Pretreatment Role Expectations, Alliance, and Outcome

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ABSTRACT

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Data from 68 clients treated in a naturalistic setting were used to test a meditational model wherein the alliance was hypothesized to mediate the relationship between clients’ pretreatment role expectations and psychotherapy outcome. This proposed model was tested with the procedures developed by Baron and Kenny (1986). All three expectations factors (Personal Commitment, Facilitative Conditions, Counselor Expertise) were related to the alliance. Only expectations for Counselor Expertise related to outcome, although a Sobel test revealed that this relationship was not mediated by the alliance. Suggested research directions, clinical implications, and study limitations are discussed.

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INTRODUCTION

Pretreatment Role Expectations, Alliance, and Outcome

Role expectations, also known as counseling or treatment expectations, refer to a client characteristic that describes one’s anticipatory beliefs about the contributions or behaviors of both the therapist and client in therapy (Nock & Kazdin, 2001). Counseling expectations were first researched in the 1950s and over the years the amount of research concerning this topic has waxed and waned, with recently renewed interest reflected in the fact that two review articles on expectancies were published during the past five years (Dew & Bickman, 2005; Greenberg, Constantino, & Bruce, 2006). The role of treatment expectations in psychotherapy process and outcome warrants further study for three primary reasons. First, research indicates that expectations have a powerful influence on individuals’ perceptions and experiences (Greenberg, Constantino, & Bruce, 2006; Kirsch, 1999). Theory suggests that expectations influence one’s perceptions in such a manner that interpersonal encounters and relationships are distorted in order to match one’s expectations (Asch, 1946; Farina & Ring, 1965; Kelley, 1950). Therefore, the therapeutic alliance and clinical outcomes are likely to be shaped by the client’s pre-existing expectations about the specific roles of therapist and client during the therapeutic process. Following this research and theory is the second major reason why pretreatment expectations warrant further study. Simply stated, research indicates that this pretreatment client characteristic can be modified with relative ease (e.g., Tinsley, Bowman, & Ray, 1988; Reis & Brown, 1999). Lastly, expectations reflect a pantheoretical construct and the implications of research on expectations are likely to be
relevant for the majority of clinicians and clients, regardless of the specific intervention being delivered. Because it seems likely that role expectations, a modifiable characteristic, influence the alliance and outcome, and some research indicates that there is a relationship between clients’ pretreatment role expectations, alliance, and outcome, this area of research merits further study (Dew & Bickman, 2005; Greenberg, Constantino, & Bruce, 2006). By gaining an understanding of the specific expectations that impact therapy process and outcome, researchers and clinicians will be able to investigate and better address the specific role expectations that shape clients’ experiences in therapy as well as their outcomes.

A large body of research demonstrates that clients’ perceptions of the alliance during the early stages of therapy (i.e., sessions 3 through 5) consistently predict therapy outcome and account for 7% to 17% of the variance in clinical outcomes (Beutler et al., 2004; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Gaston (1990) and Wampold (2001) note that the alliance is comprised of four factors: (1) the emotional aspects of the therapeutic relationship, (2) the client’s motivation and ability to collaborate with the therapist, (3) the therapist’s empathic understanding and involvement with the client, and (4) the agreement between client and therapist on the tasks and goals for therapy. Thus, the alliance encompasses both client and therapist contributions to the therapeutic relationship. Because the alliance is a relational construct and role expectations partially refer to the relational aspects of therapy, including the expected contributions of therapist and client, it follows that expectancies should be researched in the context of the alliance. The published studies
examining role expectations and the alliance indicate that these constructs do share a relationship with one another and effects sizes for this relationship range from small to large (Al-Darmaki & Kivlighan, 1993; Joyce, McCallum, Piper, & Ogrodniczuk, 2000; Joyce & Piper, 1998; Patterson, Uhlin, & Anderson, 2008; Tokar, Hardin, Adams, & Brandel, 1996).

Al-Darmaki and Kivlighan (1993) found that university counseling center clients’ relationship expectations (expect to engage in spontaneous self-disclosure while in an egalitarian therapeutic relationship) assessed after three therapy sessions were significantly related to clients’ perceptions of the alliance, but these expectations did not relate to therapist-rated alliance. In another study, Tokar and colleagues (1996) found that counseling center clients who expected to take responsibility for working in therapy were more likely to view their relationship with the therapist as collaborative and productive. However, the expectation for counselor expertise was inversely related to the task component of the alliance, meaning that the more the client expected the therapist to be directive, offer advice, and help the client solve problems then the lower the clients’ perceived agreement with the clinician on the tasks of therapy. Lastly, Tokar and colleagues (1996) found that expectations concerning whether the counselor would be accepting, genuine, and trustworthy were not related to client-rated alliance. Replicating some of Tokar and colleagues findings, Patterson, Uhlin, and Anderson (2008) found that clients who entered therapy expecting to be responsible for the work involved in treatment were more likely to form a strong working alliance (measured at session 3) with the therapist. Expectations concerning the counselor’s degree of expertise and
expectations regarding the therapist’s level of genuineness and trustworthiness were not unique predictors of client-rated alliance. Joyce, McCallum, Piper, and Ogrodniczuk (2000) expanded the research on role expectations and the working alliance by including the client’s quality of object relations (QOR) in their study and by examining changes in the alliance across therapy sessions. HLM analyses revealed that for high-QOR clients, the lower the pretreatment expectation of being able to contribute to the process of therapy, then the greater the increase in alliance across therapy sessions. While findings from these expectations and alliance investigations indicate that expectations and alliance share a relationship, one is limited to drawing tentative conclusions about the specific expectations that impact the alliance due to the following reasons: (1) the disparate types of expectations measured across studies, (2) in one study clients’ expectations were measured after clients attended therapy (Al-Darmaki & Kivlighan, 1993), (3) some studies had small sample sizes (e.g., n = 37; Tokar, Hardin, Adams, & Brandel, 1996), and (4) some studies did not include well-established measures of expectations or alliance (Joyce, McCallum, Piper, & Ogrodniczuk, 2000; Joyce & Piper, 1998).

