Assuming you could afford to pay, how much would you be willing to pay for this type of therapy?

1 2 3 4 5 6

$1-$5/ hour $6-$10/ hour $11-$15/ hour $16-$20/ hour $21-$25/ hour $26-$30/ hour

15. If you had a similar problem and were receiving this type of therapy, how beneficial do you feel it would be for you?

1 2 3 4 5 6

Not at all Of little Of Minimal Of Some Of Good Extremely Beneficial

If any Benefit Benefit Benefit Beneficial Benefit

16. How familiar are you with the type of treatment the therapist was conducting?

1 2 3 4 5 6

Completely Moderately Somewhat Somewhat Moderately Completely

Familiar Familiar Familiar Unfamiliar Unfamiliar Unfamiliar
APPENDIX G
Post-experimental Questionnaire

Instructions: This questionnaire is designed to give you an opportunity to express your reactions to this experiment and your ideas about its purposes. Please answer the following questions as thoroughly and honestly as possible. The information you provide here could prove extremely important in our understanding the results of this investigation.

1) Please explain what you think the purposes of this study might have been:

2) Please describe what you think the experimenter was hoping you and the other subjects might do:

3) How realistic did you find the written therapy transcripts?
   a) Transcript A
      1  2  3  4  5  6  7
      Very Unrealistic
      Very
      Realistic
   b) Transcript B
      1  2  3  4  5  6  7
      Very Unrealistic
      Very
      Realistic

4) Do you feel your expectations, preferences, or views about psychotherapy have been influenced in any way by this study:
   ___ Yes   ___ No   Please explain:

5) Considering the case description of Mary that you read, how realistic did the description seem to you?
   1  2  3  4  5  6  7
   Very Unrealistic
   Very
   Realistic
6) After reading the description of Mary, how able were you to picture her?

1 2 3 4 5 6 7
I had no picture of her
I pictured her clearly

7) How able were you to place yourself in Mary's role while reading the therapy transcripts?

1 2 3 4 5 6 7
Not at all able
Did so completely

8) Keeping in mind the case description you read, have you ever experienced similar problems in your own life?

1 2 3 4 5 6 7
Yes, definitely
No, definitely not

9) How able were you to imagine yourself as experiencing some type of personal problem and considering going for help with it when you filled out the Treatment Expectations and Preferences Scale?

1 2 3 4 5 6 7
Not at all able
Did so completely

10) How favorable is your attitude toward psychotherapy in general?

1 2 3 4 5 6 7
Completely unfavorable
Completely favorable

11) In your opinion, how effective is psychotherapy in general?

1 2 3 4 5 6 7
Completely ineffective
Completely effective

12) At the present time, how much do you know about the following treatment procedures?

a) Psychoanalytic Therapy: 1 2 3 4 5 6 7
Very little
Moderate amount
A great deal

b) Behavior Therapy: 1 2 3 4 5 6 7
Very little
Moderate amount
A great deal
c) Client-centered Therapy: 1 2 3 4 5 6 7
Very little Moderate amount A great deal

13) In your opinion, how effective are each of the following?

a) Psychoanalytic Therapy: 1 2 3 4 5 6 7
Completely ineffective
Completely effective

b) Behavior Therapy: 1 2 3 4 5 6 7
Completely ineffective
Completely effective

c) Client-centered Therapy: 1 2 3 4 5 6 7
Completely ineffective
Completely effective
Table 1

Mean Ratings of the Descriptiveness of Treatment Expectations and Preferences Scale Items for Behavior Therapy and Insight-Oriented Therapy

<table>
<thead>
<tr>
<th>Item no.</th>
<th>Behavior therapy items</th>
<th>Insight-oriented therapy items</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1st sample of raters*</td>
<td>2nd sample of raters**</td>
</tr>
<tr>
<td>29</td>
<td>2.82</td>
<td>2.80</td>
</tr>
<tr>
<td>6</td>
<td>2.76</td>
<td>2.10</td>
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<tr>
<td>26</td>
<td>2.76</td>
<td>2.70</td>
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<td>27</td>
<td>2.71</td>
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<td>2</td>
<td>2.65</td>
<td>2.60</td>
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<td>4</td>
<td>2.53</td>
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<td>2.47</td>
<td>2.30</td>
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<td>28</td>
<td>2.47</td>
<td>2.30</td>
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<td>19</td>
<td>2.41</td>
<td>2.40</td>
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<td>18</td>
<td>2.29</td>
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<td>2.40</td>
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<tr>
<td>14</td>
<td>2.18</td>
<td>2.00</td>
</tr>
<tr>
<td>9</td>
<td>2.06</td>
<td>2.10</td>
</tr>
<tr>
<td>22</td>
<td>2.06</td>
<td>2.00</td>
</tr>
<tr>
<td>12</td>
<td>2.00</td>
<td>2.00</td>
</tr>
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</table>

