EXPECTATIONS AND ANXIETY ABOUT COUNSELLING

HAMISH JOHN MCLEOD

1992

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EXPECTATIONS AND ANXIETY ABOUT COUNSELLING

A thesis presented in partial fulfilment of
the requirements for the degree of
Master of Arts in Psychology at
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HAMISH JOHN MCLEOD

1992

ABSTRACT

Prior research into expectations about counselling has assumed that failing to meet client expectations will have a detrimental effect on process variables such as state anxiety and adherence to treatment. However, the empirical support for this is equivocal. Both self-regulation theory and the attentional-bias model suggest that experiencing the confirmation of accurate, but negative expectations will result in an increase in state anxiety. Therefore, instead of focussing only on improving accuracy of client expectations it is suggested that the affective valence of the expectations must also be acknowledged. The aim of the present study was to investigate the differential effects of confirmation/disconfirmation of positive or negative expectations on anxiety about seeing a counsellor. Thirty-nine adult clients attending their first session at a university counselling centre completed pre- and post-session measures which assessed their expectations about counselling, and state and trait anxiety. As hypothesised, the effects of disconfirmation of expectations on state anxiety were moderated by the valence of the expectations. However, contrary to what was predicted, those client's who experienced confirmation of negative expectations did not display greater state anxiety than those with positive expectations, and there was no significant relationship between trait anxiety and negative expectations. Simple exposure to therapy resulted in a decrease in state anxiety for all clients regardless of confirmation/disconfirmation and expectation valence. Finally, those clients who had their negative expectations confirmed did not drop out of treatment more than any other group. A preliminary investigation of the validity of using the Expectations About Counseling questionnaire (EAC) to measure positive and negative expectations about counselling revealed that it was not as effective as had been suggested by previous researchers. It was concluded that this factor and a lack of power contributed to the paucity of significant results. The results are discussed in the context of self-regulation theory and the attentional-bias model and an argument is made for the continued use of these two paradigms in future research.

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CHAPTER ONE

The Development of Research into Expectations About Counselling

1.1 Overview of the introduction

It has long been thought that gaining an understanding of the ways client expectations influence therapy will benefit both the practicing clinician and the recipient of any treatment. For instance, Bordin (1955) advocated the modification of counsellor behaviour in order to meet client expectations and thus reduce anxiety and treatment avoidance. However, much of the research in this area is methodologically weak and has been predicated on unsubstantiated assumptions. One such assumption is that disconfirming client expectations inevitably has a detrimental effect on the therapeutic process (eg. Baekeland & Lundwall, 1975). For the purposes of the current research, this assumption will be referred to as the "congruency hypothesis" as it infers that achieving congruency between client expectations and experience is of prime therapeutic importance.

Despite the fact that the congruency hypothesis is not drawn from any clear theoretical base, it's widespread acceptance has led many researchers to develop induction procedures for client's entering psychotherapy. This highlights a major weakness in this area, that is, the development of theory has failed to keep up with applied research. Consequently, the findings of research into client expectations about counselling have been equivocal.

Improving understanding of the influence of client expectations on therapy can best be achieved by: (a) acknowledging and avoiding the methodological problems identified in previous studies; and, (b) drawing theoretical input from related, but more theoretically advanced disciplines. Therefore, the current work begins with an overview of research into client expectations with particular emphasis on the problems that have compromised previous studies. Following this is an examination of developments in the area of medical psychology, specifically the emergence of self-regulation theory, and the influence of expectations on preoperative emotional states and post-operative recovery. Self-regulation theory is then discussed in terms of expectations about psychological counselling.

Next, the attentional-bias model of information processing is introduced. This model augments self-regulation theory and provides an insight into the way specific types of expectations influence anxiety. The inclusion of this theory provides added insight into the way the valence of client expectations (whether they are positive or negative) affects anxiety about counselling. The attentional-bias model suggests that some individual's preferentially attend to threatening environmental cues and subsequently experience increased state anxiety, whereas others direct their attention

away from the threat and report less state anxiety. Therefore, it seems plausible that focussing on the negative aspects of an impending experience (holding negative expectations) will increase state anxiety and may adversely influence that experience. Whether or not the expectations are **accurate** may well be immaterial, the important factor may be whether they are predominantly positive or negative.

The current study has three main objectives. Firstly, it aims to address the gap that exists between theory and applied research into expectations about counselling. Secondly, it will attempt to test the congruency hypothesis by examining the relationship between positive versus negative expectations about counselling and state anxiety. Finally, the way expectations and anxiety influence premature termination of treatment will be briefly discussed in order to provide a preliminary insight into the way these variables may influence therapeutic outcome.

1.2 The origins of research into client expectations about counselling

The idea that client expectations play an important role in counselling has been examined frequently over the past four decades. Numerous studies have attempted to link expectations to: adherence to treatment (Baekeland & Lundwall, 1975; Hardin, Subich, & Holvey, 1988; Hynan, 1990); satisfaction (Lebow, 1982); therapeutic outcome (Sipps & Janeczek, 1986); service utilization (Kushner & Sher, 1989; Tinsley, Brown, de St. Aubin, & Lucek, 1984); client ethnicity (Yeun & Tinsley, 1981); psychosocial development (Tinsley, Hinson, Holt, & Tinsley, 1990); and gender (Hardin & Yanico, 1983; Sipps & Janeczek, 1986). Yet, despite the presence of these and other studies Hardin & Subich (1985) state that "...the most important questions that remain to be answered concern the practical significance of expectations on the actual counseling process, the ways expectations affect the outcome of counseling, and how expectations are modified over the course of counseling." (p.134).

The 1950's is the point in time from which most of today's expectations research has emanated. Kelly (1955) postulated that clients' hold a personalised conceptualisation of the therapeutic relationship and the therapists role within that relationship, before they even enter the first session. This idea was developed further by Goldstein (1962b, cited in Duckro, Beal, & George, 1979, p.260) who delineated two types of expectations held by both therapists and clients. These were: (a) prognostic expectations, which reflect the perceived probability of therapeutic success as defined by the client or the therapist; and, (b) participant role expectations which were defined as the anticipations held by both parties regarding behaviours that will be displayed and by whom.

Through much of the 1960's, the importance of achieving client-therapist congruency became fixed in the minds of theorists and practicing counsellors alike. Unfortunately this uncritical acceptance of the congruency hypothesis was followed by the emergence of applied studies which were not based on any empirically supported theories. The consequence of this has been that the field has developed in a haphazard and inefficient manner. The following is an overview of research into client expectations and their relationship to specific aspects of the counselling process.

1.3 Expectations and adherence to treatment

Baekeland and Lundwall (1975) completed an extensive, and often cited, review of the premature termination of treatment literature and emphatically stated that "...discrepant expectations about treatment promote dropping out." (p.758). However, this conclusion was supported by the citation of only six studies, five of which were published prior to 1965.

More recent research has been marked by ambiguous results and semantic problems. For instance, Hardin et al. (1988) used the Expectations About Counseling Questionnaire (EAC, Tinsley, Workman, & Kass, 1980) to link client expectancies to premature termination of treatment. The results provided no support for the hypothesis that differences in precounselling expectations can explain differences in termination status. Also, they found that problem type did not seem to affect expectations.

Hardin et al. (1988) make several recommendations for future research. Firstly, they encourage the formulation of clear definitions of concepts such as premature termination, and state that client **expectations** must be treated as something distinct from client **preferences**. They also question the ability of the EAC to measure discrete client expectations and suggest that this possible lack of sensitivity may have contributed to their non-significant results. In support of this Hardin et al. cite the doctoral work of Prospero (1987) which suggested that, rather than assessing discrete expectations, the short form of the EAC may be a measure of global positive or negative set toward counselling. This suggestion is highly pertinent to the current study and supports the contention that too much attention has been paid to discrete expectations and their accuracy rather than exploring the role of the predominant affective valence of an individual's expectations.

Heesacker and Heppner (1988) postulated that client motivation and expectations should predict premature termination and, like Hardin et al. (1988), they encouraged the formulation of clear construct definitions. Instead of using an arbitrary definition of premature termination based on the number of completed therapy sessions, the authors made their assessment based on the careful analysis of therapist notes. The main findings were that in brief psychotherapy, those who terminated prematurely displayed less favourable expectations than those who did not. In longer

psychotherapy, premature terminators reported more favourable expectations. This finding is consistent with increasing recognition that different factors may influence dropping out in various phases of treatment (eg. Baekeland & Lundwall, 1974; Pekarik, 1985a). Heesacker and Heppner attempted to explain this by suggesting that a person with **negative** expectations may have them confirmed more rapidly due to a scanning and memory bias which favours negative material. In contrast, they suggest that those who hold positive expectations which are disconfirmed become **gradually** disillusioned. This proposition is consistent with the attentional-bias model discussed in Chapter 3, and suggests that allaying a first-time client's negative expectations may be necessary to ensure that they adhere to treatment long enough to gain some benefit from it.

Hynan (1990) found that early terminators discontinued therapy due to discomfort and situational constraints more often than late terminators. Those who ended therapy later did so because of improvement attributed to the therapeutic experience. Hynan suggested a modest relationship exists between positive experiences in therapy and adherence but this observation failed to reach significance (most probably due to the small sample size used). When viewed in the light of other research (such as Heppner & Heesacker, 1988) it would seem that fostering **positive** expectations prior to counselling and minimising negative experiences in the initial sessions is desirable as this should increase adherence and enhance the possibility that an individual will be exposed to therapy long enough for it to do some good.

In summary, the exact influence of expectations on adherence to treatment is still unclear. However, there is evidence which indicates that the affective valence of expectations and the subsequent confirmation or disconfirmation of those expectations may relate closely to termination status. It is intended that the current study will explore this issue.

1.4 Expectations and satisfaction

An extensive review dealing with satisfaction with mental health treatment revealed that few conclusions can be drawn from previous research (Lebow, 1982). This was attributed to the newness of the field complicated by problems with some of the techniques used to assess consumer satisfaction. The role that client expectations play in determining satisfaction was also unclear. For instance, Severinson (1966, cited in Lebow, 1982) reported that disconfirming client expectations regarding counsellor empathy inevitably reduced satisfaction, while Gladstein (1969, cited in Lebow, 1962) asserted that the multidimensional nature of client expectancies meant that the disconfirmation of any one expectation was not enough to have a detrimental effect. Because the present research is not concerned with assessing satisfaction with

treatment, it is not necessary to elaborate on this issue. However, it can be noted that satisfaction research shares many of the problems evident in other investigations into expectations about counselling.

1.5 Expectations and gender

Hardin and Yanico (1983) used the Expectations About Counseling questionnaire (EAC; Tinsley et al., 1980) to compare expectations, counsellor gender, and problem type. This analogue study failed to find any significant effects attributable to counsellor gender, but did show a significant main effect for subject gender. Also, female subjects expected to assume more responsibility in counselling, and expected counsellors to be more accepting, genuine, and confrontational than did the male subjects. In contrast, men expected counsellors to be more directive and self-disclosing than women did. The authors suggested that their design was not sufficiently sensitive to extrapolate the complicated effect of counsellor gender.

An extension of Hardin and Yanico's (1983) work compared pre-counselling expectations with subject gender traits (Sipps & Janeczek, 1986). Sipps and Janeczek postulated that previously observed differences in client expectations were not simply due to gender but are instead attributable to the individual's level of femininity or masculinity. The results indicate that degree of femininity does significantly influence client expectations, irrespective of the client's gender.

1.6 Expectations and service utilisation

Kushner and Sher (1989) examined the relationship between fear of psychological treatment and service utilisation. Treatment fearfulness was seen as "...a subjective state of apprehension arising from aversive expectations surrounding the seeking and consuming of mental health services." (p.251). Based on scant prior research, the authors predicted that service seekers would be less fearful than those who avoided treatment. Psychological distress and fear of psychotherapy were measured with the Brief Symptom Inventory (BSI; Derogatis, 1975, cited in Kushner & Sher, 1989) and the Thoughts About Psychotherapy Survey (TAPS; Kushner & Sher, 1989) respectively. As predicted, treatment avoiders displayed the highest level of fearfulness, followed by those who reported that they "never needed treatment". Those who needed treatment and sought it displayed the lowest level of fearfulness.

In conclusion, Kushner and Sher (1989) suggest that their results are consistent with, but do not necessarily substantiate the view that fearfulness leads to service avoidance. The correlational design made it imprudent to infer any causal relationship between level of treatment fearfulness and service utilisation but there was a positive relationship between fearfulness and level of psychological distress. That is, those

who displayed more fear were more distressed prior to entering therapy. The authors note that therapy can be "...a potentially difficult, embarrassing, and overall risky enterprise..." (Kushner & Sher, p.256) and thus can be viewed in a negative or fear-provoking way. This has practical implications in that many people who could benefit from psychological help may avoid therapy because they find it frightening. This is consistent with the views espoused in the current study. That is, the nature of an individual's expectations (i.e. are they positive or negative) must be acknowledged if service delivery is to be enhanced.

Tinsley et al. (1984) found that the client's view of the problem and the perceived skills of the health professional involved can affect expectations and service utilisation. They found that certain problems are seen as appropriate for some help-providers but not for others and conclude that any study of help-seeking behaviour needs to address the possible moderating influence of problem type. This means that researchers need to rule out the possibility that treatment avoidance is simply due to the client perceiving the identified help-giver as inappropriate for their specific problem.

Paradoxically, Tinsley et al. (1984) cling to the view that failing to meet client expectancies has negative consequences yet state that researchers must still answer the question "...just what are the effects of violating client expectancies?" (p.159). This is indicative of the degree to which the congruency hypothesis has become established in this field despite the absence of strong empirical support. In response to Tinsley et al.'s finding's, the current design controls for any unwanted variance attributable to problem type.

1.7 Expectations and client ethnicity

Yeun and Tinsley (1981) used the EAC to compare the expectancies of American university students with those of African, Chinese, and Iranian students. This study was born out of the increasing need to accommodate foreign students in campus counselling settings and the acknowledgement of the possible role that ethnicity plays in determining expectations. The authors point out that expectancies are modified through interaction with the environment and therefore are strongly influenced by cultural factors. Significant differences were found between the four groups of students on 12 of the 17 expectancy scales. The authors observed that the Chinese, Iranian, and African students expected to play a more passive role in the counselling process. In contrast, the American students expected to assume more personal responsibility while the counsellor adopted a less directive and passive role. Findings like this reflect the degree to which extraneous factors such as socialisation and ethnicity can impinge on the formation of expectations and therefore may cause unwanted variance if they are not controlled for. As a consequence, the current study

made provision for subjects to indicate which ethnic group they identified with, thus allowing for further analysis based on this information should the need arise.