Research concerning role expectations and therapy outcome has yielded promising findings. In a review of the expectancy literature, Arnkoff, Glass, and Shapiro (2002) found that the majority of the 37 studies examining treatment expectations and outcome (e.g., continuation in therapy, client improvement, client satisfaction with therapy, therapeutic alliance), revealed a significant and positive relationship between expectations and outcome. Across studies, the strength of the relationship between expectations and outcome is characterized by small and medium effect sizes. For
example, open-ward psychiatry patients with more negative expectations about receiving guidance, understanding, and concern had poorer outcomes (coping patterns, level of functioning) than clients who did not endorse these negative treatment expectations (Jacobs, Muller, Anderson, & Skinner, 1972). In another study, Heppner and Heesacker (1983) examined the relationships between counseling center clients’ pretreatment role expectations and client satisfaction with therapy. Results indicate that expectations for client openness and counselor trustworthiness share a positive relationship with therapy satisfaction, but when entered in a multiple regression analysis, these expectations did not predict treatment satisfaction. Joyce and Piper (1998) examined clients’ pretreatment expectations for the usefulness and comfort of a typical therapy session, the alliance, and outcome (e.g., symptomatic improvement, social adjustment) in a sample of clients who participated in a controlled trial of short-term individual therapy. Results of regression analyses suggest that the expectation that sessions will be productive may help the formation of a productive therapy relationship (expectations accounted 18-40% of the variance in alliance) and expectations contributed approximately 7-10% of the variance in therapy outcome. Overall, the relationship between clients’ expectations and outcome was smaller than, albeit still substantial, the relationship between expectations and the alliance. Similar to the research on expectations and the alliance, the findings from investigations of expectations and outcome suggest that further research would be valuable due to the fact that there appears to be a relationship between treatment expectations and outcome, but this body of research contains certain limitations, such as the use of measures that are not well-established (e.g., Joyce & Piper, 1998).
In spite of methodological limitations, the results from all of the aforementioned studies on expectations, alliance, and outcome provide evidence for the theory that at least some aspects of role expectations relate to, or predict, alliance and outcome. To summarize, research indicates that role expectations relate to client-rated alliance (Al-Darmaki & Kivlighan, 1993; Patterson, Uhlin, & Anderson, 2008; Tokar et al., 1996), changes in the alliance across sessions (Joyce et al., 2000), client improvement in terms of behaviors in areas such as impulse control and interpersonal relationships (Jacobs, Muller, & Anderson, 1972), client satisfaction with therapy (Heppner & Heesacker, 1983), symptom reduction (Joyce & Piper, 1998), and improved levels of adjustment in social and intimate relationships (Joyce & Piper, 1998). With the exception of one study by Joyce and Piper (1998), investigators have examined the relationship between role expectations and alliance, and the relationship between role expectations and outcome in isolation from one another. In the single study that examined expectations, alliance, and outcome, the relationship between expectations and the alliance was stronger than the relationship between expectations and outcome (Joyce & Piper, 1998). Thus, it may be that client expectations have a direct effect on the working alliance and an indirect effect on clinical outcomes, and it is possible that the therapeutic alliance mediates the relationship between expectations and outcome.

The primary aim of the current study was to advance understanding about the relationships between clients’ pretreatment role expectations, clients’ perceptions of the alliance during the early phase of therapy, and clinical outcomes. A more specific aim of this study was to apply the Baron and Kenny (1986) approach to test a meditational
model, originally proposed (but not tested) by Dew and Bickman (2005), wherein the working alliance is hypothesized to mediate the relationship between clients’ pretreatment role expectations and therapy outcomes. In order to test this model, further understanding of the role of counseling expectations in therapy process and outcome, and advance prior research in this area, the following methodological steps were included in this study: (1) counseling expectations, the alliance, and therapy outcome were assessed with well-established instruments that have adequate psychometric properties, (2) expectations were assessed prior to clients’ first therapy session, (3) alliance was assessed after the third therapy session because early alliance ratings (i.e., sessions 3 through 5) consistently predict treatment outcome, and (4) outcome was assessed at the intake and final sessions.

METHOD

Participants

The archival data used in this study came from a research and training clinic that routinely collects data for research and training purposes. This outpatient clinic is housed in the Department of Psychology at a mid-sized university. This clinic serves both university students (no fee) and community members (small fee).

Clients. Of the 132 clients that received one or more therapy sessions during the 45-month data collection period and consented to having their data used for research purposes, 64 clients did not meet criteria for participation in the study. Clients were excluded from the study for the following reasons: (1) clients did not complete the EAC-B prior to the first therapy session, n = 15 (11.4%), (2) clients were included in the
database more than one time (i.e., they were treated at the clinic, terminated, and they were treated and terminated again) and only data from the first series of therapy sessions were included in this study, \( n = 2 \) (1.5%), (3) clients did not complete the WAI at session 3, \( n = 41 \) (31.1%), (4) clients did not attend four or more therapy sessions, \( n = 5 \) (3.8%), and (5) one client (0.8%) did not complete the OQ at baseline.

The sample for the present study included 68 clients (42 females, 26 males). Clients ranged in age from 18 to 77 and the mean age of clients was 23.71 (\( SD = 8.85 \)). Clients identified as Caucasian (\( n = 58 \)), Hispanic (\( n = 2 \)), African-American (\( n = 1 \)), and the remaining 7 clients did not provide information about ethnicity. The majority of the clients were single (\( n = 54 \)), 3 clients were married, 3 clients were divorced, and 8 clients did not provide information regarding their marital status. Most of the clients (\( n = 52 \)) were university students (13 freshman, 9 sophomores, 11 juniors, 12 seniors, 7 graduate students). Of the 16 clients that were community members, 10 were employed and 6 were unemployed or retired. The primary diagnoses of clients included the following: Major Depressive Disorder (\( n = 15 \)), Adjustment Disorder (\( n = 11 \)), V-Code (\( n = 11 \)), Generalized Anxiety Disorder (\( n = 8 \)), Dysthymic Disorder (\( n = 6 \)), Posttraumatic Stress Disorder (\( n = 3 \)), Alcohol Abuse (\( n = 1 \)), Anxiety Disorder NOS (\( n = 1 \)), Bipolar Disorder (\( n = 1 \)), Bulimia Nervosa (\( n = 1 \)), Depressive Disorder NOS (\( n = 1 \)), and diagnostic data was not available for 7 clients. Clients attended an average of 12.96 (\( SD = 9.77 \)) therapy sessions, with a range from 4 to 63 sessions. The average baseline OQ score for clients was 71.66 (\( SD = 24.59 \)), which indicates that on average clients entered treatment in the
clinical range. The mean change on the OQ from baseline to termination was 15.30
points, which indicates that on average clients evidenced reliable change in treatment.

Therapists. A total of 33 therapists (21 females, 12 males) treated clients that participated
in this study. The number of clients seen by any one therapist ranged from 1 to 6, with
each therapist treating an average of 2.09 clients (SD = 1.51). The majority of the
therapists (n = 28) were between the age of 20 and 30; 3 therapists were between the age
of 31 and 40, and 2 therapists were over the age of 40. Of the 33 therapists that
participated in this study, 28 were graduate students enrolled in a clinical psychology
doctoral program, 4 were graduate students enrolled in a social work program, and 1
clinician was a clinical psychology professor. In terms of level of training, 23 therapists
were in their second year of clinical training, 4 therapists were in their third training year,
3 therapists were in their fourth year of training, 2 therapists were in the fifth training
year, and 1 therapist had more than 15 years of clinical experience. Typically students in
this training clinic received 1-hour of individual and 2-hours of group supervision each
week. Information regarding theoretical orientation was not available; however
interpersonal, psychodynamic, cognitive-behavioral, and eclectic theoretical orientations
were represented by the supervisors in this clinic.

Most clients are referred to the clinic by the university’s counseling center. Others
learn about the clinic through a friend, academic advisor, or instructor and then present to
the clinic directly (without a referral). Community members typically learn about the
clinic through word-of-mouth. The majority of the clients treated at this clinic present
with depressive and anxiety disorders.
Measures

*Expectations About Counseling – Brief Form (EAC-B; Tinsley, 1982).* The EAC-B is a 66-item self-report measure of one’s expectations about counseling. Each item is rated on a 7-point fully anchored scale that ranges from 1 (not true) to 7 (definitely true). Items are prefaced by either “I expect to…” or “I expect the counselor to…” The 66-item EAC-B contains an experimental realism scale that consists of items that reflect the typical practices of the clinic where the measure is being administered; thus, the validity of the realism scale is unknown. Some of the items from the realism scale include the following: I expect to take psychological tests; I expect to see an experienced counselor; and I expect do assignments outside of the counseling interview. Another scoring option is for researchers to score and interpret 53-items from the EAC-B (i.e., score all items except those items that comprise the realism scale).