*_{n}=17, rounded to 2 decimal places
**_{n}=10
Table 2

Treatment Expectations and Preferences Scale:
Descriptive Statistics for Pilot and Current Samples

<table>
<thead>
<tr>
<th>Group</th>
<th>TEPS Expectation score</th>
<th>TEPS Preference score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Standard deviation</td>
</tr>
<tr>
<td>Pilot sample&lt;sup&gt;a&lt;/sup&gt;</td>
<td>8.652</td>
<td>18.015</td>
</tr>
<tr>
<td>Current sample&lt;sup&gt;b&lt;/sup&gt;</td>
<td>9.484</td>
<td>9.991</td>
</tr>
</tbody>
</table>

<sup>a</sup> n=23  
<sup>b</sup> n=95
Table 3
Mean Total Expectation and Preference Scores
across Forms EP and PE of the
Treatment Expectations and Preferences Scale

<table>
<thead>
<tr>
<th></th>
<th>Total Expectation Score</th>
<th>Total Preference Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Form EP</td>
<td>Form PE</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------</td>
<td>--------------</td>
</tr>
<tr>
<td>M</td>
<td>11.56</td>
<td>7.36</td>
</tr>
<tr>
<td>SD</td>
<td>10.76</td>
<td>8.74</td>
</tr>
</tbody>
</table>