1.8 General research into client expectations

Tinsley and Harris (1976) carried out an important study which looked at the counselling expectations of 287 undergraduate students attending Southern Illinois University. In contrast to other work at the time, they measured a wide range of client expectations pertaining to the counsellor and the counselling environment. Close examination of those expectations presented an insight into the way a non-therapeutically sophisticated population views counselling. Essentially, the subjects indicated that they believed counselling could be *generally* helpful but they doubted that it could ever be of any help to them personally. In response, Tinsley and Harris suggested that many potential clients may never seek counselling due to their low expectancy that they will be helped.

This research was followed by the development of the Expectations About Counseling questionnaire (EAC, Tinsley et al., 1980) which has become a popular research instrument due to it's psychometric properties and ease of administration. Tinsley et al. (1980) constructed this measure in order to address what they saw as the inadequacies present in previous expectations research. They note, as did Duckro et al. (1979), that previous efforts had focussed on too narrow a band of client expectancies and had subsequently paid insufficient attention to prognostic and participant role expectations. Hence, the EAC was constructed in order to try and measure "...all of the theoretically important expectancies a client might have about counseling." (Tinsley et al., 1980, p.563). It includes scales which measure expectancies regarding: counselling outcome, the client's attitudes and behaviours, the counsellor's attitudes and behaviours, counsellor characteristics, and characteristics of the counselling process.

Two advantages of the EAC over the customised instruments used in many other studies are that it's widespread use allows for outcome comparisons between studies and the standardisation of measurement procedures reduces unwanted variance previously attributed to differing research methodologies.

Other research into general expectations and attitudes about counselling has been carried out using a variety of measures (Cash, Kehr, & Salzbach, 1978; Surgenor, 1985; Furnam & Wardly, 1990). Cash et al. measured client help seeking attitudes in an analogue study using the Fischer-Turner Attitudes Toward Seeking Professional Psychological Help inventory (ATSPPH, Fischer & Turner, 1970, cited in Cash et al., 1978). They found that therapeutically experienced subjects held more favourable attitudes toward counselling than those who were therapeutically naive and

that the Fischer-Turner scale reliably differentiates between these two groups. Those who had not experienced therapy before expressed doubts about it's helpfulness. This finding is consistent with the view that fostering **positive** or favourable attitudes toward counselling will enhance service utilisation (Kushner & Sher, 1989; Tinsley & Harris, 1976).

Surgenor (1985) used a modified version of the Fischer-Turner scale to measure attitudes toward counselling in New Zealand. Young people and the therapeutically naive displayed negative attitudes toward seeking and obtaining psychological help while those who were therapeutically experienced, female, well educated, and older displayed more positive attitudes. The author suggests that this is a warning to psychology as a profession that there is a need to examine ways in which services can be made available to all those who need it, not just a select few.

The idea that experience is an important determinant of attitudes toward psychological help was also explored by Furnham and Wardley (1990). However, the pattern they observed was the opposite to that reported by Surgenor (1985). Overall, the subjects' responses were mostly positive, but older subjects tended to be **more** skeptical about the benefits of psychotherapy while those who were more educated believed **less** in it's possible benefits. However, the most important point was that experience in psychotherapy correlated with **higher** levels pessimism about the process. This finding is at odds with the research that has been cited up until now and could be construed as support for the view that this area is poorly understood. However, the most parsimonious explanation is that the use of a "psychotherapy" rather than "counselling" client sample led to differing results.

One of the main benefits of general research into expectations about counselling and psychotherapy is that it provides an insight into the clients perception of the encounter. The fact that practitioners are constantly exposed to their discipline inevitably means that they lose touch with how a therapeutically naive person views the experience. It is therefore desirable to gain an understanding of the expectations that people bring with them to therapy in order to more effectively establish rapport and trust. Hence, the current study is useful in that it quantifies the expectations of a group of therapeutically naive clients, and by using the EAC it is possible to make comparisons with other samples.

1.9 A summary of the main problems with expectations research

In the most influential review of the expectations literature to date, Duckro, Beal, & George (1979) challenge the assumption that the disconfirmation of client expectations automatically has a deleterious effect on therapy process and outcome. Of the 43 studies reviewed, 21 provided support for the congruency hypothesis, while 22

did not. This lack of concordance was attributed to the following methodological limitations present in the literature.

Firstly, there has been a tendency for researchers to use ill-conceived research methodologies (eg. Klepac & Page, cited in Duckro et al., 1979). This criticism reflects Duckro et al.'s dissatisfaction with the means by which client expectations have been measured by some researchers. For instance, some studies used open-ended response forms which were subjectively interpreted by the investigator. In another instance, the instrument items were objectively generated but were administered verbally by an intake worker giving rise to the suggestion that a positive response bias occurred. These concerns are also voiced by Tinsley, Bowman, & Ray (1988) who advocate a programmatic approach to expectations research. They recommend the use of the EAC due to it's psychometric properties, widespread use, and broad focus.

A second weakness of previous research relates to ambiguity regarding the definition of *"expectations"*. Apfelbaum (1958, cited in Duckro et al., 1979) defined expectations as the *anticipation* of some event. However, this practice of stating clear construct definitions has not been emulated by many other authors and consequently, the problem of separating client *expectations* from client *preferences* has emerged. To avoid these problems, Duckro et al state that researchers should clearly define client "expectations" at the outset of any study. In response to this, the current study adopts a precise operational definition of "expectations" taken from the work of Grantham and Gordon (1986). (See Section 4.2).

A final concern expressed by Duckro et al. (1979) is that the theories that have been used in this area in the past have predominantly been inappropriate and have not enhanced the development of the field. The current study acknowledges all of these concerns in it's design: A psychometrically sound and widely used research instrument has been chosen - the EAC. A clear definition of "expectations" has been selected, and an attempt is being made to forge a link between appropriate theory and applied research. It is to the introduction of relevant theory that we now turn.

CHAPTER TWO

Preparation for Stressful Medical Procedures and Self Regulation Theory

2.1 Rationale for drawing on the medical psychology literature

As has already been noted, one of the main criticisms of research into expectations about counselling is that many authors have uncritically accepted spurious theoretical assumptions (such as the congruency hypothesis) and have ascribed them factual status. Recognition of this failing has prompted a call for the reappraisal of the models and theoretical constructs used in expectations research (Duckro et al., 1979). One way of enhancing this process is by taking note of the theoretical developments that have occurred in related areas, such as medical psychology, and introducing them into investigations of expectations about counselling. For instance, the effects of preparation for stressful medical procedures has received considerable attention in recent times and, unlike research into expectations about counselling, the development of theory has kept abreast of applied research.

There are two main reasons for turning to the medical psychology literature for theoretical input. Firstly, surgery and psychological counselling share a number of characteristics. For instance, they both represent relatively ambiguous situations to the uninitiated and inexperienced; they are both invasive (one at a physical level, the other at an emotional level); and they both involve what Kushner & Sher (1989) termed the "...letting go of the familiar and a taking on of the unknown." (p. 256). Secondly, given that the current research focusses on anxiety about counselling, the fact that the single most commonly reported preoperative emotional state is anxiety (Johnston, 1986) makes it sensible to capitalise on the advances made in the medical psychology literature.

2.2 An overview of research into coping with stressful medical procedures

A number of techniques have been used to enhance patient coping with stressful medical procedures including: psychological support; information provision; skills training; hypnosis; relaxation training; filmed modeling; and cognitive-behavioural interventions (Kendall & Watson, 1981). Of these strategies, the effects of information provision prior to the stressful event has received most of the research attention and the most promising results (Johnson, 1973; Ridgeway & Mathews, 1982; Anderson, 1987; Johnson, Lauver, & Nail, 1989; Suls & Wan, 1989).

One of the main findings to emerge from this literature that is relevant to the current study regards the importance of fostering accurate, but non-threatening expectations about an impending stressful event. For instance, Johnson (1973) carried

out a series of experiments which looked at the effects of preparatory information on subject expectations and subsequent distress associated with artificially induced ischemic pain. The experimental group were given information regarding the types of sensations that most people experience when they have a tourniquet applied to their upper arm. The control group were only provided with information about the procedure of the study. The main hypothesis was that accurate expectations about the physical sensations that were to be experienced would reduce the distress displayed by the subjects. However, Johnson found that a reduction in distress only occurred when the individual held accurate expectations about the sensations to be experienced **and** directly experienced those sensations. Prior to actually experiencing the ischemic pain, there was no difference in anticipated levels of distress for the experimental and control groups. It was suggested that information provision helped subjects structure their expectations and quell any fears arising from not being able to anticipate what was going to happen. Hence, when the sensations occurred, they could be processed in non-threatening terms because they were congruent with what was expected. In contrast, those who did not receive preparatory information lacked an appropriate reference point and thus were unable to ascertain whether the sensations were going to intensify, diminish or remain constant. It is likely that this ambiguity lead to anticipatory arousal and distress due to a lack of understanding of what could occur next. Thus, facilitating the formation of accurate expectations appeared to provide a cognitive template against which subjects could compare their experience. The likely effect of this was the reduction of the arousal that can occur when the future is unknown and potentially unpleasant.

2.3 Sensory Vs. procedural preparatory information

As research into pre-operative preparation has expanded it has become clear that preparatory techniques can differ markedly in terms of both their emphasis and subsequent effects. For instance, a clear distinction can be made between *sensory* information which describes the sensations that the patient is likely to experience, and *procedural* information which only describes the sequence of events that the individual will be exposed to (Suls & Wan, 1989). The emergence of this distinction has prompted the examination of how different **types** of preparatory information affect coping and surgical outcome.

Ridgeway & Mathews (1982) provided hysterectomy patients with one of three types of pre-operative information. The two experimental groups were given either: (a) information about the surgical procedure and it's effects; or (b) guidance in a cognitive coping technique. The control group was given general information about the hospital and the ward on which they would convalesce. Results showed that both

experimental groups experienced reductions in anxiety about the operation compared to controls, but training in the cognitive coping technique was associated with the best outcome. Ridgeway and Mathews suggest that the cognitive coping condition was most effective because it invested the patient with a transferable skill which could be applied to any concern or worry that they experienced. The other advantage of the cognitive coping strategy was that it could continue to be beneficial during the post-operative recovery period. In contrast, the provision of information on it's own could only address a limited number of specific issues and therefore could miss some of the idiosyncratic concerns that an individual may have.

These findings indicate that expectations can not be treated as a unitary construct. Therefore, adopting the perspective of many researchers in the expectations about counselling area and concentrating on improving only the accuracy of an individuals expectations fails to acknowledge other subtle effects that can determine coping and outcome. The relevance of this to the current study lies with the supposition that the content (specifically, the affective valence) of an individuals expectations affects coping with a stressful event. As has already been noted, it is nonsensical to confirm a client's negative expectations without giving them appropriate coping skills or the understanding that the aversive qualities of the experience are transient and are a natural part of the therapeutic process.

Stress inoculation procedures have also been used to help surgical patients form active coping behaviours to mitigate the distress associated with hospitalisation and surgery (Wells, Howard, Nowlin, & Vargas, 1986). The experimental group in Wells et al.'s study experienced less pain and anxiety than controls, were less reliant on analgesic medication post-operatively, and were discharged from hospital an average of 3.5 days earlier. Also, in keeping with the idea that holding positive views is an important determinant of a good therapeutic outcome, Wells et al. note that positive patient perceptions of their primary surgeon correlated with less reported worry and nervousness about the surgery.

The main conclusion that emerges from the medical studies cited above echoes much of what is stated in the theoretical literature (Johnston, 1986). That is, predictability and perceived control over an event are important determinants of the degree to which an individual can cope. Although providing accurate information does lead to reductions in distress, it is not the most efficacious way of helping the individual to cope with anxiety-provoking situations. In response to these observations an number of authors have attempted to model the relationship between pre- and post-operative states. An overview of the main findings is presented below.

2.4 Expectations, pre-operative emotional states and recovery

Johnston (1986) completed a comprehensive critique of the theoretical models developed to explain the relationship between pre-operative emotional states and post-operative recovery. In addition to this, the review identified fallacious theoretical assumptions from those which were based on empirically sound studies. The subsequent findings that are relevant to the present study are as follows:

(a) patients who displayed high pre-operative anxiety experienced poor post-operative outcomes. In contrast, those who displayed low pre-operative anxiety experienced good outcomes.

(b) those patients who displayed an active and energetic (positive) pre-operative mood were most likely to demonstrate fast post-operative recovery.

(c) inaccurate patient expectations prior to surgery only correlated with post-operative difficulties if the problems were *underestimated.* This point was made with particular reference to expectations about post-operative pain, that is, those who underestimated the amount of pain experienced more post-operative difficulties. This is in contrast to other research that suggests **any** inaccurate expectation will result in a poor post-operative outcome (Johnson, 1973, Leventhal & Johnson, 1983).

The relevance of these findings to research into expectations about counselling is twofold: Firstly, the presence of a reliable correlation between low pre-operative anxiety and good post-operative outcome lends strong support to the view that reducing patient anxiety prior to psychotherapy is desirable. Intuitive thinking along these lines has prompted a lot of the work aimed at preparing people for both psychotherapy and stressful medical procedures (see Tinsley et al, 1988; and Ridgeway & Mathews, 1982, for reviews). Secondly, as in the expectations about counselling literature, the exact influence of accurate patient expectations is ambiguous (see point (c) above). However, instead of persevering with obsolete theory as has been done in the counselling literature, the field of medical psychology has built on the findings of previous research and has developed models that equate with what has been observed in empirical studies.

2.5 The development of theory

Johnston (1986) presents an analysis of nine theoretical positions that have been developed to explain the ways pre-operative emotions influence recovery. These perspectives range from strict psycho-physiological explanations which implicate the body's biochemical response to perceived stress, to the other extreme which postulates a pure behavioural-communication model (in which the patients disclosure of distress

influences the assessments made by medical staff). In between these two extremes is the school of thought which assimilates a cognitive-behavioural perspective with physiological variables.