Several factor-analytic studies indicate that a three-factor solution best fits the EAC-B, both the 66-item and 53-item versions (e.g., Ægisdottier, Gerstein, & Gridley, 2000; Hatchett & Han, 2006; Hayes & Tinsley, 1989; Tinsley, Holt, Hinson, & Tinsley, 1991). For this study, clients’ responses to the EAC-B were scored according to the three factor solution of the 53-item EAC-B that was found by Ægisdottier and colleagues (2000). This three factor solution consists of Personal Commitment, Facilitative Conditions, and Counselor Expertise.

Personal Commitment assesses clients’ expectations for the following aspects of therapy: taking responsibility for personal decisions and the tasks or ‘work’ that is done outside of therapy sessions, feel safe and openly express emotions, remain in counseling
for at least a few sessions even if it is a painful process, enjoy being with the therapist, use the counseling relationship to learn how to relate to others and practice new ways of solving problems, and improve relationships by gaining a better understanding of people.

Overall, the Personal Commitment factor corresponds to expectations about being committed and responsible for the work of therapy and expectations about using the relationship with the counselor as practice for relating with individuals outside of the therapy relationship.

Facilitative Conditions taps clients’ expectations concerning whether the therapist will be a calm, genuine, warm, trustworthy, and supportive person who will help in the identification of feelings and problematic behaviors, as well as point out discrepancies between the client’s thoughts and behaviors. Taken together, the Facilitative Conditions factor measures clients’ expectations for the therapist’s attributes (warm, genuine, nurturing) and expectations concerning whether the therapist will help in the identification of problems, which occasionally requires the therapist to be confrontational.

Counselor Expertise reflects clients’ expectations about whether the therapist will help the client identify and solve problems, understand the client’s feelings when the client has not verbally expressed his or her feelings or when the client is unable to translate his or her feelings into words, and expectations about whether the therapist will self-disclose attitudes and experiences when these attitudes and experiences relate to the client’s difficulties. In sum, the Counselor Expertise factor assesses expectations that the
therapist will be active and directive, have insight into the client’s feelings, engage in self-disclosure when relevant, and help the client identify and solve problems.

A number of studies have focused on the psychometric properties and construct validity of the EAC-B (e.g., Hatchett & Han, 2006; Hayes & Tinsley, 1989; Tinsley et al., 1991). These studies indicate that the EAC-B has adequate psychometric properties and is a valid measure of expectations about counseling. Tinsley (1982) reported that the internal consistency of the EAC-B scales ranges from 0.69 to 0.82, with a median of 0.76. With a two-month interval, the EAC-B scales had test-retest reliability ranging from 0.47 (responsibility scale) to 0.87 (empathy scale) with a median test-retest reliability of 0.71 (Tinsley, 1982). For the present sample, the internal consistency of the three EAC-B factors was as follows: Personal Commitment ($\alpha = 0.90$), Counselor Expertise ($\alpha = 0.82$), and Facilitative Conditions ($\alpha = 0.91$).

The Outcome Questionnaire-45 (OQ-45; Lambert, Lunnen, Umphres, Hansen, & Burlingame, 1994). This 45-item self-report instrument measures patient progress in therapy. Response options range from 0 (never) to 4 (almost always). The total score for the OQ ranges from 0 to 180, with higher scores indicating more distress. The total score, which represents a global measure of functioning, has adequate internal consistency ($\alpha = .93$). The OQ has three subscales: subjective discomfort, interpersonal relations, and social role performance. These three subscales have adequate internal consistency: subjective discomfort (22 items, $\alpha = .92$), interpersonal relations (11 items, $\alpha = .74$), and social role performance (9 items, $\alpha = .70$). Concurrent validity has been demonstrated with well-established clinical measures. In this study, the total score was included in
analyses involving outcome and the coefficient alpha for the total score in the present sample was 0.95. A total score of 64 or above indicates that it is significantly likely that the individual’s score belongs to a clinical sample and reliable change is set at 14 points.

*The Working Alliance Inventory-Short Form Revised (WAI-SR; Hatcher & Gillaspy, 2006).* This 12-item self-report instrument assesses the strength of the therapeutic alliance. Items are rated on a 5-point Likert scale. A total score and three subscale scores can be derived from the WAI-SR. These three subscales measure agreement on tasks, agreement on goals, and the strength of the bond between client and therapist.

The WAI-SR was developed with two different client samples. The first sample consisted of 231 individuals from a large Midwestern university’s adult psychotherapy clinic. The second sample consisted of 235 persons from a group of counseling centers and outpatient clinics located in the southwest. Calculations based on these samples indicate that the WAI-SR has adequate internal consistency (\(\alpha = .91; \alpha = .92\)) for the total alliance score. Coefficient alphas for the goals subscale are .87 and .85. For the tasks subscale, coefficient alphas are .85 and .87. Coefficient alphas for the bond subscale are .90 and .85. For this study, the WAI-SR total score was utilized in data analyses involving the alliance. In the present sample, the coefficient alpha for the total score was 0.92.

*Procedure*
Using a naturalistic design, data were collected at an outpatient training clinic previously described under the ‘participants’ heading of this paper. Clients received an intake packet that included a consent form that provided clients with the opportunity to accept or decline participation in archival research projects that utilize the clinic data. As part of routine practice, clients completed the EAC-B prior to the intake session, the OQ-45 prior to each therapy session, and the WAI-SR immediately after each therapy session. Therapists had access to their clients’ data and the clinic maintained a de-identified database of clients’ intake packets and all measures completed at the clinic, including the EAC-B, the OQ-45, and the WAI-SR. Clients were included in the present sample if they completed the EAC-B prior to the first therapy session, completed the WAI-SR at the conclusion of session 3, completed the OQ-45 at the beginning of the intake and termination sessions, and attended a total of four or more therapy sessions.

DATA ANALYSIS

Plan of Analysis

To examine whether the alliance mediates the relationship between clients’ pretreatment role expectations and outcome, the Baron and Kenny (1986) statistical procedure for testing a mediational model was applied to the data. According to Baron and Kenny (1986), testing a mediational model requires the following:

Step 1. The predictor variable (i.e., pretreatment role expectations) must be significantly associated with the criterion variable (i.e., therapy outcome).

Step 2. The predictor variable (i.e., pretreatment role expectations) must be
significantly associated with the proposed mediating variable (i.e., alliance).

Step 3. A simultaneous regression analysis (criterion variable is regressed on the predictor and the proposed mediator) must reveal a significant relationship between the potential mediator and the criterion variable and the relationship between the predictor and criterion must be smaller than it was in Step 1 (partial mediation) or the relationship between the predictor and the criterion must disappear (complete mediation).

Step 4. The regression coefficient for the predictor variable in Step 3 must be significantly smaller than the regression coefficient for the predictor variable in Step 1. This difference is assessed with a $z$ test (Preacher & Hayes, 2004; Sobel, 1982), which is the test of the mediational relationship between the predictor, proposed mediator, and criterion variable.