\(a \quad n=95\)
<table>
<thead>
<tr>
<th>Item</th>
<th>Mean expectation rating</th>
<th>Mean preference rating</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Helping me understand how the different parts of my personality conflict with each other.</td>
<td>2.02</td>
<td>2.10</td>
<td>.73</td>
<td>.40</td>
</tr>
<tr>
<td>2. Having the therapist demonstrate and practice with me the new behaviors I should learn.</td>
<td>-.65</td>
<td>-.78</td>
<td>-.69</td>
<td>.40</td>
</tr>
<tr>
<td>3. Getting help understanding my dreams and fantasies.</td>
<td>1.26</td>
<td>1.47</td>
<td>1.21</td>
<td>.20</td>
</tr>
<tr>
<td>4. Getting practical experience relating to other people in new ways, rather than insights into my personality.</td>
<td>-.84</td>
<td>-1.39</td>
<td>-3.89</td>
<td>.001***</td>
</tr>
<tr>
<td>5. Learning how to reward myself for doing things differently.</td>
<td>-.86</td>
<td>-1.00</td>
<td>-.97</td>
<td>.20</td>
</tr>
<tr>
<td>6. Learning to be less afraid by staying relaxed while I imagine and am exposed to things that upset me.</td>
<td>-1.96</td>
<td>-1.98</td>
<td>-.17</td>
<td>.50</td>
</tr>
<tr>
<td>7. Exploring how my feelings about my parents relate to current experiences.</td>
<td>1.38</td>
<td>1.32</td>
<td>-.39</td>
<td>.50</td>
</tr>
<tr>
<td>Item</td>
<td>Mean expectation rating</td>
<td>Mean preference rating</td>
<td>$t^a$</td>
<td>$p$</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>8. Seeing that my behavior is caused by certain feelings, needs, or ideas I'm not aware of.</td>
<td>2.26</td>
<td>1.93</td>
<td>-3.31</td>
<td>.005**</td>
</tr>
<tr>
<td>9. Getting trained to relax in situations that upset me.</td>
<td>-1.91</td>
<td>-2.13</td>
<td>-1.82</td>
<td>.10</td>
</tr>
<tr>
<td>10. Getting help discovering parts of myself that have been too painful to accept.</td>
<td>1.79</td>
<td>1.21</td>
<td>-3.73</td>
<td>.001***</td>
</tr>
<tr>
<td>11. Discussing my feelings about the therapist with him or her as therapy progresses.</td>
<td>1.00</td>
<td>.62</td>
<td>-2.22</td>
<td>.05*</td>
</tr>
<tr>
<td>12. Deliberate attempts' being made to stop behavior that makes me anxious.</td>
<td>-.77</td>
<td>-.79</td>
<td>-.12</td>
<td>.50</td>
</tr>
<tr>
<td>13. Learning how childhood events are at the root of my feelings and behavior.</td>
<td>1.88</td>
<td>1.42</td>
<td>-3.31</td>
<td>.005**</td>
</tr>
<tr>
<td>14. Having the therapist frequently give me advice on how I should act.</td>
<td>.23</td>
<td>.79</td>
<td>2.70</td>
<td>.01**</td>
</tr>
<tr>
<td>15. Being helped to rework the way I see the past.</td>
<td>.81</td>
<td>.34</td>
<td>-2.71</td>
<td>.01**</td>
</tr>
<tr>
<td>16. Saying anything that comes into my mind.</td>
<td>1.81</td>
<td>1.25</td>
<td>-3.39</td>
<td>.005**</td>
</tr>
<tr>
<td>Item</td>
<td>Mean expectation rating</td>
<td>Mean preference rating</td>
<td>t</td>
<td>P</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
<td>---</td>
<td>-----</td>
</tr>
<tr>
<td>17. Being shown how my problem behaviors developed through learning and can be changed by relearning.</td>
<td>-1.88</td>
<td>-1.68</td>
<td>1.72</td>
<td>.10</td>
</tr>
<tr>
<td>18. Having the therapist suggest specific ways to change situations that cause me to react the way I do.</td>
<td>-1.39</td>
<td>-1.35</td>
<td>.26</td>
<td>.50</td>
</tr>
<tr>
<td>19. Being told to try out and practice new ways of behaving in situations that are hard for me.</td>
<td>-1.72</td>
<td>-1.43</td>
<td>2.00</td>
<td>.05*</td>
</tr>
<tr>
<td>20. Having the therapist ask a lot about my childhood memories.</td>
<td>1.76</td>
<td>.84</td>
<td>-6.63</td>
<td>.001***</td>
</tr>
<tr>
<td>21. Finding the hidden causes of my behavior and feelings.</td>
<td>2.37</td>
<td>2.08</td>
<td>-2.35</td>
<td>.025*</td>
</tr>
<tr>
<td>22. Having the therapist suggest new ways I can act in difficult situations.</td>
<td>-1.58</td>
<td>-1.39</td>
<td>1.32</td>
<td>.20</td>
</tr>
<tr>
<td>23. Helping me relive traumatic experiences.</td>
<td>1.55</td>
<td>.80</td>
<td>-4.55</td>
<td>.001***</td>
</tr>
<tr>
<td>24. Bouncing my ideas off the therapist to become more aware of unrecognized motives and thoughts.</td>
<td>1.29</td>
<td>1.10</td>
<td>-1.32</td>
<td>.20</td>
</tr>
<tr>
<td>Item</td>
<td>Mean expectation rating</td>
<td>Mean preference rating</td>
<td>$t^a$</td>
<td>$p$</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------</td>
<td>------------------------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>25. Having therapy emphasize that my behavior will change automatically as I understand myself better.</td>
<td>.87</td>
<td>.62</td>
<td>-1.50</td>
<td>.10</td>
</tr>
<tr>
<td>26. Getting help changing the consequences of my behavior, so I get rewarded for behaving in new ways.</td>
<td>-.92</td>
<td>-.60</td>
<td>2.07</td>
<td>.05*</td>
</tr>
<tr>
<td>27. Being trained in specific skills in areas in which I'm lacking.</td>
<td>-.34</td>
<td>-.74</td>
<td>-2.22</td>
<td>.05*</td>
</tr>
<tr>
<td>28. Having therapy focus on ways to get rid of my symptoms, not on their underlying causes.</td>
<td>.18</td>
<td>.45</td>
<td>1.32</td>
<td>.20</td>
</tr>
<tr>
<td>29. Teaching me new behaviors I can start practicing right now.</td>
<td>-.60</td>
<td>-.47</td>
<td>.74</td>
<td>.40</td>
</tr>
<tr>
<td>30. Having therapy not just focus on getting rid of my symptoms, but on helping me understand how and why they developed.</td>
<td>2.39</td>
<td>2.32</td>
<td>-.67</td>
<td>.40</td>
</tr>
</tbody>
</table>

---

*a df=93

$p < .05$

** $p < .01$

*** $p < .001$
Table 5
Mean Total Expectation and Total Preference Scores
for 2 X 2 X 2 and 2 X 2 Subject Classifications

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean expectation score</th>
<th>Mean preference score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AB&lt;sup&gt;a&lt;/sup&gt;</td>
<td>BA&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>IP X IE</td>
<td>17.14</td>
<td>19.28</td>
</tr>
<tr>
<td>IP X BE</td>
<td>5.43</td>
<td>5.00</td>
</tr>
<tr>
<td>BP X BE</td>
<td>.14</td>
<td>-.43</td>
</tr>
</tbody>
</table>