One of the earliest theories to account for the influence of preoperative emotional states on recovery was by Janis (1958). This Emotional-Drive model was predicated on the idea that a certain amount of anxiety was needed to motivate an individual to engage in active coping behaviours. Janis posited a curvilinear relationship between preoperative anxiety and outcome, and suggested that patients needed to engage in the "work of worry" if they were to cope adequately with the stressful event. However, subsequent research has failed to replicate Janis' original findings (Johnston, 1986; Johnson, Lauver, & Nail, 1989) and thus it is no longer viewed as a tenable theory.

The models that have proven to be more heuristic than Janis' Emotional-Drive Theory suggest a linear relationship between pre- and post-operative emotional states. Leventhal (1970, cited in Leventhal & Johnson, 1983) proposed that there are two distinct responses to a threatening situation: (a) attempt to deal with the fearful response, and (b) attempt to deal with or avert the impending threat. The experience of fear does not automatically prompt the individual to engage in danger control behaviour, instead, this response is influenced by factors such as locus of control and perceived controlability of the threatening situation. Therefore, if an individual does not possess the requisite skills to engage in danger control, or if they believe that the situation is out of their hands they will attempt to mitigate the fear reaction instead. So, rather than attempting to cope with the stimulus that is eliciting the fearful response, they will attempt to cope with the response itself. This view is incompatible with Emotional-Drive theory as it infers that increasing an individuals level of anxiety will not automatically elicit the emission of an appropriate coping response if one is not available. Instead, what is likely to happen is that an increase in anxiety will elicit a reaction designed to cope with the anxiety, not the situation causing it.

These ideas were further developed by Johnson (1973) who examined whether making the sensations associated with surgery more predictable enhanced the emission of a coping response. The results of this and numerous other studies have been used as the empirical base from which self-regulation theory has developed (Leventhal & Johnson, 1983).

2.6 Self-regulation theory

Self-regulation theory is an information processing model which has been systematically developed from a broad experimental and applied research base. It has been used to explain how the provision of sensory preparatory information helps

individuals cope with stressful events such as: gastroendoscopy (Johnson, Morrissey, & Leventhal, 1973, cited in Leventhal & Johnson, 1983); radiation therapy (Johnson et al, 1989); and childbirth (Leventhal, Leventhal, Shacham, & Easterling, 1989). Leventhal and Johnson contend that the provision of accurate, non-emotional, pre-operative information allows the formation of an appropriate cognitive representation (schema) of the impending event. The presence of this schema then facilitates the non-threatening interpretation of environmental events which results in reduced patient distress and enhanced post-operative recovery.

One of the strengths of this model is that it has developed in a number of inductive (theory-generating) and deductive (theory-testing) steps which have allowed the systematic rejection of any spurious assumptions (Wooldridge & Schmitt, 1983). Also, the studies on which the theory is based display a range of methodologies and were carried out in a number of different settings.

To provide an indepth critique of the research from which the theory has emerged here would be redundant given that: (a) it is accepted that the broad range of research techniques used in the development of the model make it difficult to question it's validity based on any major methodological concern (Wooldridge & Schmitt, 1983), and; (b) detailed reviews are available elsewhere (eg. Leventhal & Johnson, 1983; Johnson, 1982). Therefore, the following discussion does not seek to critically appraise the research base of the self-regulatory model, instead it highlights it's relevance to the current study.

2.7 Two interpretations of the self-regulation model

The fact that self-regulation theory has developed from both experimental and applied research has lead to the emergence of two distinct, but closely related interpretations of the model. Both perspectives attempt to encapsulate the cognitive process that accompany the provision of sensory pre-surgical information. The interpretation favoured by Howard Leventhal is derived primarily from the findings of laboratory based experimental studies in which the subjects' opportunities to engage in active coping behaviours are scarce. This perspective focuses on the role that sensory information plays in the reduction of the patient's distress reaction. In contrast, the view favoured by Jean Johnson is based on the findings of field research in which the individual may emit a range of active coping behaviours. Thus, Johnson emphasises the role that sensory information plays in facilitating coping. Both authors agree that the provision of accurate sensory information prior to a stressful medical procedure is beneficial because it provides the individual with an accurate schema of the impending event.

2.8 Leventhal's interpretation

It is proposed that there are two possible responses to the presence of a noxious environmental event: (1) a basic *informational* response which maps the event's parameters at a neurological level in terms of its intensity, temporal magnitude, and sensory properties such as appearance and feel; and (2) an *emotional-distress* response characterised by a specific pattern of autonomic arousal (Leventhal & Johnson, 1983). Leventhal holds the view that sensory information acts to reduce the intensity of the *emotional-distress* response by preventing the association of the current experience with emotionally laden memories. It is suggested that noxious stimuli prompt severe emotional reactions when they are linked in memory with prior events where the individual experienced emotions such as anxiety, distress, anger, and so forth.

It is suggested that the linking of current experience with emotional memories occurs automatically at a preconscious level and as such is beyond the voluntary control of the individual. In order to gain some clarification of this issue, Leventhal, Brown, Shacham, and Engquist (1979) conducted an elaborate experimental study which looked at the influence of different types of preparatory information on reports of pain and distress during exposure to a cold pressor stimulus. Three pairs of groups received the following types of preparatory information: (a) that which described the sensations produced by the cold-pressor stimulus (such as coldness, numbness, tightness of the skin); (b) procedural information about the sequence of events that would occur, and; (c) information regarding the common bodily symptoms that accompany arousal due to fear or distress (butterflies in the stomach, sweating on the non-immersed hand and so on). In addition to this, one pair from each information condition were given the following pain cue as part of the general instructions: "...you will notice the ...sensation of pain, which will begin to get very strong about this time." (Leventhal et al., p.693). The inclusion of this additional information was intended to alter the connotations of the situation so that for three of the groups the emergence of each sensation could be construed as a signal of imminent severe pain.

This design allowed the exploration of two possible influences of sensory information. Firstly, if the **accuracy** of the information is most important the inclusion of the pain cue should not affect the observed level of distress as it merely represents another piece of accurate information. The alternative perspective suggests that the automatic, preconscious interpretation of the sensations is what matters. Therefore the presence of the pain cue will connect the stimulus to emotional memories thereby suppressing the distress reduction usually seen with sensory information.

The results indicate that the provision of accurate sensory information without the pain cue was most effective at reducing subject distress. This lead the authors to suggest that accuracy on it's own is not enough, instead the individual must be able to

interpret environmental events in non-threatening terms. Leventhal et al. (1979) completed two more experiments which were designed to indicate whether sensory information led the subject to form a concrete schema that prevented the stimulus from eliciting noxious emotional memories. It was concluded that the effect of sensory information is twofold: (a) it reduces the anticipatory arousal induced by surprise, uncertainty and perceived threat, and (b) it reduces distress by facilitating rapid *habituation* to the fear response, that is, it prevents the connection of the current experience with previous noxious emotional experiences.

This *habituation hypothesis* is the main factor which distinguishes between Leventhal and Johnson's respective interpretations of the self-regulation model. It predicts that providing sensory information will facilitate habituation and reduce distress by allowing for the more rapid formation of a schema of the event, thereby reducing it's novelty and/or activating power (Leventhal et al., 1989). However, this pattern has only been observed in experimental studies in which the participant could engage in few active coping behaviours. Research in applied settings, such as that carried out by Johnson and colleagues (Johnson, 1973; Johnson & Leventhal, 1974; Johnson & Rice, 1974) supports the view that, rather than *directly* affecting the individual's emotional response, sensory information exerts an *indirect* influence through it's effects on coping (Leventhal & Johnson, 1983).

2.9 Johnson's interpretation

The findings of research in clinical settings suggest that sensory preparation is beneficial because it increases the individual's ability to process information and subsequently apply appropriate coping strategies from their existing repertoire (Leventhal & Johnson, 1983). Unlike subjects in Leventhal's laboratory studies, participants in clinical field studies are placed in situations in which they can take overt action to reduce their distress. Several studies have shown that providing guidance in active coping behaviours and instructing subjects to monitor specific sensations associated with the impending event results in reductions in both self reports and behavioural indices of distress (eg. Johnson & Leventhal, 1974; Leventhal et al., 1989).

The cognitive intervention used in the clinical studies carried out by Johnson served the following functions: It described the impending sensations in objective terms; identified the cause of those sensations; and gave an indication when each sensation would be likely to terminate. This provision of accurate, objective information served the dual purpose of indicating to the subject what was going to happen, while also quelling any distress related to worry over what could possibly happen. Hence, the subject could form an accurate schema against which the

experience could be compared. This permits the evaluation of any emitted coping response and the modification of that response in a proactive rather than reactive manner.

Johnson (in Leventhal & Johnson, 1983) likens the schema to a road map in that it allows one to proceed toward a specified goal without having to focus on every detail along the way. As a person experiences feedback that is consistent with the schema, confidence in the schema's predictive ability will increase and the individual will become more confident in their ability to cope. In contrast, the absence of an appropriate cognitive map will promote anticipatory arousal and distress because there is no indication when the experience will end or how the individual has fared. This will give rise to a perceived lack of control and will hamper the emission of coping behaviours.

Langer, Blank, & Chanowitz (1978) suggest that the main benefit of an accurate schema is that it allows the guidance of behaviour by specific situational cues without the individual having to concentrate on those cues. Hence the depletion of information processing resources is avoided and the individual is able to concentrate more fully on the task in hand. Because the schema operates at a relatively automatic level and makes use of the individual's existing repertoire of coping behaviours there is no need to struggle with the acquisition of new skills - the provision of preparatory information has obviated this need.

2.10 Summary

The different perspectives on self-regulation theory presented by Leventhal and Johnson appear to be a function of the differing research settings in which they were conducted. The experimental setting served to emphasise the habituation process as it virtually precluded the emission of active coping behaviours, whereas the applied setting allowed the individual to assume a more active role. However, both authors agree that successful adaptation to stressful circumstances requires the formation of a clear representation of the environment (the schema) and guidance in appropriate coping behaviours. The individual must also be able to gain a clear indication of what constitutes successful coping so that the coping behaviours that are being emitted can be evaluated and modified as necessary. Finally, the experience must be seen as non-threatening, that is, the individual must interpret subsequent sensations in benign terms and be confident in their ability to cope.

The model proposed by Leventhal and Johnson (1983) relates to the current study in the following ways. Firstly, it refutes the view that mere accuracy of information is enough to facilitate coping. This is exemplified in the work of Leventhal et al. (1979) which found that reframing the impending experience in threatening terms

by including a simple pain cue increased distress. The accuracy of the preparation remained unchanged but the connotations of the sensations were altered such that they changed from being objective stimuli to signals of impending pain. This reframing of the sensations in threatening terms enhances the likelihood that the individual will try to form a schema based on previous pain experiences and this will result in the recall of the noxious emotions that were associated with those experiences. Thus, the self-regulation model adds theoretical support to the view espoused in the current study, that is, that the emotional valence of an individuals expectations (their schema if the impending event) will have a dramatic effect on the amount of distress they experience.

The next chapter examines more closely the role that the valence of an individual's expectations will play in determining emotional arousal by combining Leventhal and Johnson's self-regulation theory with the attentional-bias model forwarded by Mathews and MacLeod (1985).

CHAPTER THREE

The Attentional-Bias Model

3.1 Perceived threat and emotional arousal

Many researchers have found that providing information prior to a potentially noxious event reduces distress and enhances coping both during and after the event (Johnson, 1973; Johnson & Leventhal, 1974; Langer, Janis, & Wolfer, 1975; Kendall, Williams, Pechacek, Graham, Shisslak, & Herzoff, 1979; Ridgeway & Mathews, 1982; Suls & Wan, 1989). The self-regulation model proposed by Leventhal and Johnson (1983) suggests that it is beneficial to provide concrete, objective preparatory information which frames an impending experience in non-threatening terms. This allows the individual to form an accurate schema of an event and minimises anticipatory arousal. This model shows potential for expanding our understanding of the way first time counselling clients cope with the stress of the initial session. However, before exploring this idea it is necessary to address an under-developed aspect of the self-regulation model.

Although Leventhal (in Leventhal & Johnson, 1983) alludes to some preconscious process which leads to schema formation and subsequent levels of distress , the self-regulation model fails to adequately specify the nature of this process. Therefore, there is a need to draw input from other work.

3.2 The attentional-bias model

Mathews & MacLeod (1985) posit an information processing model which provides insight into way that focussing on threatening environmental cues can give rise to the cognitive and physiological correlates of anxiety. Their contention is that anxiety states are attributable to the selective processing and interpretation of threat cues. They have observed that some individuals preferentially direct attentional resources toward threatening environmental cues and experience an increase in anxiety, while others direct their attention away and display less anxiety.

Almost all of the research in this area has been aimed at substantiating the view that generalized anxiety disorder is attributable to the presence of stable personality factors (trait variables), specifically, a predisposition to attend to threatening environmental cues. However, this does not limit the value of the model in the context of the current research. Rather the findings augment the view that the degree to which an individual sees an impending event in **positive** or **negative** terms will affect the level of anxiety displayed by that individual. Also, the terminology and constructs used by researchers exploring attentional-bias effects are closely related to those used by Leventhal, Johnson and colleagues.

3.3 Schemata

Like Leventhal and Johnson (1983), the authors of the attentional-bias model emphasise the role that schemata play in determining the interpretation of incoming information and the subsequent reaction to that information. This construct is based on the observation that human attention and memory are not passive systems which deal with literal representations of environmental events. Instead, an individuals reported perception of an event will often be distorted or embellished depending on the specific biases displayed by that individual (Williams, Watts, MacLeod, & Mathews, 1988). These biases will be influenced by both past experiences and the expectations held by the individual.

Although many definitions have been developed, in the context of the current study it is sufficient to view a schema as "...a stored body of knowledge which interacts with the encoding, comprehension and/or retrieval of new information...by guiding attention, expectancies, interpretation and memory search" (Williams et al., 1988, p.92). In practical terms this means that people interpret fragments of an experience as they are forthcoming and use them to structure the event and infer it's likely progress.

However, when an inappropriate schema is activated the result can be confusion and distress. The following example illustrates the process of schema activation based on fragmented information:

(i) John was on his way to school.
(ii) He was terribly worried about the maths lesson.
(iii) He thought he might not be able to control the class again today.
(iv) It was not a normal part of a janitor's duty.

(Sanford & Garrod, 1980, cited in Williams et al, 1988, p. 94)

The first two statements infer that John is a school pupil, and as a result the reader will be prompted to access a schema along those lines. Doing this provides a reference point against which John's behaviour can be compared and evaluated. However, the third statement suggests that John is in fact a teacher and therefore the "school pupil" schema is inappropriate. This necessitates the discarding of the initial schema in favour of one which matches the incoming information more closely. Finally, the cognitive representation of John as a teacher does not accommodate the fourth statement and consequently the reader must make further adjustments.