**Assumptions**

Prior to conducting data analyses, all data were examined with SPSS Version 16 for accuracy of data entry, missing values, outliers, and fit between the distribution of the study variables and the assumptions of multiple regression. These variables included the three expectations factors (Personal Commitment, Facilitative Conditions, Counselor Expertise), the WAI, and the OQ at intake and termination. There were no missing data for any of the variables included in the analyses and outlier cases were not present in the data. Preliminary analyses revealed that the data did not violate the assumptions of
linearity, multicollinearity, or homoscedasticity. Personal Commitment, Facilitative Conditions, and the WAI were non-normal. Transformations were applied to these variables, but a normal distribution was not obtained. Therefore all of the analyses were performed on the untransformed variables which aid interpretation of the results.

RESULTS

Preliminary Analyses

In order to determine any differences in expectations between clients included in the study and clients who were excluded from the study, a series of t-tests were conducted with expectations factors as the dependent variables. Results of these analyses indicate that the expectations of clients who were included in the study did not differ from the expectations of clients who were not included in the study. More specifically, there was not a significant difference for clients included in the study and clients who were excluded from the study on expectations for Personal Commitment ($t (130) = -.26, p = ns$), Facilitative Conditions ($t (130) = -.60, p = ns$), or Counselor Expertise ($t (130) = .21, p = ns$). Prior to conducting the mediational analyses, the relationships between initial symptoms (baseline OQ), the alliance, and termination OQ were examined with Pearson bivariate correlations. Because baseline OQ was correlated with both the alliance ($r (68) = -.31, p < .05$) and termination OQ ($r (68) = .68, p < .05$), baseline OQ was controlled for in all further analyses.

Means, standard deviations, ranges, and partial correlations (controlling for baseline symptoms) for the EAC-B factors, WAI-SR total score, and termination OQ are presented in Table 1. According to Cohen’s (1992) guidelines, correlations between the
expectations factors (Personal Commitment, Facilitative Conditions, Counselor Expertise) and the alliance reflect small, medium, and large effect sizes ($r$s ranged from .27 to .60). Expectations for Personal Commitment and expectations for Facilitative Conditions were not related to outcome (i.e., termination OQ with the effects of baseline OQ controlled for); whereas the relationship between expectations for Counselor Expertise and outcome was significant. A medium effect size was found for the relationship between expectations for Counselor Expertise and outcome ($r = -.32$). A large effect size was found for the significant relationship between the alliance and outcome ($r = -.38$). Because Personal Commitment and outcome were not related to one another, analyses for the proposed mediational model with expectations for Personal Commitment were not possible. Similarly, because expectations for Facilitative Conditions and outcome were not related to one another, analyses for the proposed mediational model with Facilitative Conditions were not possible. Based on the significant correlations between expectations for Counselor Expertise, the alliance, and outcome, this expectation factor was included in the tests for mediation.

**Tests for Mediation**

**Step 1: Association Between Predictor (Expectations for Counselor Expertise) and Outcome**

Results from the regression analyses conducted for Step 1 of the Baron and Kenny (1986) approach to tests of mediation are presented in Table 2. For the first step in testing for mediation, regression analyses were conducted to determine whether the predictor variable was significantly (and directly) related to outcome. Baseline OQ was
entered in the first step of the hierarchical regression analysis and accounted for a significant 46% of the variance in outcome. Expectations for Counselor Expertise was entered in the second step and explained a significant amount (5.4%) of the variance in outcome, after controlling for baseline OQ. These findings indicate that Counselor Expertise had a direct relationship with outcome and thus the first criterion for mediation was met.

**Step 2: Association Between Predictor (Expectations for Counselor Expertise) and the Potential Mediator (Alliance)**

For the second step in testing for mediation, a regression analysis was conducted to determine whether expectations for Counselor Expertise would predict the alliance when controlling for baseline OQ (see Table 3). Baseline OQ was entered in the first step of the regression analysis and accounted for a significant 9.5% of the variance in the alliance. Expectations for Counselor Expertise accounted for a significant amount (6.5%) of the variance in alliance, after controlling for the significant contribution (9.5%) of baseline OQ scores. Thus, Counselor Expertise had a direct relationship with the alliance and satisfied the second criterion for mediation.

**Step 3: Outcome Regressed on Predictors ((Expectations for Counselor Expertise) and the Potential Mediator (Alliance))**

Results of the regression analyses for Step 3 of the Baron and Kenny (1986) approach for tests of mediation are presented in Figure 1. The third step in testing for mediation requires that a regression analysis (outcome regressed on expectations and alliance while controlling for baseline OQ) results in a significant relationship between
alliance and outcome, and that the relationship between expectations and outcome must decrease relative to the strength of the relationship in Step 1 (outcome regressed on expectations). Results of a regression analysis with Counselor Expertise and the alliance entered simultaneously as predictors of outcome, revealed that the alliance was a significant predictor of outcome in the presence of Counselor Expertise. Results of this regression analysis also revealed that in the presence of the alliance, expectations for Counselor Expertise did not account for a significant amount of variance in outcome, which suggests complete mediation. More specifically, the standardized regression coefficients revealed that the strength of the relationship between Counselor Expertise and outcome was smaller than the relationship observed in Step 1. Thus, the third criterion for mediation was met for the Counselor Expertise expectations factor.

**Step 4: Decrease in the Regression Coefficients for Expectations**

The fourth and final criterion for a test of mediation is that the regression coefficient for the predictor (Counselor Expertise) in Step 3 must be significantly smaller than the regression coefficient for the predictor (Counselor Expertise) in Step 1. This test, a $z$ test (Preacher & Hayes, 2004; Sobel, 1982), indicates whether the difference between the regression coefficient for the relationship between the predictor and outcome is smaller in Step 3 than it was in Step 1. Thus, the $z$ test determines whether the alliance mediates the relationship between expectations and outcome after controlling for baseline symptoms. Results of the sobel test were not significant ($Sobel \ z \ value = -1.73, \ p = .08$). This finding suggests that the alliance is not a mediator of the relationship between expectations for Counselor Expertise and outcome (see Figure 1). In other words, these
findings indicate that expectations for Counselor Expertise do not impact treatment outcome via the therapeutic alliance.

DISCUSSION

Despite the knowledge that pretreatment role expectations reflect a malleable client characteristic that appear to relate to both the alliance and treatment outcome, research on the role of treatment expectations in therapy process and outcome has been minimal and often limited by methodological and measurement issues (Dew & Bickman, 2005; Greenberg, Constantino, & Bruce, 2006). The purpose of this study was to address the limitations found in some of the prior investigations and advance this area of research by examining the relationships between clients’ pretreatment role expectations (expectations for Personal Commitment, Facilitative Conditions, Counselor Expertise), clients’ perceptions of the alliance at the third therapy session, and clinical outcomes in a naturalistic setting. In order to investigate these relationships, tests of mediation were conducted on data from a sample of 68 clients who attended therapy at an outpatient training clinic that routinely collects client data for research and training purposes.

To my knowledge, this study represents the first test of mediation for pretreatment role expectations, alliance, and therapy outcome. Findings from this study indicate that after controlling for baseline symptoms, all three types of clients’ pretreatment role expectations were related to the alliance. Only expectations for Counselor Expertise related to treatment outcome. Although expectations for Counselor Expertise predicted therapy outcome, this relationship was not explained through the proposed mediating
pathway of the therapeutic alliance. Thus, the primary study hypothesis (that the alliance would mediate the relationship between expectations and outcome) was not supported.