<sup>a</sup> Behavioral-insight transcript order (n=7)
<sup>b</sup> Insight-behavioral transcript order (n=7)
<sup>c</sup> Both transcript orders (n=14)
Table 6
Group Means across 15 Insight and 15 Behavioral Treatment Expectations and Preferences Scale Items

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean total score across 15 insight items</th>
<th>Mean total score across 15 behavioral items</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expectation ratings</td>
<td>Preference ratings</td>
</tr>
<tr>
<td>IP X IE⁺</td>
<td>24.86</td>
<td>23.78</td>
</tr>
<tr>
<td>IP X BE⁻</td>
<td>25.07</td>
<td>22.86</td>
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<tr>
<td>BP X IE⁺</td>
<td>25.14</td>
<td>11.57</td>
</tr>
<tr>
<td>BP X BE⁻</td>
<td>30.78</td>
<td>14.00</td>
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</tbody>
</table>

⁺ Insight preference X insight expectation (n=14)
⁻ Insight preference X behavioral expectation (n=14)
⁺⁺ Behavioral preference X insight expectation (n=14)
⁻⁻ Behavioral preference X behavioral expectation (n=14)
Table 7
Means and F Tests for the 16 Dependent Measures:
Main Effect for the Repeated-Measures or Transcript Factor

<table>
<thead>
<tr>
<th>Item number</th>
<th>Mean rating, behavioral transcript</th>
<th>Mean rating, insight transcript</th>
<th>F(1,48)</th>
<th>p</th>
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<tbody>
<tr>
<td>1</td>
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<td>4.08</td>
<td>2.314</td>
<td>.131</td>
</tr>
<tr>
<td>2</td>
<td>4.43</td>
<td>3.93</td>
<td>5.779</td>
<td>.019**</td>
</tr>
<tr>
<td>3</td>
<td>4.48</td>
<td>4.03</td>
<td>7.878</td>
<td>.007***</td>
</tr>
<tr>
<td>4</td>
<td>4.80</td>
<td>4.46</td>
<td>4.056</td>
<td>.047*</td>
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<td>5</td>
<td>4.53</td>
<td>4.28</td>
<td>3.399</td>
<td>.068</td>
</tr>
<tr>
<td>6</td>
<td>4.62</td>
<td>4.07</td>
<td>9.873</td>
<td>.003***</td>
</tr>
<tr>
<td>7</td>
<td>2.16</td>
<td>2.58</td>
<td>5.053</td>
<td>.027*</td>
</tr>
<tr>
<td>8</td>
<td>2.21</td>
<td>2.69</td>
<td>4.775</td>
<td>.032*</td>
</tr>
<tr>
<td>9</td>
<td>4.91</td>
<td>4.45</td>
<td>3.628</td>
<td>.059</td>
</tr>
<tr>
<td>10</td>
<td>2.61</td>
<td>3.16</td>
<td>7.627</td>
<td>.008***</td>
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<tr>
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<td>2.45</td>
<td>1.98</td>
<td>4.983</td>
<td>.028*</td>
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<tr>
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<td>4.05</td>
<td>3.977</td>
<td>.048*</td>
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<tr>
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<td>4.07</td>
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<tr>
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<td>8.817</td>
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<td>4.176</td>
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<td>3.41</td>
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<td>.089</td>
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*p < .05
**p < .02
***p < .01
Table 8
Post-experimental Questionnaire: Means and Significant F Tests for Preference, Expectation, and Order Factors

<table>
<thead>
<tr>
<th>Item no.</th>
<th>Overall mean rating</th>
<th>Significant main effect or interaction&lt;sup&gt;a&lt;/sup&gt;</th>
<th>F&lt;sup&gt;b&lt;/sup&gt;</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>3a</td>
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<td>3b</td>
<td>4.96</td>
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</tr>
<tr>
<td>5</td>
<td>5.78</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>6</td>
<td>5.59</td>
<td>Preference X transcript order</td>
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<td>.009**</td>
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<tr>
<td>7</td>
<td>5.30</td>
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<td>---</td>
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<tr>
<td>8</td>
<td>3.00</td>
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<td>---</td>
</tr>
<tr>
<td>9</td>
<td>4.48</td>
<td>Expectation</td>
<td>5.137</td>
<td>.026*</td>
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<td>11</td>
<td>4.93</td>
<td>Preference</td>
<td>8.800</td>
<td>.004**</td>
</tr>
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<td>12a</td>
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<td>---</td>
</tr>
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<td>12b</td>
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<td>.029*</td>
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<td>Preference</td>
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</tr>
<tr>
<td>13b</td>
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<tr>
<td>13c</td>
<td>4.82</td>
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</tbody>
</table>

<sup>a</sup> None significant if blank