The failure to accommodate unexpected information such as that described above is reflected in both comprehension difficulties and increased reading time latencies for most people. This observation highlights one of the main functions of an accurate schema, that is, it permits the rapid assimilation and interpretation of incoming

information thus ensuring that the individual is ready to act in a manner consistent with the needs of the situation.

The manifestation of many clinical disorders has been attributed to the activation of a specific schema or constellation of schemata which influence the nature of the individual's perceptions, memories and interpretation of environmental events. Hence, depression is thought to be associated with the presence of schemata concerned with loss, negative aspects of the self, and a poor view of the future. Similarly, Mathews and MacLeod (1985) contend that generalised anxiety states emerge when an individual adopts threatening cognitive representations of the environment ("danger schemata").

3.4 "Danger schemata"

One of the core assumptions of the attentional bias paradigm is that some individuals organise incoming information using "danger schemata" which are either constantly operating or easily activated (Mathews & MacLeod, 1985). The presence of these schemata render the individual hypersensitive to environmental cues which signal impending noxious events. As a result of this bias, benign environmental events are construed in a threatening manner which results in a feed-forward cycle in which emotional distress and autonomic arousal spiral upwards in intensity. For instance, the passer-by on a dark street may be viewed as a potential assailant and the presence of mild somatic symptoms may be interpreted as the early signs of a serious disease.

In the attentional-bias model, as in self-regulation theory, schema formation is thought to be based on prior experiences and memories. However, the observation that two individuals can share an almost identical experience and yet react in remarkably different ways is thought to indicate the presence of an intra-individual process which renders some individuals more susceptible to stress. In an attempt to clarify this, Mathews, MacLeod and colleagues have carried our numerous studies aimed at determining the relative influence of trait and state variables in the manifestation of clinical anxiety states. The main findings of this research are outlined below.

3.5 Summary of research into the allocation of attention to threat

Mathews and MacLeod (1985) used an adapted version of the Stroop Colour-naming Task (Stroop, 1938, cited in Mathews & MacLeod, 1985) to ascertain whether the presence of threatening cues would compromise the task performance of anxious individuals. The experiment required subjects to name out loud the colour in which a range of words were written. The authors predicted that the inclusion of threatening distractors (words such as *disease* and *pathetic*) would prompt the activation of danger

schemata in anxious subjects which would act as interference and result in increased response latency.

The results indicate that anxious subjects were slower than controls in colour-naming all of the words used, but they were particularly slow in naming those which were threatening. The authors also note that the effects were particularly strong when the content of the currently active danger schema matched the type of threat cue that was presented. For instance, those who were concerned about their physical health displayed greater response latencies for cues that were physically threatening. However, MacLeod, Mathews, and Tata (1986) failed to replicate this finding.

Further research was carried out by Mathews and MacLeod (1986) who attempted to determine whether attending to threatening environmental cues represents a volitional or automatic process. Their results strongly suggest that anxious individuals automatically attend to threatening cues at a subconscious level, and that this leads to a drain on processing resources and a subsequent decline in task performance. In contrast, non-anxious subjects failed to display such a pattern. This finding fits well with Leventhal's (Leventhal & Johnson, 1983) assertion that schema activation is an automatic response to a basic need to structure environmental events in order to guide behaviour. It appears that providing preparatory information influences the nature of the schema which is accessed, which allows any automatic tendency to expect the worst to be circumvented.

In an attempt to build on the findings cited above MacLeod et al. (1986) investigated the relationship between anxiety and the deployment of information processing resources. They postulate two explanations for previous results: either (a) clinically anxious individuals process innocuous information to the same degree as non-anxious people, but become emotionally aroused by the threatening material and are less able to attend to other tasks; or (b) threat related material attracts more attention from anxious individuals making fewer processing resources available for other tasks. The latter explanation suggests the presence of an attentional bias.

The results indicate that anxious subjects shift their attention *toward* threatening material, while non-anxious subjects shift their attention *away* from the same cues. On the basis of this and prior observations, MacLeod et al. (1986) propose that non-anxious individuals screen out potentially threatening environmental cues until they reach some intensity or threshold above which some form of action is prudent and adaptive. In contrast, anxious subjects show no sign of such a threshold and are thus rendered overly susceptible to environmental stress.

The observation that anxious individuals direct attentional resources toward threatening cues also provides some insight into the way anxiety states escalate and are maintained. Because ambiguous threat cues are readily apparent in the environment an

individual with negative expectations is able to have those expectations rapidly confirmed by the selective processing and misinterpretation of benign cues (such as an idle remark by a friend or a novel bodily sensation). The perception of threat will result in an increase in physiological and cognitive arousal which will serve to confirm the individuals feeling of vulnerability, resulting in further increases in arousal and so on. The counselling environment is full of ambiguous cues which can either be interpreted in a a benign or threatening manner. For instance, if an anxious first time client views the counsellors style as overly interrogative or judgemental they are likely to become even more distressed.

Mathews, Richards, & Eysenck (1989) found additional support for the view that anxious individuals process threatening information in a different manner to normals. When asked to spell potentially threatening homophones, anxious subjects more readily used threatening spellings than did controls. For instance, an anxious individual was more likely to interpret the aural presentation of the word "dye" in a threatening way and spell it "die".

One issue that previous research efforts have failed to clarify regards whether the observed attentional-bias is predominantly attributable to state or trait influences. This prompted MacLeod and Mathews (1988) to conduct a study which permitted a degree of control of those variables. They assessed the pattern of attentional response to threatening cues displayed by high- and low- trait anxious subjects (medical students) when state anxiety was low (twelve weeks before exams) and again when it was high (one week before exams). The authors conclude that the previously observed attentional bias can not be wholly attributed to either enduring individual differences in information processing style (trait variables) or current mood state (state anxiety). Instead they suggest that trait variables will interact with current state to determine attentional response to threatening stimuli.

3.6 The relative influence of trait vs. state variables in the allocation of attentional resources

Because the attentional bias model has been developed to explain the etiology of generalised anxiety states, most researchers in this area assert that the preferential processing of threat cues in the environment is attributable to a static personality characteristic. However, the findings of the studies cited above suggest an interactive relationship between trait variables and situational influences. In order to clarify the relative influence of both factors, Mathews, May, Mogg, and Eysenck (1990) completed a study which permitted the delineation of both trait and state influences in the manifestation of clinical anxiety.

Mathews et al. (1990) examined the performance of currently anxious, recovered and control subjects on tasks that required either selective search of threatening and benign cues, or focussed attention. The results led the authors to conclude that the previously observed differences in task performance for anxious subjects is contingent on whether the subject is instructed to focus attention on a specific point, or whether they are required to engage in selective search behaviour. It was observed that, when attentional focus had been established, the presence of distractors of any kind did not impair task performance for any of the participants. In contrast, when selective search was required, and salient distractors were present (both threatening and benign words such as: cemetery, hopeless, horizon, competent) currently anxious subjects were significantly slower at performing the experimental task.

When the influence of distractor valence and selective search was examined more closely, Mathews et al. (1990) noted that the presence of distractor's of **any** type correlated with reduced performance for currently anxious subjects. However, the presence of **threatening** distractors caused an increase in response latency for both currently anxious **and** recovered subjects. Therefore, the results indicate that: (a) currently anxious subjects are more distractable than both recovered and control subjects, irrespective of the valence of the distractor (threatening versus non-threatening); and (b) recovered subjects are more distracted by threatening cues than control subjects.

Mathews et al. (1990) suggest that their findings present strong support for the presence of an enduring cognitive trait which renders certain individual's more susceptible to environmental stress. The suggested consequences of this trait are that either: (a) the individual adopts a vigilant perceptual mode which causes them to preferentially scan for threat cues; or (b) when scanning, they are unable to screen out threatening cues. Further support for this comes from the work of MacLeod and Mathews (1988) mentioned previously which concluded that the state anxiety attenuates the emission of the dominant response to stress. Hence, high-trait anxious individuals will direct their attention threat cues that reflect their dominant concern (e.g. impending exams) while those who are low trait anxious will direct their attention away from the same cues.

However in Mathews et al.'s (1990) study, although their was a correlation between trait anxiety scores and the allocation of attentional resources to threat cues, there was **no** significant difference in the trait anxiety scores displayed by the recovered subjects and those in the control group. This weakens the proposition that the attentional bias is attributable to a static personality trait and indicates that the development of the theory is still in a state of flux. Therefore, by including the

attentional-bias model in the current work it is possible to investigate the relationship between trait anxiety and the preferential processing of threat cues in a clinical population which is not solely comprised of those diagnosed generalized anxiety disorder.

3.7 Integrating the attentional-bias and self-regulation models

Investigations using the attentional-bias model present a number of findings which can be used to amplify our understanding of self-regulation theory. For instance, Mathews et al. (1990) found that when subjects were told where a target cue was to appear, the presence of distractors outside of the focal area did not impair task performance for any of the groups. It seems plausible to argue that preoperative preparation has a similar effect, that is, it provides the individual with a focus and thereby minimises the intrusion of threatening cues. Thus, preparation prevents the individual from engaging in selective search and as a result, those who would preferentially scan for threat cues will be discouraged from doing so. It could also be argued that preparing clients for psychotherapy has an equivalent effect, that is, the client is informed of the important aspects of the experience and the presence of any threatening cues is downplayed.

The observation that state anxiety correlates with a reduced capacity to screen out threatening stimuli also points to the therapeutic importance of facilitating the non-threatening interpretation of an event. Mathews et al. (1990) noted that **any** elevation in current emotional state correlated with increased sensitivity to the presence of threat cues and resulted in a subsequent drain on information processing resources. Thus, the benefits of facilitating the benign interpretation of environmental events appear to lie with the mitigation of the anxious response to threat. This mitigation of the anxious response will then help minimise the cognitive impairment that accompanies autonomic arousal. In practical terms this may mean that ensuring the non-threatening interpretation of an event allows the individual to remain calm and therefore attend to and absorb the advice provided by the clinical psychologist, counsellor, or medical professional.

Further support for the integration of the attentional-bias and self-regulation paradigms is found in a view posited by Howard Tinsley (personal communication with Martin Heesacker, June 10, 1986, cited in Heesacker & Heppner, 1988). He suggests that people who hold pessimistic expectations regarding therapy can have their expectations rapidly confirmed "...presumably through a process of biased scanning and memory" (p.10) and as a result terminate therapy prematurely. The links between this view and the attentional-bias model are striking and provide additional support for the introduction of this model to the study of counselling client behaviour. Therefore in

the terminology of the attentional-bias and self-regulation models: clients who enter counselling with negative expectations and then preferentially interpret ambiguous environmental cues in a threatening manner may cope by terminating prematurely. Preparation may prevent this by modifying the individuals negative expectations and focussing attention thereby preventing selective search for threat cues.

3.8 Summary

The attentional-bias model provides an explanation of the ways in which focussing on the negative aspects of an experience can give rise to increased anxiety and impaired cognitive performance. It suggests that anxiety-prone individuals are characterised by a predisposition to direct attentional resources toward threatening cues in the environment (MacLeod & Mathews, 1988; Mathews et al., 1990). In contrast, non-anxious individuals tend to direct attentional resources away from threat cues until they reach a certain threshold above which some form of action is prudent and adaptive (MacLeod & Mathews, 1988). It appears that the expression of this attentional bias can be minimised if the individual's attention is focussed, however, when selective search is required the anxiety-prone individual's attention will be captured by threat cues. Research in this area also indicates that elevated levels of **state** anxiety will lead to greater distractability and will cause increased sensitivity to emotional stimuli. It remains for the current study to ascertain whether the laboratory based findings of MacLeod, Mathews, and colleagues can be used to expand our understanding of counselling client behaviour.

CHAPTER FOUR

Recapitulation and Hypotheses

4.1 Recapitulation

The pretherapeutic expectations of counselling clients have received considerable research attention over the past four decades. Investigators have explored the interrelationships between client expectations and: gender; ethnicity; service utilisation; adherence to treatment; and therapeutic outcome. However, the advance of applied research has occurred in the absence of theory, resulting in the emergence of an equivocal body of knowledge which adds little to our understanding of the **specific** ways client expectations impinge on counselling process and outcome.

The current study introduces two information processing paradigms which have been combined to form a model of counselling client behaviour. These are: Self-regulation theory (Leventhal & Johnson, 1983) which has been developed to account for the effects of preparatory information on coping with stressful medical procedures; and Mathews and MacLeod's (1985) Attentional-bias model which has been used to explain the etiology of pathological anxiety states. The main aim of the current study is to clarify the role that the valence of client expectations plays in determining anxiety states before and after the first counselling session, with specific emphasis on challenging the spurious assumption that inaccurate client expectations automatically have a deleterious effect on the counselling process.

Support for the view that the affective valence of a client's expectations is more important than mere accuracy in determining a desirable outcome can be found in the medical, experimental, and counselling psychology literature. For instance, the work of Leventhal, Johnson, and colleagues indicates that the interpretation of an impending stressful event in non-threatening terms is of greater therapeutic value than the formation of accurate, but threatening expectations. Similarly, the work of Mathews, MacLeod, and associates indicates that some individuals, when faced with a novel situation, will exhibit an increase in state anxiety due to the preferential processing of ambiguous or threatening environmental cues.

Although much of the literature reported in Chapter One draws attention to the over-emphasis on the congruency hypothesis, acknowledgement of the influence of positive and negative expectations on the counselling process is not idiosyncratic to the current study. Ziemelis (1974) examined the effects of manipulating the valence of client expectancies prior to entering the initial interview. Client preferences for counsellor characteristics were assessed following which subjects underwent either a positive, negative, or nonexistent expectancy induction. The results revealed that positive or no expectancy inductions had similar favourable effects on client

evaluation's of the counselling experience, whereas negative inductions generally led to poor evaluations of the encounter. This observation prompted Ziemelis to suggest that "...preventing client's from establishing negative expectations about their counsellor may be more important than arousing positive expectations." (p.29).

The finding that the presence of negative expectations has a detrimental effect on quality assessments of the therapeutic encounter is consistent with the predictions made by the two models used in the current study. The results substantiate the view that fostering benign or positive expectations about counselling is desirable. However, before stating the experimental hypotheses it is important that the terms to be used in the current study are clarified. This practice is encouraged by several authors who note that semantic problems and the use of ambiguous definitions have reduced the value of previous work in this area (Ziemelis, 1974; Duckro et al., 1979; Tinsley et al., 1988).