The correlational findings indicated that expectations for Personal Commitment (expect to be committed to and responsible for the work of therapy) and expectations for Facilitative Conditions (expect the therapist to be warm, genuine, nurturing) were related to the alliance is partially consistent with results reported in previous research (Tokar et al., 1996; Patterson, Uhlin, & Anderson, 2008). Taken together, a growing body of research suggests that clients’ pretreatment expectations concerning the commitment and work involved in therapy are critical to alliance development, with effect sizes for these relationships ranging from medium to large. Research concerning the relationship between expectations for Facilitative Conditions and the alliance has resulted in mixed findings. More specifically, one prior study found that these constructs did not share a relationship (Tokar et al., 1996); whereas another study revealed an association between relationship expectations (expectations that are similar to Facilitative Conditions) and the alliance. Additionally, a more recent study found that expectations for Facilitative Conditions and the alliance were correlated with one another (Patterson, Uhlin, & Anderson, 2008). Although the majority of the research suggests that there is a relationship between these constructs, further empirical work is needed to determine whether expectations concerning the therapist’s warmth and genuineness relate to the quality and strength of the therapeutic alliance. Although expectations for Personal Commitment and expectations for Facilitative Conditions were related to the alliance, these expectations were not related to outcome. Therefore the hypothesis that the alliance
would mediate the relationship between expectations and outcome could not be tested with the Personal Commitment and Facilitative Conditions factors.

As was predicted, clients’ pretreatment expectations for Counselor Expertise (expect the therapist to be directive, insightful, and helpful in solving problems) was directly related to both alliance and outcome, with higher expectations relating to stronger alliances and better outcomes. Consistent with findings reported by Joyce and Piper (1998), the relationship between expectations and the alliance were stronger than the relationship between expectations and therapy outcome.

In the presence of the significant predictive relationship between alliance and outcome, expectations for Counselor Expertise no longer predicted outcome. However, a Sobel test revealed that the primary study hypothesis that the alliance would mediate the effect of expectations on outcome was not supported. In sum, results of the regression analyses that were used to test for mediation revealed that clients who enter therapy with strong expectations that the therapist will be a directive expert are likely to form collaborative and productive bonds with the therapist during the early stage of therapy. Also, results of these analyses support the large body of research (e.g., Martin, Garske, & Davis, 2000) that demonstrates that strong alliances contribute to positive clinical outcomes. Lastly, tests of the proposed mediational model in the present study indicate that clients’ pretreatment role expectations for Counselor Expertise facilitate positive clinical outcomes, but these effects on outcome are not brought about by the working alliance. Taken together, these findings advance our current understanding of the contributing client characteristics (pretreatment expectations) to therapy process (the
alliance) and treatment outcome (amelioration of symptoms). Although these findings advance prior research, they also leave unanswered questions as to how expectations impact outcome. Further conceptual and empirical work is needed to elucidate how expectations contribute to clinical outcome.

Several research implications can be drawn from this study’s results. Most importantly, it appears that clients’ pretreatment role expectations reflect a client characteristic and common factor of therapy that influence the relational process of therapy, as well as the outcome of therapy. Thus, role expectations represent one of the few client variables (e.g., pretreatment level of perfectionism in the treatment of depression; Blatt, Shahar, & Zuroff, 2002) that have been identified as impacting both the alliance and outcome. Based on the timing of the assessment of the variables in the present study, there are implied causal links between expectations (pretreatment), alliance (session 3), and outcome (symptoms at baseline and termination). However, it is important to note that causality is not certain and other constructs or processes may be responsible for the relationships found among role expectations, alliance, and therapy outcome. For example, it may be that another pretreatment client characteristic, such as attachment style, is responsible for one’s scores on the expectations factors, alliance ratings, and progress in therapy. Alternatively, it could be that clients’ expectations influence a therapist variable such as empathy, and empathy influences both the alliance and outcome. Therefore, additional client and therapist variables should be included in future research on the role of expectations in therapy process and outcome. In addition to determining other factors that may impact expectations, alliance, and outcome, future
research should examine the most effective methods for shaping clients’ role expectations early in treatment because as was previously mentioned, a key feature of role expectations is the relative ease with which they can be modified and shaped (Tinsley, Bowman, & Ray, 1988; Reis & Brown, 1999).

Although further research is needed to determine the best methods for addressing clients’ expectations, tentative clinical recommendations are provided. Findings from this study suggest that prior to the initial treatment session or during the first few therapy sessions, expectations should be addressed by having clients view or listen to a role induction and/or by having therapists initiate a discussion about the expected and actual roles of the client and therapist during treatment. To facilitate a strong alliance, role inductions and in-session explorations of expectations should include the following aspects of the roles involved in therapy: the commitment and responsibilities of the client (e.g., openly express emotions during therapy, work on difficulties outside of therapy), the characteristics of the therapist (e.g., warm, trustworthy, expert), and the responsibilities of the therapist (e.g., help the client identify and label feelings, help the client identify and solve problems). Additionally, if the therapist notices difficulties forming a strong alliance early in treatment, the client’s expectations should be attended to during therapy sessions. Once a client’s expectations for the characteristics and responsibilities of the therapist are aligned with the therapist roles described in the preceding sentence, she or he will be more likely to form a strong working alliance with the therapist and enhance the outcome of treatment.
**Limitations**

Although this study addressed limitations found in previous investigations of role expectations, alliance, and outcome, there were limitations of the current study that must be noted. Clients’ outcomes were measured with a single self-report instrument (OQ-45). The OQ-45 was designed to measure progress in therapy and captures several domains of client functioning, including symptom distress, interpersonal functioning, and social role performance. Nevertheless, the use of a single self-report measure of outcome limits the conclusions that can be drawn from this study. Future research could be strengthened by the inclusion of additional outcome measures that tap other domains pertinent to therapy outcome and include multiple raters. Another important limitation of this study concerns the relatively homogeneous sample of therapists. With the exception of 1 therapist, all of the clinicians were graduate students and the majority of these student-therapists were in their first year of clinical training. The client sample was equally homogeneous and primarily consisted of Caucasian college students. The lack of diversity in the participating clinicians and clients limits the generalizability of this study’s results to similar training clinics that treat similar clients.

**Conclusions**

The strength and quality of the therapeutic relationship relates to clients’ expectations for the roles of both the client and the therapist in treatment. More specifically, clients who expect that they will be committed to and responsible for the work of therapy, that the therapist will create facilitative therapeutic conditions (i.e., warmth, trust, nurturance), and that the therapist will be knowledgeable and helpful in
solving problems are more likely to form strong and collaborative therapeutic
relationships. Additionally, clients who expect the therapist will knowledgeable and
helpful in solving problems will likely have better outcomes than clients who do not have
these expectations, but this relationship is not mediated by the alliance.

Because clients’ role expectations reflect a modifiable client characteristic, these
expectations should be addressed early in treatment to facilitate the process of therapy
and the resultant beneficial outcomes. The findings from this study contribute to our
understanding of the relationships between a client characteristic (expectations) that is
present prior to the initial therapy session, the relational processes that occur during
treatment, and the final outcome of therapy. By incorporating pretreatment, process, and
outcome variables in future psychotherapy studies, we will advance our understanding of
the numerous variables and mechanisms responsible for the effectiveness of therapy.
REFERENCES


Table 1

*Descriptive Statistics and Partial Correlations of EAC-B Factor Scores (Personal Commitment, Facilitative Conditions, Counselor Expertise), WAI-SR Total Score, and OQ Score at Termination, while Controlling for Baseline OQ*

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Personal Commitment</td>
<td>___</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Facilitative Conditions</td>
<td>0.73**</td>
<td>___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Counselor Expertise</td>
<td>0.44**</td>
<td>0.72**</td>
<td>___</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. WAI-SR</td>
<td>0.60**</td>
<td>0.49**</td>
<td>0.27*</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>5. Termination OQ</td>
<td>-0.18</td>
<td>-0.22</td>
<td>-0.32*</td>
<td>-0.38**</td>
<td>___</td>
</tr>
</tbody>
</table>

| M   | 5.66 | 5.37 | 4.05  | 4.19   | 56.35 |
| SD  | 0.94 | 1.06 | 1.19  | 0.60   | 26.82 |
| Range | 2.44-7.00 | 2.10-7.00 | 1.67-7.00 | 2.33-5.00 | 5.00-133.17 |

*Note. N = 68.*

*p < .05. **p < .01.
Table 2

*Step 1 of Mediation Analyses: Hierarchical Regression Analysis with Expectations Factors Predicting Outcome while Controlling for Baseline OQ Scores*

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
<th>R²</th>
<th>F</th>
<th>ΔR²</th>
<th>ΔF</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.46</td>
<td>56.25**</td>
<td>0.46</td>
<td>56.25**</td>
<td>1, 66</td>
</tr>
<tr>
<td>Baseline OQ</td>
<td>0.740</td>
<td>0.099</td>
<td>0.678</td>
<td>7.50**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.51</td>
<td>34.33**</td>
<td>0.05</td>
<td>7.16*</td>
<td>1, 65</td>
</tr>
<tr>
<td>Baseline OQ</td>
<td>0.697</td>
<td>0.096</td>
<td>0.639</td>
<td>7.29**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselor Expertise</td>
<td>-5.303</td>
<td>1.981</td>
<td>-0.235</td>
<td>-2.68*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. N = 68.

*p < .05. **p < .01.
Table 3

*Step 2 of Mediation Analyses: Hierarchical Regression Analysis with Expectations Factors*

*Predicting the Alliance while Controlling for Baseline OQ Scores*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model</th>
<th>Step</th>
<th>$B$</th>
<th>$SE B$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$R^2$</th>
<th>$F$</th>
<th>$\Delta R^2$</th>
<th>$\Delta F$</th>
<th>$df$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance</td>
<td>0.095</td>
<td>6.93*</td>
<td>0.10</td>
<td>6.93*</td>
<td>1, 66</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline OQ</td>
<td>-0.008</td>
<td>0.003</td>
<td>-0.308</td>
<td>-2.63*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>counselor</td>
<td>0.131</td>
<td>0.058</td>
<td>0.258</td>
<td>2.23*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. $N = 68.$

*p < .05. **p <
Figure 1. Mediation of the relationship between clients’ expectations for Counselor Expertise and therapy outcome by the working alliance, after controlling for baseline symptoms. All values are standardized regression coefficients (βs). The value in parentheses is the coefficient for the regression of outcome on Counselor Expertise (the direct, unmediated relationship). The regression coefficient for this direct path decreased minimally when the indirect path through the alliance was included in the regression equation. *p < .05. **p < .01.
Appendix A:

Methods
FAMILY INFORMATION:
Parents' marital status: Married  Divorced  Single  Other: ______________

<table>
<thead>
<tr>
<th>FAMILY MEMBER</th>
<th>NAME</th>
<th>AGE (Give date if deceased)</th>
<th>EDUCATION</th>
<th>OCCUPATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister(s)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Ethnicity: _____ Asian American  _____ Black/African American  _____ Latino/Hispanic  _____ Multi-racial American
          _____ Native American  _____ White, Non-Hispanic  _____ Other  _____ International Student

Whom did you live with while you were growing up? ________________________________
How would you describe your family relationships? ________________________________
Whom do you feel closest to in your family? ________________________________
Your marital status: Single  Married  Divorced  Other: ________________________________

<table>
<thead>
<tr>
<th>FAMILY MEMBER</th>
<th>NAME</th>
<th>AGE</th>
<th>EDUCATION</th>
<th>OCCUPATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child(ren)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you feel like you have meaningful peer friendships?

EDUCATIONAL HISTORY: Starting with high school, list all educational institutions attended.

<table>
<thead>
<tr>
<th>INSTITUTION</th>
<th>DATES ATTENDED</th>
<th>MAJOR(S)</th>
<th>DEGREES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>

WORK HISTORY: Starting with most recent, list major work experiences.

<table>
<thead>
<tr>
<th>EMPLOYER</th>
<th>POSITION</th>
<th>DATES</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Psychology and Social Work Clinic
#112-96 Rev 12/01
REPRODUCTIVE HISTORY:

MEDICAL INFORMATION:
List any medical problems that you currently have or have had in the past. Circle those for which you are currently being treated.

List any medications you have taken in the past six (6) months. Circle those you are currently taking.

List dates and reasons for any hospitalizations.

Place an “X” in the appropriate boxes indicating commitments (i.e., class, lunch, work, etc.) you have during the week which would prevent you from coming to the Ohio University Psychology Clinic.

<table>
<thead>
<tr>
<th></th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 - 9:00 A.M.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9:00 - 10:00 A.M.</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>10:00 - 11:00 A.M.</td>
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</tr>
<tr>
<td>11:00 - 12:00 P.M.</td>
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</tr>
<tr>
<td>12:00 - 1:00 P.M.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:00 - 2:00 P.M.</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>2:00 - 3:00 P.M.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:00 - 4:00 P.M.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:00 - 5:00 P.M.</td>
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<td></td>
</tr>
</tbody>
</table>

Individuals coming to the Ohio University Psychology Clinic have a variety of expectations concerning our services. Please check any expectations that apply to you:

1. I will have an opportunity to talk about my problems and concerns with my counselor.

2. I will understand myself better, but that my problems and concerns cannot be resolved.

3. I expect my counselor to listen, but I will have to solve my own problems.

4. I will get advice from my counselor about what to do about my problems and concerns.

5. I don’t know what to expect.
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1. I'm at ease with other people.</td>
<td>27. Feeling inferior.</td>
</tr>
<tr>
<td>2</td>
<td>2. Feeling that no one understands me.</td>
<td>28. Not being the kind of person I should be.</td>
</tr>
<tr>
<td>3</td>
<td>3. Having a problem I find difficult to talk about.</td>
<td>29. Feeling too easily hurt.</td>
</tr>
<tr>
<td>5</td>
<td>5. Sometimes acting childish or immature.</td>
<td>31. Worrying about my sexuality.</td>
</tr>
<tr>
<td>7</td>
<td>7. Worrying about unimportant things.</td>
<td>33. Troubled by sexual experiences.</td>
</tr>
<tr>
<td>8</td>
<td>8. Nervousness.</td>
<td>34. Fearful of and avoid members of the opposite sex.</td>
</tr>
<tr>
<td>10</td>
<td>10. Having a troubled or guilty conscience.</td>
<td>36. Difficulty with marriage.</td>
</tr>
<tr>
<td>12</td>
<td>12. Unhappy home life.</td>
<td>38. Shoving and/or hitting.</td>
</tr>
<tr>
<td>13</td>
<td>13. Not getting along with member(s) of my family.</td>
<td>39. Being shoved or hit by girlfriend/boyfriend/spouse.</td>
</tr>
<tr>
<td>14</td>
<td>14. Unable to concentrate well.</td>
<td>40. Fearful of close relationships.</td>
</tr>
<tr>
<td>15</td>
<td>15. Not knowing how to study effectively.</td>
<td>41. Being talked about or watched.</td>
</tr>
<tr>
<td>16</td>
<td>16. Not spending enough time studying.</td>
<td>42. Bothered by unwanted and disturbing thoughts.</td>
</tr>
<tr>
<td>17</td>
<td>17. Fearing failure in college.</td>
<td>43. Hearing or seeing unusual things.</td>
</tr>
<tr>
<td>18</td>
<td>18. Worrying about poor grades.</td>
<td>44. Having angry, hostile feelings.</td>
</tr>
<tr>
<td>19</td>
<td>19. Doubting the wisdom of my vocational choice.</td>
<td>45. Losing my temper.</td>
</tr>
<tr>
<td>20</td>
<td>20. Purpose of going to college not clear.</td>
<td>46. Worrying about how much I drink.</td>
</tr>
<tr>
<td>21</td>
<td>21. Undecided about major.</td>
<td>47. Worrying about my use of drugs.</td>
</tr>
<tr>
<td>26</td>
<td>26. Being lazy.</td>
<td>52. Concerns about racial or ethnic identity.</td>
</tr>
</tbody>
</table>
Expectations About Counseling-Brief Form