4.2 Clarifying terms

As Tinsley et al. (1988) point out, it is imperative that the terminology used in any study of expectations about counselling is clearly defined at the outset. For instance, the problem of some authors using the terms expectation and preference interchangeably has contributed, in part, to the ambiguous findings that have been reported in the literature. Also the use of a word in the vernacular can have a markedly different meaning when introduced in a scientific context.

The current study draws it's definition of "expectations" from the work of Grantham and Gordon (1986). They suggest that an individual will process and assimilate environmental cues in order to generate a mental picture (a schema) of any anticipated event. The outcome of this process is an expectation: "...a configuration of anticipated characteristics unique to that situation and that individual" (p. 397). Other authors have adopted similar definitions which emphasise that an expectation reflects the subjective assessment of the likelihood of an event, regardless of whether the event is preferred or otherwise (eg. Tinsley et al., 1988; Ziemelis, 1974).

The definition of anxiety adopted in the current study is taken from the work of Spielberger (1983). In this conceptualisation, the cognitive and physiological components of anxiety states include: subjective feelings of tension, nervousness, worry, apprehension, and arousal of the autonomic nervous system. Spielberger's view of anxiety also differentiates between: (a) state anxiety, which represents the response to identifiable stressors present in the individual's environment at any given time; and (b) trait anxiety, which refers to the stable personality characteristics that determine the degree to which state anxiety ie elevated in the presence of a stressor. Hence, **trait** anxiety values are seen as an indication of an individual's disposition to react to stressful situations with varying levels of **state** anxiety.

Defining confirmation and disconfirmation of client expectations is complicated by the fact that allowances must be made for the **degree** to which the client's expectations are congruent with what is experienced. It is logical to assume that the magnitude of any discrepancy will influence the severity of the individual's reaction, therefore this factor must be taken into account when making predictions about the effects of disconfirmation of expectations. Helson (1964) presents a bipolar hypothesis which deals with this issue. It is suggested that, for expectations with an affective component, the consequences of disconfirmation emerge as a function of the direction, as well as the magnitude of the discrepancy. Therefore, if the individual's experience is more desirable than what was expected, the result will be positive affect and approach motivation. In addition to this, Helson predicted that the greater the discrepancy between the actual experience and the expectation, the more intense the positive or negative reaction. In acknowledgement of this, the current study takes note of both the magnitude and the direction of any change in client expectations. A conscious effort has been made to address all of the above issues in the formulation of the following hypotheses.

4.3 Hypotheses

1. Increases in post-session state anxiety following disconfirmation will be moderated by the affective valence of pre-session expectations.

This hypothesis represents a direct challenge to the widespread assumption that the disconfirmation of client expectations inevitably has a deleterious effect on the counselling process (the congruency hypothesis). In addition to examining the influence of the valence of client expectations, attention is also paid to the magnitude and direction of any discrepancy between what was expected and what was experienced by the client. Helson's (1964) bipolar hypothesis suggests that any negative effects of disconfirmation will be affected by whether the actual experience was more or less desirable than what was expected. In support of this concept, Duckro et al. (1979) note that it is too simplistic to only ask whether the client's expectations were confirmed or disconfirmed, one must also ascertain whether the person wanted what he or she expected. If *hypothesis 1* is supported, the degree of confirmation and the positiveness of the client's expectations should interact to produce changes in post-session state anxiety.

2. Clients who have their negative expectations confirmed will experience greater state anxiety at the completion of the initial counselling session than clients who experience the confirmation of positive expectations.

Self-regulation theory predicts that adopting a benign cognitive representation of an impending event will result in low state anxiety. Because the individual does not

construe the situation in threatening terms they will not display the autonomic and cognitive arousal that accompanies the subjective impression of vulnerability experienced by someone with negative expectations. Thus, although it is likely that the individual will experience some anticipatory arousal, the confirmation of their positive expectations should lead to an overall reduction in state anxiety by the end of the session. Observing this pattern would support Leventhal's (in Leventhal & Johnson, 1983) *habituation hypothesis* where the confirmation of a non-threatening schema will lead to the novel situation losing it's activating power. Also, the presence of accurate positive expectations will prevent the individual from linking the current experience with aversive memories which will be associated with negative emotions.

The likely effects of experiencing confirmation of negative expectations are best described in terms of the attentional bias model. The individual who enters the counselling session with negative expectations (an active danger schema) will be primed to attend to threatening cues that are present in that situation. The preferential processing of threatening cues will then lead to a narrowing of the client's perceptual field and will result in a feed-forward cycle where cognitive and autonomic arousal (the correlates of anxiety) will spiral upwards in intensity. Tinsley (1986, cited in Heesacker & Heppner, 1988) alludes to this process when he suggests that confirmation of a negative expectation will occur more rapidly than disconfirmation of a positive expectation because of a memory and processing bias which favours negative information. Therefore, the presence of this bias should be reflected in elevated levels of post-session state anxiety for clients who have their negative expectations confirmed.

3. There will be a positive correlation between negative pretherapeutic expectations and trait anxiety.

This represents an exploratory hypothesis which seeks to clarify the ambiguous observations made by MacLeod and Mathews (1988) and Mathews et al. (1990). MacLeod and Mathews found that high **trait**-anxious medical students directed their attention **toward** threatening material, whereas those who displayed low-**trait** anxiety directed their attention away. Similarly, Mathews et al. found that there was a correlation between trait anxiety and the preferential processing of threat cues. However, if the predisposition to attend to threat cues is an enduring cognitive characteristic of those vulnerable to anxiety disorders, the trait anxiety scores of those who were experiencing generalised anxiety disorder and those who had recovered would be comparable. Mathews et al. failed to observe such a relationship, instead the trait anxiety scores of the recovered group were more comparable to those of the control group who had never been diagnosed as being pathologically anxious. Therefore, *hypothesis 3* seeks to clarify the relationship between trait anxiety and attention to negative cues in the counselling environment. If the preferential processing of threat

cues is attributable to the influence of an enduring cognitive characteristic, there should be a positive correlation between trait anxiety scores and negative expectations.

4. Clients who have their negative expectations confirmed will fail to keep their next scheduled appointment more often than other groups.

In an extensive, and often cited review, Baekeland and Lundwall (1975) conclude that the discrepant expectations will promote dropping out of treatment. More recently, Hardin et al. (1988) failed to find a significant difference in the expectations of premature terminators versus those who ended treatment at a mutually agreed point. Tinsley (1986, cited in Heesacker & Heppner, 1988) implicates the confirmation of negative expectations in the premature termination of treatment. He suggested that such confirmation will increase the likelihood that the therapeutic situation will gain aversive properties and will prompt an avoidance reaction which will be reflected in early disengagement from therapy. This may be expressed in either of two ways: (a) psychological disengagement, characterised by an unwillingness to make changes and a general reluctance to participate fully in the therapeutic process; or, (b) physical disengagement which will be expressed in the premature termination of treatment. As the design and focus of the current study precludes the examination of psychological disengagement, it is only possible to investigate the relationship between negative expectations and premature termination of treatment. For this hypothesis to be supported, those who display negative expectations which are subsequently confirmed will drop out of treatment at a higher rate than other client groups.

5. There will be no significant difference between pre- and post-session levels of state anxiety for clients whose negative expectations are disconfirmed.

This exploratory hypothesis tests whether the negative consequences of having a schema disconfirmed are cancelled out by having a more desirable experience. Self-regulation theory predicts that a lack of congruency between what the client expected and what they experienced will result in **increased** anxiety because they do not possess an appropriate schema to guide their behaviour. In contrast, the attentional-bias model predicts a **decrease** in state anxiety because the disconfirmation of negative expectations will truncate the feed-forward cycle which accompanies the preferential processing of threat cues. A lack of prior research makes it impossible to infer the relative influence of these two processes, hence the suggestion that they will cancel each other.

CHAPTER FIVE

Method

5.1 Subjects

Participants in the current study were first-time student clients at the Massey University Student Counselling Service between the 29th of July and 11th of December 1991. This service provides free psychological counselling, vocational guidance, and help with study problems to individuals who have paid a health service levy as part of their university fees. Involvement in the study was voluntary, and receiving treatment was not contingent on participation.

Of the 39 participants, 22 (57%) were female and 17 (43%) were male, with an age range of 17 to 40 years. Reasons for referral fell into the following categories: (a) Personal-Social-Emotional problems (n = 31); (b) study problems (n = 2); (c) vocational guidance (n = 2); and (d) other, e.g. impaired performance, aegrotat assessment (n = 4). Chi square analyses indicate that there was no significant difference between those who participated in the data collection and those who did not, in terms of both gender (X^2 (1) = 0.21, $p < .05$), and age (X^2 (3) = 2.53, $p < .05$). However, a significant difference was observed for problem type. Of the research sample, 10% referred for miscellaneous reasons (e.g. impaired performance assessments) while in contrast, 38% of non-participants fell into this category. This may indicate that clients with non-psychological problems felt that it was not appropriate for them to take part in the study. Hence, participants in the current study were representative of the greater population of first time clients who attended for help with **psychological** difficulties.

5.2 Instruments

In order to avoid the methodological problems which have devalued previous research efforts, the instruments employed in the current study were chosen because of their widespread use and sound psychometric properties. However, this need for empirical vigour was balanced against the desire to maximise subject participation by keeping the questionnaire as short as possible. Hence, the short form of the EAC (53 items) was used in favour of the brief form (66 items). In addition to this, the short form of the was selected as it has been identified by both Hardin et al. (1988) and Prospero (1987) as a possible measure of global positive or negative set toward counselling.

Data collection involved the administration of two questionnaires: Questionnaire 1 (see Appendix A) which was given to participants before they entered the first session; and Questionnaire 2 (see Appendix B) which was completed

immediately after the first session. The instruments used to construct the questionnaires are outlined in table 5.1.

Table 5.1: *Instruments used to measure experimental constructs*

Construct	Instrument
Expectations	Expectations About Counseling questionnaire - short form (EAC)
State anxiety	State-Trait Anxiety Inventory - Version Y, state scale (STAI-Y1)
	7-item Situation-Response Inventory of Anxiousness (SR7)
Trait anxiety	State-Trait Anxiety Inventory - Version Y, trait scale (STAI-Y2)

5.3 Expectations About Counseling questionnaire (EAC)

The short form of the Expectations About Counseling questionnaire (EAC; Tinsley et al., 1980) was used as one of the main dependent measures in the current study. This 53-item instrument has been derived from Tinsley et al.'s original factor analysis which yielded the full 135-item EAC. The original scale was formulated in order to encourage the systematic study of expectations about counselling using a psychometrically robust instrument. Prior to this, researchers tended to develop specific scales which were only pertinent to the study in question, hence generalisation to other situations and comparison with other work was complicated, if not impossible.

The 53-item short form of the EAC comprises 17 distinct scales identified for their ability to tap various expectancies about: client attitudes and behaviours (Responsibility, Motivation, and Openness); counsellor attitudes and behaviours (Acceptance, Confrontation, Genuineness, Directiveness, Empathy, Self-Disclosure, and Nurturance); characteristics of the counsellor (Attractiveness, Expertise, Trustworthiness, and Tolerance); and, process and outcome characteristics (Immediacy, Concreteness, and Outcome). For example, the statement: "I expect to feel safe enough with the counsellor to say how I really feel." is one of three items which make up the "Openness" subscale (see Appendix C for a full summary of the items comprising each subscale). The item stems used ("I expect to..." or "I expect the counsellor to...") are printed at the top of each page and subject responses are recorded using a 7-point Likert type scale ranging from *Not true* (1) to *Definitely true* (7).

After conducting a study which explored the cognitions prompted by the EAC-B, Tinsley and Westcot (1990) concluded that the scale displays construct validity. In addition to finding that the items comprising the EAC-B elicited statements about expectations 70% of the time, the authors note that it was the sixth most frequently used

research instrument across all topic areas reported in the Journal of Counselling Psychology between 1982-85 (Pipes & Stratton, 1986, cited in Tinsley & Westcot, 1990). Thus, the EAC represents a well conceived and widely used instrument which has maintained a reputation as a useful research tool for the past decade.

Psychometric Properties of the EAC

The long form of the EAC was constructed so as to maximise convergent and discriminant item validities. Reported internal consistency coefficients and scale reliability scores range from .70 to .85, and .77 to .89 respectively. Also, factor analysis yielded four major scale factors: personal commitment, facilitative conditions, counsellor expertise, and nurturance (Tinsley et al., 1980).

Scale reliability data for the short form of the EAC range from .69 for counsellor directiveness to .82 for counsellor confrontation (Tinsley, 1981, cited in Hardin et al., 1988). In addition to this, the brief scales have been found to correlate well with those of the long form (.78 to .95) and are more highly related to external validity criteria (Washington & Tinsley, 1982, cited in Hardin et al., 1988). However, the current study is not primarily concerned with the ability of the short form of the EAC to measure discrete client expectations, rather, it is Prospero's (1987) suggestion that it assesses global positive or negative cognitive set toward counselling that is of most interest.

The EAC as a measure of global positive or negative attitudes toward counselling

A basic premise underlying the development of the EAC was that the seventeen scales tapped distinct, independent client expectations. However, Harden et al. (1988) cite the findings of a doctoral study carried out by Prospero (1987) which observed "moderately high" intercorrelations among the subscales at pretest. This led to speculation that a response bias was operating whereby subjects completing the short form of the EAC tended to respond in either a consistently positive (high scores) or consistently negative (low scores) manner. Prospero went on to suggest that the EAC may actually measure global positive or negative attitudes toward counselling, rather than discrete client expectations. Given that the current study is concerned with examining the influence of the valence of client expectations on anxiety about counselling, the possibility that the EAC may measure this construct appeared promising. However, a preliminary assessment of the characteristics of both the EAC items and response format raised questions about the validity of Prospero's interpretation.

It is clear that adopting Prospero's (1987) suggested interpretation of the EAC would be expedient when executing any data analysis, however, the justification for

this approach was not clear from Hardin et al.'s (1988) citation. It was decided that the consequences of viewing high and low scores as indicating negative and positive expectations respectively required closer attention. Obtaining a copy of Prospero's original work revealed that the conceptual development necessary to support the interpretation was lacking. This unexpected finding added another dimension to the current research which was not envisaged at the outset. It became necessary to expand the focus of the work and investigate the utility of the EAC as a measure of positive and negative expectations about counselling.