DIRECTIONS
You are going to see a therapist for your first interview. We would like to know just what you think therapy will be like. On the following pages are statements about therapy. In each instance you are to indicate what you expect therapy to be like. The rating scale we would like you to use is printed at the top of each page. Your ratings of the statements are to be recorded in the space to the left of each statement. For each statement, write the number corresponding to the scale number which most accurately reflects your expectations.
Finish each page before going on to the next.

NOW TURN THE PAGE AND BEGIN
<table>
<thead>
<tr>
<th></th>
<th>Not True</th>
<th>Slightly True</th>
<th>Somewhat True</th>
<th>Fairly True</th>
<th>Quite True</th>
<th>Very True</th>
<th>Definitely True</th>
</tr>
</thead>
</table>

**I EXPECT TO...**

1. Take psychological tests.
2. Like the counselor.
3. See a counselor in training.
4. Gain some experience in new ways of solving problems within the counseling process.
5. Openly express my emotions regarding myself and my problems.

**I EXPECT TO...**

6. Understand the purpose of what happens in the interview.
7. Do assignments outside the counseling interviews.
8. Take responsibility for making my own decisions.
9. Talk about my present concerns.
10. Get practice in relating openly and honestly to another person within the counseling relationship.

**I EXPECT TO...**

11. Enjoy my interviews with the counselor.
12. Practice some of the things I need to learn in the counseling relationship.
13. Get a better understanding of myself and others.
14. Stay in counseling for at least a few weeks, even if at first I am not sure it will help.
15. See the counselor for more than three interviews.

**I EXPECT TO...**

16. Never need counseling again.
17. Enjoy being with the counselor.
18. Stay in counseling even though it may be painful or unpleasant at times.
19. Contribute as much as I can in terms of expressing my feelings and discussing them.
20. See the counselor for only one interview.

**I EXPECT TO...**

21. Go to counseling only if I have a very serious problem.
22. Find that the counseling relationship will help the counselor and me to identify problems on which I need to work.
23. Become better able to help myself in the future.
24. Find that my problem will be solved once and for all in counseling.
25. Feel safe enough with the counselor to really say how I feel.
I EXPECT TO...

26. See an experienced counselor.
27. Find that all I need to do is answer the counselor’s questions.
28. Improve my relationships with others.
29. Ask the counselor to explain what he or she means whenever I do not understand something that is said.
30. Work on my concerns outside the counseling interviews.
31. Find that the interview is not the place to bring up personal problems.

THE FOLLOWING QUESTIONS CONCERN YOUR EXPECTATIONS ABOUT THE COUNSELOR

I EXPECT THE COUNSELOR TO...

32. Explain what’s wrong.
33. Help me identify and label my feelings so I can better understand them.
34. Tell me what to do.
35. Know how I feel even when I cannot say quite what I mean.

I EXPECT THE COUNSELOR TO...

36. Know how to help me.
37. Help me identify particular situations where I have problems.
38. Give encouragement and reassurance.
39. Help me to know how I am feeling by putting my feelings into words for me.
40. Be a “real” person not just a person doing a job.

I EXPECT THE COUNSELOR TO...

41. Help me to discover what particular aspects of my behavior are relevant to my problems.
42. Inspire confidence and trust.
43. Frequently offer me advice.
44. Be honest with me.
45. Be someone who can be counted on.

I EXPECT THE COUNSELOR TO...

46. Be friendly and warm towards me.
47. Help me solve my problems.
48. Discuss his or her own attitudes and relate them to my problem.
49. Give me support.
50. Decide what treatment plan is best.
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not</td>
<td>Slightly</td>
<td>Somewhat</td>
<td>Fairly</td>
<td>Quite</td>
<td>Very</td>
<td>Definitely</td>
</tr>
<tr>
<td>True</td>
<td>True</td>
<td>True</td>
<td>True</td>
<td>True</td>
<td>True</td>
<td>True</td>
</tr>
</tbody>
</table>

**I EXPECT THE COUNSELOR TO...**

- 51. Know how I feel at times, without my having to speak.
- 52. Do most of the talking.
- 53. Respect me as a person.
- 54. Discuss his or her experiences and relate them to my problems.
- 55. Praise me when I show improvement.

**I EXPECT THE COUNSELOR TO...**

- 56. Make me face up to the differences between what I say and how I behave.
- 57. Talk freely about himself or herself.
- 58. Have no trouble getting along with people.
- 59. Like me.
- 60. Be someone I can really trust.

**I EXPECT THE COUNSELOR TO...**

- 61. Like me in spite of bad things that he or she knows about me.
- 62. Make me face up to the differences between how I see myself and how I am seen by others.
- 63. Be someone who is calm and easygoing.
- 64. Point out to me the differences between what I am and what I want to be.
- 65. Just give me information.
- 66. Get along well in the world.
### Outcome Questionnaire (OQ®-45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

#### Name: ____________________ Age: ________

#### ID#: ____________________ Sex: M □ F □

<table>
<thead>
<tr>
<th>Session #</th>
<th>Date</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I get along well with others.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I tire quickly.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I feel no interest in things.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I feel stressed at work/school.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I blame myself for things.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I feel irritated.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I feel unhappy in my marriage/significant relationship.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I have thoughts of ending my life.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I feel weak.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. I feel fearful.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark “never”).</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. I find my work/school satisfying.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. I am a happy person.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. My work/study is too much.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. I feel worthless.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. I am concerned about family troubles.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. I have an unsatisfying sex life.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. I feel lonely.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. I have frequent arguments.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. I feel loved and wanted.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21. I enjoy my spare time.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22. I have difficulty concentrating.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23. I feel hopeless about the future.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24. I like myself.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25. Disturbing thoughts come into my mind that I cannot get rid of.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>26. I feel annoyed by people who criticize my drinking (or drug use).</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>(If not applicable, mark “never”).</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>27. I have an upset stomach.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>28. I am not working/studying as well as I used to.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>29. My heart pounds too much.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>30. I have trouble getting along with friends and close acquaintances.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>31. I am satisfied with my work/school.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>32. I have trouble at work/school because of drinking or drug use.</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>(If not applicable, mark “never”).</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

#### Total:

---

Clinician Name: ____________________
Date ___________ Client Name ____________________________ Clinician Name ______________________

Instructions: Below is a series of statements about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space - as you read the sentences, mentally insert the name of your therapist in place of ______ in the text. For each statement, please take your time to consider your own experience and then circle the appropriate number.