In order to determine which of the 53 items comprising the short form of the EAC reflected the presence of positive, negative or neutral ratings, a third questionnaire (Questionnaire 3, Appendix D) was complied and given to a group of independent raters (n = 15). The raters were clients from the counselling centre who had not participated in the main data collection, students, and academics. Questionnaire 3 used exactly the same items as the short form of the EAC but instead of responding "not true" (1) to "definitely true" (7), the raters indicated whether they thought the individual items reflected the presence of a "positive" (P), "neutral" (O), or "negative" (N) expectation. The outcome of this rating process is detailed in section 6.3.

5.4 State-Trait Anxiety Inventory - Version Y (STAI-Y)

Spielberger's (1983) State-Trait Anxiety Inventory-Version Y was chosen as the main dependent measure of state and trait anxiety in the current study due to both it's sound psychometric properties and widespread use in a variety of research settings. The STAI-Y is a revision of Spielberger's (1973) original instrument (known as the STAI-Version X) which has been used in over 3000 studies, including investigations in: psychology, psychiatry, medicine, dentistry, sports competition, and education (Spielberger & Krasner, 1988). The purpose of the revision was threefold. Firstly, there was a need to enhance the ability of the scale to discriminate between anxiety and depression (Knight, Waal-Manning, & Spears, 1983); secondly, a number of the items were "psychometrically weak" and therefore needed to be replaced; and thirdly, the factor structure of the trait scale needed to be balanced so that parity was gained between the anxiety-present versus anxiety-absent items (Spielberger, 1983).

In the context of the STAI-Y, state anxiety (A-State) is viewed as a transitory emotional state characterised by subjective feelings of tension and apprehension. Because these states fluctuate in intensity over time, subject's completing the state scale are asked to indicate how they feel *at that moment* (e.g., "I feel calm"; "I am jittery"). Trait anxiety refers to the individual's tendency to respond to threatening situations with elevated levels of state anxiety. Hence, when completing the trait scale of the STAI-Y, respondents are instructed to indicate how they *generally* feel by marking the frequency

with which each of the statements applies to them (e.g. "I am a steady person": almost never, sometimes, often, almost always)[1].

Psychometric Properties of the STAI-Y

Normative data for the STAI-Y has been collected for a number of groups including: high school and college students; working adults; military recruits; psychiatric, medical and surgical patients, and prison inmates (Spielberger & Krasner, 1988). The Y-version has been found to be highly correlated with the STAI-X with coefficients between .96 and .98 being observed for high school and college students.

Spielberger (1983) reports test-retest reliability correlation coefficients between .34 and .62 for the state scale (STAI-Y1) based on a sample of 357 high school students. When the state scale from version X was used, this value dropped to as low as .16. However, due to the transient nature of state anxiety, these variations can be attributed to the natural fluctuations of A-State over time resulting from the interaction between the person and situational stress (Anastasi, 1988). The alpha coefficients calculated for large samples (from 71 to 1,893) of college students, military recruits, and working adults were all above .90, with only male high school students returning a value of .86 (Spielberger, 1983). Hence, there is strong support for the internal consistency of the scale.

Test-retest reliability correlation coefficients from .65 to .75 were observed for high school students completing the trait scale at 30 and 60 days. Thus, given that trait scale scores are supposed to reflect stable personality characteristics, the observed coefficients indicate adequate stability of the scale (Spielberger, 1983). As with the state scale, the internal consistency of the trait scale was supported by the presence of alpha coefficients ranging from .89 to .91 for working adults, high school and college students, and military recruits.

The construct validity of both the state and trait scales has been demonstrated in a number of ways, including original item selection, the method of contrasted groups, and the evaluation of the effects of experimental manipulations designed to raise or lower anxiety (e.g. seeing a film depicting accidents in a woodworking shop; undergoing ten-minutes of relaxation training). The ability of the trait scale to differentiate between clinical and non-clinical groups was noted by Spielberger (1983) who found that the trait scale scores for neuropsychiatric patients were substantially higher in comparison to "normal" subjects. Also, support for the construct validity of the STAI-Y1 was found when the state scale scores of military recruits undergoing

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[1] Due to an administrative error which occurred during the compilation of questionnaires 1 and 2, the anchors used on the trait scale were the same as those used on the state scale (i.e. Not at all; Somewhat; Moderately so; Very much so), thus the validity of the trait scale as presented in the current study is unknown. (See section 6.5).

stressful training were found to be higher than those of high school students of the same age who were tested in less stressful conditions.

5.5 The 7 item Situation-Response Inventory of Anxiousness (SR7)

The SR7 is a brief, situation specific state anxiety measure formulated by Deane, Spicer, and Leathem (1991) to tap the physiological and avoidance aspects of state anxiety. The rationale for developing such a measure stems from the observation that although the STAI-Y assesses the cognitive-worry aspects of anxiety satisfactorily, it appears to lack items which address the physiological symptoms that typically accompany elevations in state anxiety. Also, there is a need to differentiate between heightened state anxiety attributable to worry about "the problem" versus anxiety due to the specific situation. Hence the instructions of the SR7 make it clear that subjects are to indicate how they feel about seeing a "counselling psychologist". Finally, the observation that treatment avoidance and premature termination of treatment are associated with anxiety suggests the need to investigate the avoidance aspect of elevations in A-State (e.g. Heesacker & Heppner, 1988; Kushner & Sher, 1989).

Deane et al. (1991) derived the SR7 from the S-R Inventory of Anxiousness-Form O developed by Endler, Hunt, and Rosenstein (1962, cited in Deane et al, 1991). A factor analysis of the original scale (by Endler et al.) yielded seven response modes, the strongest of which comprised Factor 1, referred to as "distress-disruption-avoidance". These items were then used to form the basis of the SR7: 1. Heart beats faster; 2. Get an "uneasy feeling"; 3. Emotions disrupt action; 4. Become immobilised; 5. Want to avoid situation; 6. Perspire; and, 7. Mouth gets dry. The response format consists of a 5 point Likert-type rating scale ranging from "not at all" (1) to "Very much" (5).

Cronbach alpha coefficients indicated high internal consistency for all of the scales with the state and trait scales of the STAI-Y recording .93, and the SR-7, .87. Also, moderate positive simple correlations were observed between the SR7 and the A-State scale ($r = .75$, $p < .001$), and A-Trait scale ($r = .56$, $p < .001$). The moderate to strong positive relationship between the SR7 and the A-State scale persisted when the effects of A-Trait were partialed out (partial $r = .51$, $p < .001$). In contrast, eliminating the effects of the A-State lead to a substantial drop in the strength of the relationship between the SR7 and the A-Trait scale (partial $r = .07$, $p > .05$). Finally, controlling for the effects of the SR7 did not markedly dilute the relationship between the A-State and A-Trait scales (partial $r = .61$, $p < .001$). On the basis of these findings, Deane et al. (1991) postulate that the SR7 successfully isolated situation specific aspects of state anxiety which are neglected by the STAI-Y. It is suggested that, because the STAI-Y does not clearly specify the situation to

respondents, scores observed on the A-State scale are contaminated by the influence of trait anxiety.

In conclusion, the decision to include the SR7 in the current study was influenced by the desire to augment the STAI-Y with a measure which assesses the physiological and avoidance components of state anxiety. This is particularly relevant to the testing of *hypothesis 4* which examines the role that expectations and anxiety play in avoidance of treatment. The brevity of the scale and the promising results from it's initial application meant that it offered an economical means of gathering additional data absent from the STAI-Y.

5.6 Measuring adherence to treatment

A simple measure of attendance was included in order to permit a preliminary exploration of the relationship between types of expectations, anxiety and adherence to treatment. The counsellor assigned to each participant in the study completed a short "Adherence Form" (see Appendix E) which recorded the client's problem type, whether a second appointment was scheduled, and if so, whether that appointment was kept. Heesacker and Heppner (1988) recommend counsellor input in the measurement of adherence to treatment because it is important to ascertain which clients terminate because they no longer need help versus those who terminate for other reasons. Measuring adherence based only on session numbers obscures this information.

5.7 Procedure

The soliciting of client participation and the administration of the questionnaires was carried out by the two secretaries employed at the Student Counselling Service. Once the procedures involved in getting to see a counsellor had been satisfactorily explained the client was asked if they would be willing to participate in a voluntary study which "looked at first time client's expectations about psychological counselling". If the client agreed to participate, the nature of the study was outlined further and an appointment time was made which allowed the client to arrive 30 minutes early. Those who made the initial contact in person were given a copy of the "Consent Form" (see appendix F) which outlined the study and defined what their participation would entail. Those who made their initial contact by telephone were simply asked to arrive at the service half an hour before their scheduled appointment time. In order to standardise the induction procedure as much as possible each secretary was provided with a copy of the instructional flowchart found in Appendix G.

Those clients who agreed to participate in the study and arrived at the centre half an hour before their scheduled appointment time were allocated a code number which was recorded on Questionnaire 1 and the Adherence Form. They were then asked to

sign the consent form and were given Questionnaire 1 to complete. They then entered their first session with the counsellor. The desire to carry out the research with a minimum of impact on the normal running of the service meant that if a client failed to arrive in sufficient time to complete Questionnaire 1 they were lost from the study.

Immediately after completing their first session with the counsellor, participants were given Questionnaire 2 to complete. If a client was unwilling to continue with the study the secretary indicated on Questionnaire 1 that Questionnaire 2 had not been completed and, where possible, a reason for this was given. Those who did complete the second part were thanked for their participation and were informed that they did not need to contribute anything more to the research.

The Adherence form was completed by the counsellor who indicated which of four categories best described the case (Personal-Social-Emotional; Study; Vocational; or Other) and they also indicated whether a second appointment was scheduled with that client. The gathering of this data permitted the testing of *hypothesis 4* and provided an indication how representative the experimental sample was of the first time client population. The Adherence form remained in the file, and if a second appointment had been scheduled the counsellor indicated whether or not it was kept. This information was then retrieved from the files at the end of the data collection period and the Adherence sheets were matched with Questionnaires 1 and 2 based on the client's code number.

5.7 Ethical considerations

The current study was conducted in accordance with the ethical guide-lines of the New Zealand Psychological Society (1985) and was approved by the Massey University Human Ethics Committee. The procedures established for the induction of participants and data collection were designed to maximise confidentiality through the use of code numbers on all written material except the consent form. The voluntary nature of the study was emphasised on the consent form and verbally reinforced by the secretaries. In addition to this, clients were assured that they could terminate their participation in the study at any point.

Appraisal by the Massey University Human Ethics Committee revealed that, because the present study incorporated a measure of the degree to which client expectations were met (pre- and post-session EAC scores), it was possible that this information could be construed as an indirect evaluation of counsellor expertise. Therefore, informed consent was obtained from the counselling staff as indicated on the Counsellor Consent Form (Appendix H). Also, it was not possible to tell from the written materials which counsellor the participants had been assigned to.

Finally, in order to minimise the impact of the current work on the delivery of treatment to the client, those who did not arrive in time to complete Questionnaire 1 before their appointment time were not requested to do so as this would have decreased the time that they spent with the counsellor.

5.8 Statistical Analyses

The statistical analyses were carried out using SPSS/PC (Norusis, 1988) and the techniques used were dictated by the focus of the specific hypotheses. For *hypothesis 1*, multiple regression was used to test the moderating effect of affective valence of client expectations on post-session state anxiety following confirmation or disconfirmation. Baron and Kenny (1986) advocate this approach when both the independent variable and moderator variable are continuous, as is the case here. Adopting this approach permitted the control of identified confounds (such as age and problem type) and the delineation of any main and interaction effects. *Hypothesis 2* examined whether there was a significant difference in post-session state anxiety scores for the two client groups who experienced confirmation of positive or negative expectations. Pre-session EAC scores were used to quantify valence of expectations, the numerical difference between the pre- and post-session EAC item-scores were used to assess confirmation, and mean post-session STAI scores were used to indicate state anxiety. The statistical technique employed to compare the means was one-way ANOVA.

The testing of *hypothesis 3* involved the calculation of simple correlations between trait anxiety and the affective valence of client expectations (as indicated by total pre-session EAC scores) in order to assess whether the "negativeness" of expectations increased concurrently with observed levels of trait anxiety. Chi square analysis with Yates correction (Glasnapp & Poggio, 1985) was used to test *hypothesis 4* which looked at attendance/non-attendance among clients who experienced the confirmation or disconfirmation of positive or negative expectations. Finally, paired t-tests were used to test *hypothesis 5* which examined whether there was a significant difference in post-session state anxiety scores for clients who experienced confirmation/disconfirmation of positive or negative expectations.

CHAPTER SIX

Results

6.1 An overview of the results

The results are divided into three main sections: (a) testing of *hypothesis 1*; (b) presentation of the ratings of the EAC items for positiveness, neutrality, and negativeness, and testing of hypotheses 2 to 5; and (c) supplementary analyses. *Hypothesis 1* is presented in isolation because, unlike the remaining hypotheses, it is primarily concerned with assessing the empirical rigour of the congruency hypothesis. Also, the testing of *hypothesis 1* did not depend on obtaining ratings of the EAC items for positiveness, neutrality, and negativeness.

Prior to analysis, the raw data set was examined for accuracy of data entry and missing values. Cases containing missing data were deleted listwise from subsequent calculations. Calculation of internal consistency reliabilities for the EAC yielded alpha coefficients ranging from .54 (for the concreteness subscale) to .88 (confrontation) with a median reliability of .78. These results compare favourably with the values observed in Tinsley et al.'s (1980) original calculations (.77 to .89) carried out on the full 135 item measure (Table A1 in Appendix I presents a complete summary of the values observed for the current work and Tinsley et al.'s original sample). For the present study only 3 of the 17 scales displayed alpha levels below .74, and of these only one (concreteness) was lower than .64. Therefore, the scales displayed sufficiently high internal consistency to allay any fears that the benefits of using the 53 item short form had been at the cost of it's psychometric integrity.

6.2 Hypothesis 1

Increases in post-session state anxiety following disconfirmation will be moderated by the affective valence of pretherapeutic expectations.

Hypothesis 1 expands on previous expectations research by accounting for the magnitude as well as the direction of any discrepancy between what was expected and what was experienced by the client. If *hypothesis 1* is supported, changes in post-session state anxiety will emerge as a function of an **interaction** between confirmation of expectations (the numerical difference between the pre- and post-session EAC item scores) and the valence of client expectations (pre-session EAC score). Support for the congruency hypothesis will be indicated by the presence of a main effect for confirmation on post-session state anxiety. In the first calculation, the measures of positiveness and confirmation were entered on the first step along with possible confounds identified in previous studies. These were: problem type (Tinsley et al.,

1984); gender (Hardin & Yanico, 1983); and age (Surgenor, 1985; Furnham & Wardley, 1990). However, because none of these proved to be influential they were excluded from subsequent analyses (adjusted $R^2 = -.07$, F (6,26) = .63, n.s).

Second, two regressions were conducted using post-session state anxiety (as measured by the STAI-Y1 and SR7) as the dependent variable with positiveness as the moderator, and confirmation as the independent variable. In order to control for main effects, confirmation and positiveness were entered on the first step of the calculation, with the interaction block (calculated as positiveness x confirmation) being entered at the second step. As Table 6.1 shows, neither positiveness nor confirmation predicted changes in post-session state anxiety (STAI-Y1: adjusted $R^2 = -.046$, F (2,31) = .26, n.s; SR7: adjR^2 = .019, F (2,31) = 1.33, n.s). However, the product term entered at the second step accounted for a significant amount of the observed variance (adjR^2 = .19, F (3,30) = 3.59, $p < .05$). This was considered strong preliminary evidence that confirmation and valence of pre-session expectations interact to influence post-session state anxiety.

Table 6.1: *Multiple regression of state anxiety on positiveness and confirmation of expectations (n = 34).*

	STAI-Y1		SR7	
Step/variable	adjusted R^2	F	adjusted R^2	F
1. Positiveness (P) Confirmation (C)	-.046	.26	.019	1.33
2. P x C	.191	3.59*	0.11	2.36**

Notes. STAI-Y1: State-Trait Anxiety Inventory - Version Y, State scale; SR7: 7-item Situation-Response Inventory of Anxiousness. ** $p < .01$; * $p < .05$

To test whether the observed interaction was linear, quadratic terms were computed for the moderating variable (positiveness x positiveness) independent variable (confirmation x confirmation), and interaction term (confirmation^2 x positiveness^2). The moderating and independent variables were entered on the second step of the regression, and the interaction term was added at the third step. The subsequent results did not support the presence of a quadratic relationship and therefore this line of investigation was terminated.

In order break down the specific nature of the interaction between positiveness and confirmation on post-session state anxiety, a median split was used to differentiate clients who displayed positive versus negative expectations. Figure 6.1 depicts changes in post-session state anxiety as a function of confirmation for clients with

negative versus positive expectations. As expected, greater levels of confirmation of positive expectations led to a significant reduction in post-session state anxiety ($adjR^2$ = .19, F (1,14) = 4.67, $p < .05$). The pattern observed for clients with negative expectations also followed the suggested path, with high and low confirmation only resulting in minor changes in state anxiety. However, this relationship was not significant ($adjR^2$ = -.01, F (1,16) = .79, n.s.).

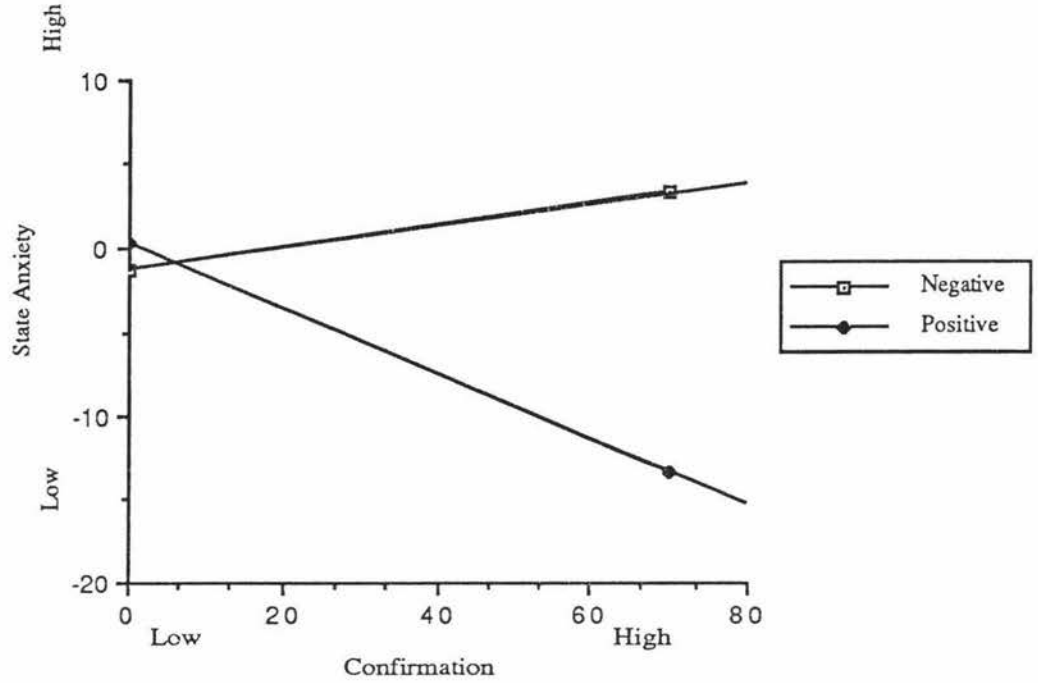

Figure 6.1: Changes in post-session state anxiety as a function of confirmation of low-positive and high-positive expectations.

6.3 *Defining positive, neutral and negative expectations*

A preliminary examination of the EAC items and response format raised doubts about the validity of Prospero's (1987) view that treats high and low scores as indicating positive and negative expectations respectively. To investigate this more fully it was decided to use independent ratings to distinguish those items which were positive from those which were negative or neutral. Table 6.2 presents those items which were considered **positive** by more than 73% of the 15 raters (ratings of all of the items are listed on Table A2, Appendix I) This level of agreement was chosen as the cut-off point as it allowed for almost half (47%) of the 53 items to be included in the final set of "positive" expectations.

Identifying those items which were neutral or negative proved to be more difficult. Only 6 items (11, 37, 42, 45, 46, and 53) were considered to be **neutral** by over half of the raters, with agreement ranging from 53 to 60%. Even greater difficulty was encountered when trying to isolate items which the majority viewed as **negative**. Fifty-three percent of the raters considered item 23 ("I expect the counsellor to tell me what to do") to be negative while 33% considered it to be neutral, and 13% (two people) rated it as positive. Similarly, item 32 ("I expect the counsellor to frequently

offer me advice") was labelled negative by 46% of the raters, but the same number of people indicated that they considered it to be a neutral expectation. No other items were rated negative by more than half the raters and therefore were considered too unstable to be used. Hence, only 2 possible negative items were identified by the rating process.

Table 6.2: *Percentage agreement by 15 raters for positive items from the short form of the EAC.*

Item	% agreement	Item	% agreement
9	100	22	80
16	100	26	80
18	100	31	80
2	93	34	80
17	93	41	80
27	93	6	78
3	86	8	73
4	86	13	73
25	86	15	73
33	86	35	73
1	80	38	73
5	80	48	73
19	80		

Notes. See Appendix A for specific items

Because only 15 raters were used, the possibility that a small sample size contributed to the equivocal results was examined. A preliminary analysis was carried out using only those 6 items for which there was more than 93% agreement for "positiveness". However, the use of those items to predict levels of pre-session state anxiety proved to be less effective than when all 25 "positive" items were used. Hence, the initial testing of *hypothesis 2* used all of the 25 items which had achieved more than 73% rater agreement for positiveness. The remaining items which displayed low levels of rater agreement were temporarily discarded from the analyses.

6.4 Hypothesis 2

Clients who have their negative expectations confirmed will experience greater state anxiety at the completion of the initial counselling session than clients who experience the confirmation of positive expectations.

The methodological and conceptual implications of using the EAC to define the affective valence of client expectations were not fully apparent until placed in the context of *hypothesis 2*. In order to test the first part of this hypothesis, it was necessary to quantify "negative" expectations. However, because none of the 53 items displayed inter-rater agreement for negativeness of more than 54% it was decided to use

only those 25 items which had been identified as reflecting **positive** expectations. The issues that arose subsequent to this are discussed below.

The anchors used on the response scale for the EAC appeared to provide the key to the interpretation of the data. The possible item responses open to subjects ranged from not true (1), interpreted as a non-endorsement of the item, through to definitely true (7), which was considered to reflect a strongly held expectation. Response levels 2 through to 6 all appeared to reflect agreement with the item, but at varying intensities from slightly true (2), to very true (6). Hence, indicating not true (1) for a positive item could be considered to reflect a negative expectation. Therefore, all those clients who responded with a 1 to any of the 25 items were placed in the "negative expectations" group. Unfortunately, identifying clients' who displayed negative expectations based on these criteria was of no value as the process only yielded a negative expectations group of $n = 3$.

Hence, suspicions that the EAC, in it's present form, is not a robust measure of negative expectations about counselling were reinforced by this preliminary investigation of the data. This had implications for the remaining analyses as it became unclear whether recording a low score on a "positive" EAC item indicates the presence of a negative expectation, or a positive expectation of reduced intensity. Although this issue will not be completely resolved in the context of the current design, the outcome of the rating process indicates that it cannot be assumed that a person who returns a low total score on the EAC has negative expectations about counselling. Therefore, it may be most parsimonious to view the EAC as a measure of the **degree** of positiveness, rather than positive versus negative expectations.

This finding also raises doubts about the validity of continuing to use the terms "positive" versus "negative" expectations. An alternative would be to introduce the terms "low-positive" versus "high-positive" to describe low and high scores respectively. However, using these labels is bound to become confusing and hinder the communication of the results. Therefore, the readers attention is drawn to the fact that it can not be assumed that a low score on the EAC indicates negative expectations, but in the interests of clarity the "negative" label will be retained (section 7.7 deals with this issue in more depth).

At a methodological level, the absence of a "negativeness" subscale within the EAC necessitated the use of a median split of total EAC scores to differentiate between client groups. Also, it was decided to reintroduce all of the EAC variables to the analysis based on the observation of a very strong simple correlation ($r = .92$, $p < .001$) between the 25 "positive" items and the overall scale.

6.5 Re-testing hypothesis 2

To recapitulate, *hypothesis 2* examines whether clients who experience confirmation of negative expectations display more post-session state anxiety than those

who have their positive expectations confirmed. In order to delineate these groups, pre-session EAC scores were subjected to a median split with those who scored above the median falling into the positive expectations category. Completion of a univariate F-test indicated that there was no significant difference in the post-session state anxiety scores for both groups (F (1,16) = .001, p = .97).

Therefore, contrary to what was expected, differentiating between client's on the basis of EAC scores did not lead to the observation of different levels of post-session state anxiety. In fact, examination of the raw data indicated that there was no difference between the group means (both presented a mean score of 40).

6.5 Hypothesis 3

There will be a positive correlation between negative pretherapeutic expectations and trait anxiety.

As noted in section 5.4, due to an administrative error during the compilation of questionnaires 1 and 2, the validity of the STAI trait scale in the current study is unknown. In an attempt to ascertain the degree to which the trait scale had been corrupted, a simple correlation was performed between pretherapeutic state anxiety scores and trait anxiety scores for all participants. A moderate to strong positive correlation was observed (r = .58, p < .001) which is similar to that observed by Spielberger (1983) for female college students (r = .59) and male military recruits (r = .59). Therefore, there is some support for the validity of the trait scale as used in the current study. As a result of this it was decided to continue with the testing of *hypothesis 3*.

In the context of the attentional bias model, high levels of trait anxiety should increase the degree to which individuals report negative expectations (i.e. display active danger schemata). *Hypothesis 3* attempts to determine if this effect is noticeable in the counselling setting by examining whether negative pre-session expectations increase in tandem with levels of trait anxiety. For *hypothesis 3* to be supported there should be a negative correlation between trait anxiety and EAC values. This is because lower scores on the EAC indicate more negative expectations, and higher trait anxiety values indicate greater levels of trait anxiety. A simple correlation was performed for clients who displayed negative expectations (n = 19), and as expected, a negative correlation (r = -.40) was observed but this failed to reach significance.

Two conclusions can be drawn from this: either there is no relationship between trait anxiety and negative expectations; or a lack of power prevented the observation of a significant result. Given the low cell numbers (n = 19), and the moderate correlation, it seems that the second explanation is most appropriate in this case.

6.6 Hypothesis 4

Clients who have their negative expectations confirmed will fail to keep their next scheduled appointment more often than other groups.

Hypothesis 4 was prompted by the suggestion that confirmation of negative expectations will increase the likelihood of premature termination of treatment (Tinsley, 1986, cited in Heesacker & Heppner, 1988). To test this, median splits were used to allocate each client who had a second appointment scheduled to one of four subgroups: low- versus high-confirmation of positive or negative expectations. The groups were then examined to ascertain whether those who had their negative expectations confirmed at a high level displayed a higher non-attendance rate than the other groups.

Table 6.3: *Proportion of clients who failed to attend their next scheduled appointment by positiveness of expectations and degree of confirmation.*

	Expectations	
	Low positive	High positive
High confirmation	0 out of 5	1 out of 5
Low confirmation	2 out of 6	1 out of 4

Table 6.3 shows that, contrary to expectations, clients who had their low-positive expectations confirmed showed the lowest dropout rate (0 out of 5), while those who had their low-positive expectations disconfirmed dropped out at the highest rate (2 out of 6). In between were those who held high-positive expectations which were either confirmed (1 out of 5), or disconfirmed (1 out of 4). Chi square analysis with Yates correction revealed that there was no significant differences between the groups (X^2 (3) = 1.98, p = .58). Hence, the results did not provide any support for *hypothesis 4*.

6.7 Hypothesis 5

There will be no significant difference between pre- and post-session levels of state anxiety for clients whose negative expectations are disconfirmed.

Self-regulation theory suggests that an incompatibility between what is expected and what is experienced will lead to an increase in state anxiety which will persist until the individual forms an appropriate schema of the event. However, if an experience is **less** threatening than was expected it is logical to assume that relief and reduced state anxiety should follow. *Hypothesis 5* investigates whether the negative effects of having a schema disconfirmed are negated by the positive effects of having a more

desirable experience. In order to test this, a paired t-test was used to compare the pre- and post-session state anxiety scores for clients who had their negative expectations disconfirmed. The observation of a significant difference ($t = 5.21$, $df. = 16$, $p < .001$) indicated that *hypothesis 5* was not supported. The emergence of this unexpected finding prompted an expansion of the original focus to look at the pattern observed for the remaining groups.