Important: The rating scale is not the same for all the statements. PLEASE READ CAREFULLY!

1. As a result of these sessions I am clearer as to how I might be able to change.
   1  2  3  4  5
   Seldom Sometimes Fairly Often Very Often Always

2. What I am doing in therapy gives me new ways of looking at my problem.
   1  2  3  4  5
   Seldom Sometimes Fairly Often Very Often Always

3. I believe ______ likes me.
   1  2  3  4  5
   Always Very Often Fairly Often Sometimes Seldom

4. ______ and I collaborate on setting goals for my therapy.
   1  2  3  4  5
   Seldom Sometimes Fairly Often Very Often Always

5. ______ and I respect each other.
   1  2  3  4  5
   Always Very Often Fairly Often Sometimes Seldom

6. ______ and I are working towards mutually agreed upon goals.
   1  2  3  4  5
   Always Very Often Fairly Often Sometimes Seldom

7. I feel that ______ appreciates me.
   1  2  3  4  5
   Always Very Often Fairly Often Sometimes Seldom

8. ______ and I agree on what is important for me to work on.
   1  2  3  4  5
   Seldom Sometimes Fairly Often Very Often Always

9. I feel ______ cares about me even when I do things that he/she does not approve of.
   1  2  3  4  5
   Always Very Often Fairly Often Sometimes Seldom

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.
    1  2  3  4  5
    Seldom Sometimes Fairly Often Very Often Always

11. ______ and I have established a good understanding of the kind of changes that would be good for me.
    1  2  3  4  5
    Seldom Sometimes Fairly Often Very Often Always

12. I believe the way we are working with my problem is correct.
    1  2  3  4  5
    Always Very Often Fairly Often Sometimes Seldom

PLEASE TURN OVER
Ohio University Psychology and Social Work Clinic
002 PORTER HALL, ATHENS OHIO, 45701 (740) 593-0902

CONSENT FOR RESEARCH PARTICIPATION

The Psychology and Social Work Clinic is a training clinic for service and research. Clinic data is used for a variety of clinical purposes, for example, to aid in assessing your progress during treatment, to help train or evaluate student clinicians, and to track service utilization. Data may also be used for archival research purposes, that is, data gathered from closed cases to answer clinical research questions. Access to and use of this data for research purposes will be limited to Psychology and Social Work faculty and graduate students who have received prior research approval from the Ohio University Institutional Review Board (IRB) for Studies Involving Human Subjects.

Your signature on this form gives us permission to use your data. Your permission is entirely voluntary and you will not be penalized in any way should you choose to withhold your consent.

1. I understand that data about my case and progress will be coded into a database and may be used in archival research.

2. I understand that data from my case will be coded without any identifying information attached, protecting my anonymity and the confidentiality of my data.

Client’s Signature __________________________ Date ______

Parent or guardian’s signature (if applicable) __________________________ Date ______

Researcher/Clinician Signature __________________________ Date ______

CONSENT FOR FUTURE RESEARCH CONTACT

Occasionally, the design of a research project is such that the investigator needs to contact research participants in the future to verify existing data or collect additional data. Your signature below gives a research investigator permission to make such contact with you. If you are willing for the possibility of such contact, please give us an address where we will have the most success in locating you. Any contact attempted will be in an anonymous manner, (i.e., unmarked envelopes and callers who don’t identify themselves as calling from the Psychology and Social Work Clinic until they are talking directly to you), thereby protecting your confidentiality. Your permission is entirely voluntary and you will not be penalized in any way should you choose to withhold your consent. You may consent to archival research (above) and refuse permission for future contact; simply sign the above signature line and leave blank the one below. Alternatively, you may refuse both or consent to both.

Client’s Signature __________________________ Date ______

Parent or guardian’s signature (if applicable) __________________________ Date ______

Researcher/Clinician Signature __________________________ Date ______

Please PRINT your name and Permanent Address __________________________ Telephone # ______

Psychology and Social Work Clinic
#141-62
Appendix B:

Statistical Analyses
**Reliable Change and Clinical Significance**

An OQ score of 64 or above indicates that the respondent’s score is more likely to come from a clinical, as opposed to a non-clinical population. The majority (66.2%) of clients in the present study began therapy with OQ scores reflecting a clinical population.

To evaluate whether client change on the OQ was reliable, the Reliable Change Index (RCI; Jacobson & Truax, 1991) was calculated for the current sample. For the OQ, reliable change is reflected in a change (in either direction) of 14 OQ points from baseline to termination. Results indicate that 56.9% \((n = 37)\) of the clients did not evidence reliable change. Approximately 40% \((n = 26)\) of clients showed reliable improvement and 3.1% \((n = 2)\) of clients evidenced reliable deterioration.

To be classified as having made clinically significant change, clients had to show reliable change on the OQ and fall in the functional range (OQ score falling between 0 and 63 points) at termination. A total of 19 \((27.8\%)\) of the sample met criteria for clinically significant change. It should be noted that 5 \((26.3\%)\) of these clients began therapy in the non-clinical range.

**Exploratory Analyses**

In order to understand the role of therapist-rated alliance, the relationships between initial symptoms (baseline OQ), pretreatment role expectations, therapist-rated alliance, and termination OQ were examined with Pearson bivariate correlations. Results indicate that therapists’ 3rd session alliance ratings do not share a relationship with baseline OQ, expectations, or termination OQ (see Table 1).
Table 4

Descriptive Statistics and Partial Correlations of EAC-B Factor Scores (Personal Commitment, Facilitative Conditions, Counselor Expertise), Therapist-Rated WAI-SR Total Score, Baseline OQ, and OQ Score at Termination

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Personal Commitment</td>
<td>0.00</td>
<td>0.14</td>
<td>0.14</td>
<td>0.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Facilitative Conditions</td>
<td>0.77**</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Counselor Expertise</td>
<td>0.48**</td>
<td>0.48**</td>
<td>0.73**</td>
<td></td>
<td>0.67**</td>
<td></td>
</tr>
<tr>
<td>4. WAI-SR</td>
<td>0.14</td>
<td>0.09</td>
<td>0.02</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Baseline OQ</td>
<td>-0.025*</td>
<td>-0.27*</td>
<td>-0.15</td>
<td>-0.12</td>
<td></td>
<td></td>
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<tr>
<td>6. Termination OQ</td>
<td>-0.31*</td>
<td>-0.34**</td>
<td>-0.33**</td>
<td>-0.12</td>
<td>0.65**</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5.69</td>
<td>0.95</td>
<td>2.44-</td>
</tr>
<tr>
<td>2</td>
<td>5.37</td>
<td>1.08</td>
<td>2.10-</td>
</tr>
<tr>
<td>3</td>
<td>4.04</td>
<td>1.21</td>
<td>1.67-</td>
</tr>
<tr>
<td>4</td>
<td>3.94</td>
<td>0.50</td>
<td>2.67-</td>
</tr>
<tr>
<td>5</td>
<td>71.16</td>
<td>23.99</td>
<td>10.00-</td>
</tr>
<tr>
<td>6</td>
<td>55.99</td>
<td>25.92</td>
<td>5.00-</td>
</tr>
</tbody>
</table>

Note. N = 65.

*p < .05. **p < .01.
Reference