Paired t-tests were calculated for those clients who experienced either the confirmation or disconfirmation of positive or negative expectations. Table 6.4 presents the pre- and post-session anxiety scores and *t-values* for all four groups. As mentioned above, there was a significant 32% reduction in state anxiety from pre- to post-session measurement for clients who had their negative expectations disconfirmed. The next greatest decrease was displayed by clients who had their positive expectations disconfirmed (26%), followed closely by the high confirmation of negative expectations group (25%). The smallest reduction was observed for those who displayed positive pre-session expectations which were subsequently confirmed at a high level (21%). However, it is not clear whether these decreases in post-session state anxiety are significantly different from each other.

Table 6.4: *Comparison of mean state anxiety scores at pre- and post-initial counselling session for clients for clients with confirmed or disconfirmed positive or negative expectations.*

	Pre-session state anxiety			Post-session state anxiety			
	M	SD	n	M	SD	n	t value
Disconfirmation of negative expectations	53.77	12.44	9	36.66	9.04	9	5.21****
Confirmation of negative expectations	52.88	15.95	9	39.77	12.12	9	3.37**
Disconfirmation of positive expectations	56.25	13.96	8	41.75	10.88	8	3.75***
Confirmation of positive expectations	50.87	9.37	8	40.00	11.71	8	2.38*

Notes The STAI-Y1 was used to measure state anxiety;
* $p < .05$; ** $p < .01$; *** $p < .005$; **** $p < .001$

In conclusion, the observation of a significant difference in pre- and post-session state anxiety for clients who had their negative expectations disconfirmed indicates that *hypothesis 5* was not supported. In fact all client's displayed a post-

session reduction in state anxiety regardless of whether they had their positive or negative expectations confirmed or disconfirmed.

6.8 Supplementary Analyses

The completion of analyses beyond the testing of the hypotheses serves several purposes: Firstly, calculation of Pearson correlation coefficients permits a comparison between the current work and that of Prospero (1987) who reported high intercorrelations among the EAC variables at pretest. Secondly, examining the scale scores in a manner more consistent with previous research provides scope for making cross-cultural comparisons, thus determining the extent to which certain expectations are idiosyncratic to specific client groups. In support of this, Yeun and Tinsley (1981) observed differences in the counselling expectations of African, North American, Iranian, and Chinese students attending a North American university. Finally, to the authors knowledge, the EAC has not yet been used to quantify the pre-counselling expectations of a New Zealand student sample. Therefore, in the context of clinical practice in New Zealand, it is useful to gain a preliminary impression of some of the expectations that first time clients may hold prior to entering therapy.

After observing high intercorrelations between the EAC variables at pretest Prospero (1987) suggested that a response bias was operating whereby clients were prone to respond in a consistently positive or negative manner. The calculation of Pearson correlation coefficients for the present sample yielded a comparable pattern to that observed by Prospero but with two notable differences. Firstly, where Prospero observed significant "moderate to high" positive correlations between the Directiveness subscale and all the other scales, the current study did not. Instead, the Expertness and Trustworthiness subscales displayed the highest number of significant correlations (9) with the remaining scales. Secondly, unlike Prospero, significant correlations were not observed between all subscales at pretest. Therefore, there was no support for Prospero's suggested response bias. Table A3 in Appendix I presents a full summary of the observed intercorrelations.

The following section deals with the specific types of expectations displayed by the clients in the present study and their similarity to those of a North American sample. Table 6.5 presents the mean pre-session EAC scale scores obtained in the current study and compares them with the values observed by Hardin et al. (1988) who administered the short form of the EAC to 80 clients attending a North American university counselling service.

The most obvious feature of the data is that the mean scale scores of the sample used in the current study were consistently below those reported by Hardin et al. (1988). Based on Hardin et al's criteria, the clients in the current work displayed generally high expectations (mean score = 6.13) for counsellor Genuineness (items 29, 33, and 41: I expect the counsellor to: be honest with me, be a "real" person not just a

person doing a job, and respect me as a person). Moderate expectations (ranging from 5.1 to 5.8) for: Openness (e.g. item 25: I expect to feel safe enough with the counsellor to say how I really feel); Responsibility (e.g. item 4: I expect to take responsibility for making my own decisions); Trustworthiness (e.g. item 48: I expect the counsellor to be someone I can really trust); Nurturance (e.g. item 43: I expect the counsellor to praise me when I show improvement); and quality of Outcome (e.g. item 9: I expect to get a better understanding of myself and others).

Table 6.5: *Comparison of means and standard deviations for EAC scales observed in the current study and by Hardin et al. (1988).*

	Present Study (NZ)		Hardin et al. (1988) (USA)	
EAC scale	M	SD	M	SD
Client attitudes				
Openness	5.50	0.98	5.66	0.91
Responsibility	5.80	0.64	6.12	0.86
Motivation	3.95	1.49	4.45	1.51
Counsellor characteristics				
Attractiveness	4.37	1.16	5.18	0.98
Expertness	4.70	1.29	4.96	1.32
Trustworthiness	5.58	1.13	5.96	1.01
Tolerance	4.75	1.23	5.48	1.48
Directiveness	3.41	1.59	4.50	1.46
Empathy	3.75	1.52	4.26	1.39
Nurturance	5.12	1.36	5.20	1.03
Genuineness	6.13	1.05	6.31	0.69
Acceptance	4.63	1.43	5.33	0.83
Self-disclosure	3.70	1.62	4.83	1.09
Confrontation	4.83	1.53	5.41	1.05
Process characteristics				
Immediacy	4.73	1.26	5.43	0.88
Concreteness	4.86	1.19	5.70	1.11
Quality of outcome	5.10	1.45	5.83	0.92

Notes. EAC = Expectations About Counseling questionnaire. Scale scores range from 1 to 7 (7 indicates stronger expectancies).

The New Zealand sample displayed moderate to low expectations (ranging from 4.37 to 4.86) for the following characteristics of the counsellor and the therapeutic process: Attractiveness (e.g. item 1: I expect to like the counsellor); Expertise (e.g. item 40: I expect the counsellor to be able to determine what is the matter with me); Tolerance (e.g. item 51: I expect the counsellor to be someone who is calm and easygoing); Acceptance (e.g. item 47: I expect the counsellor to like me); Confrontation (e.g. item 50: I expect the counsellor to make me face up to the differences between how I see myself and how I am seen by others); Immediacy (e.g. item 15: I expect to

find that the counselling relationship will help the counsellor and me identify problems on which I need to work); and, Concreteness (e.g. item 30: I expect the counsellor to help me discover what particular aspects of my behaviour are relevant to my problems).

Finally, the clients who participated in the current study displayed low Expectations (ranging from 3.41 to 3.95) on items assessing the following factors: Motivation (e.g. item 10: I expect to stay in counselling for at least a few weeks, even if at first I am not sure it will help); Directiveness (e.g. item 23: I expect the counsellor to tell me what to do); Empathy (e.g. item 24: I expect the counsellor to know how I feel even when I cannot say quite what I mean); and, Self-disclosure (e.g. item 45: I expect the counsellor to talk freely about himself or herself).

In summary, when compared with a North American sample, New Zealand client's displayed consistently lower pre-counselling expectations for each scale of the EAC. In addition to this, they more frequently responded at the lower end of the scale with four sub-scales having mean scores less than 3.95, while the lowest scale score observed by Hardin et al. (1988) was 4.26.

6.9 The relationship between specific subscales and state anxiety

In addition to the basic mean comparisons outlined above, simple correlations were performed to identify those subscales which correlated significantly with pre-session state anxiety. The strongest relationship was observed for the attractiveness subscale ($r = -.70$, $p < .0005$) comprising items 1, 7, and 12 (I expect to: like the counsellor; enjoy my interviews with the counsellor; and enjoy being with the counsellor). Hence, clients who scored highly on this scale displayed lower levels of pre-session state anxiety. In addition to this relationship, weak, but significant simple correlations were observed between state anxiety and the following scales: openness ($r = -.30$, $p = .035$); genuineness ($r = -.34$, $p = .0019$); and immediacy ($r = -.37$, $p = .01$). None of the remaining scales displayed a significant relationship with state anxiety.

DISCUSSION

CHAPTER SEVEN

Methodological, Theoretical and Clinical Implications of the Results

7.1 Re-emphasising the essential features of the current study

Before dealing with the implications of the results described in the previous chapter, a recapitulation of the overall study is needed. The original aim was to explore the influence of positive and negative client expectations on anxiety about counselling, with particular emphasis on using relevant theory to guide the process. This perspective was adopted for two main reasons: firstly, acknowledging the possible influence of the affective valence of expectations allowed the current work to test the widespread assumption that failing to meet client expectations automatically has a deleterious effect on therapy (the "congruency hypothesis"). Secondly, the inclusion of relevant theory (self-regulation theory and the attentional-bias model) added a dimension largely neglected in previous applied research.

The current study makes a notable methodological contribution by investigating the utility of the Expectations About Counseling questionnaire (EAC; Tinsley et al., 1980) as a measure of the affective valence of expectations. This evaluation was prompted by the discovery that the alternative interpretation of the EAC suggested by Hardin et al. (1988) and Prospero (1987) lacked conceptual integrity. Hence some unforeseen methodological issues became apparent. The resolution of these influenced the data analysis and the interpretation of the results, and lead to the emergence of a number of unexpected, but important findings. However, despite the need for modifications, the central hypothesis was clearly supported indicating that disconfirmation of pretherapy expectations does not automatically lead to an increase in post-session anxiety. Instead, the valence of the client's expectations will moderate any change.

The following is an exposition of the main findings and their relevance to theory, clinical practice and future research.

7.2 Challenging the "congruency hypothesis"

The main theme of the current study has been that the "congruency hypothesis" has been uncritically accepted for too long and this has perpetuated the equivocal findings evident in the expectations about counselling literature (Duckro et al., 1979). One area of applied research in which advances have been stifled by this over-emphasis deals with the effects of preparation on therapeutic process and outcome variables such as: adherence, post-session anxiety, and recovery. Attempts to modify client expectations

prior to therapy have tended to focus solely on reducing the discrepancy between what the client expects to happen and what actually does happen in the therapeutic environment. However, Deane (1991) found that although preparation increased the accuracy of the expectations reported by psychotherapy outpatients, there was no significant correlation between accuracy and levels of state anxiety. Although this finding is in direct opposition to the assumptions which perpetuate the congruency hypothesis, it is unlikely that it is aberrant or spurious given that the design and methodology used adheres closely to the recommendations made by Tinsley et al. (1988).

In response to Deane's (1991) observations, the current study investigated the influence of the affective valence of the expectations displayed by clients. Essentially, this required a conceptual shift from the treatment of expectations as a unitary construct to the demarcation of positive versus negative expectations. *Hypothesis one* sought to clarify how the degree of confirmation or disconfirmation of positive versus negative expectations influenced levels of state anxiety after the initial counselling session. The results indicate that simply meeting client expectations is not enough to facilitate a reduction in state anxiety. Rather, there is a strong interaction effect between the positiveness of client expectations and the degree to which they were confirmed. The graphical representation of this interaction (Figure 6.1) illustrates that clients who experience greater confirmation of positive expectations display a decrease in levels of post-therapeutic state anxiety, while for those who display less positive (or negative) expectations, confirmation or disconfirmation results in little change.

If the congruency hypothesis was supported there would have been a main effect for confirmation on state anxiety. That is, state anxiety levels should have dropped as the confirmation of client expectations increased regardless of whether they were positive or negative. However, this was not the case, there was no significant main effect for confirmation on state anxiety. Therefore, it is highly likely that if the current research had only investigated main effects, it would have joined the 50% of studies identified by Duckro et al. (1979) as failing to support the hypothesis that disconfirmation inevitably has a detrimental effect on therapy. However, by accounting for the affective valence of the expectations displayed by the client, it has been possible to extend and refine previous research. Finding a significant interaction effect between positiveness and confirmation using a relatively small sample (F (3,30) = 3.59, p = .02) adds to the power of the current study and, by implication provides strong evidence that the preoccupation with congruency evident in prior research has been inappropriately narrow.

In summary, it is clear from the results of *hypothesis one* that those clients who have positive expectations which are confirmed experience less state anxiety than those

who experience disconfirmation. For those who hold negative expectations, the influence of confirmation or disconfirmation appears to be negligible (the possible explanations for this are discussed in section 7.12). Therefore, the limitations of the congruency hypothesis cited in the introduction appear to have been vindicated. Any investigation of the effects of disconfirmation must account for the influence of the valence (particularly the level of positiveness) of an individual's expectations.

In addition to challenging the congruency hypothesis, a conscious effort was made in the current work to draw on relevant theory to explicate the effects of valence and confirmation on client behaviour. The two theoretical paradigms chosen to achieve this objective were: Self-regulation theory (Leventhal & Johnson, 1983); and the Attentional-bias model (eg. Mathews & MacLeod, 1985). In formulating hypotheses 2 to 5, it was intended that the applicability of these two models to the counselling situation would be investigated. However, before testing these hypotheses it was necessary to complete an unanticipated investigation into the ability of the EAC to measure the affective valence of client expectations. Therefore, prior to discussing the theoretical implications of the results the concerns about the EAC are elaborated.

7.3 Limitations of the EAC as a measure of negative expectations

One of the most important, but least expected findings to emerge from the current work regards the efficacy of the short form of the EAC (Tinsley et al., 1980) as a measure of negative pretherapy expectations. As mentioned earlier, Hardin et al.'s (1988) suggestion that the EAC may be "...a global measure of positive or negative set toward counseling, rather than a number of discrete expectations" (p.40) prompted it's use in the current study. Hardin et al. based this assertion on the findings of an unpublished doctoral dissertation by Prospero (1987), and in the context of their research it was unnecessary to elaborate on the analyses used to arrive at this conclusion. However, it became necessary to obtain a copy of Prospero's original work when a review of the literature failed to identify a single study which justified the use of the short form of the EAC as a measure of positive and negative expectations about counselling. Unfortunately, unanticipated and unavoidable delays meant that the conceptual work involved in the current study had been completed by the time Prospero's dissertation arrived. Hence the need to conduct the rating procedure outlined in section 6.2.

After submitting Prospero's (1987) work to close scrutiny, it became clear that there are two main issues which complicate the use of the short form of the EAC as a measure of **negative** end of the expectancy continuum. The first, and most obvious issue pertains to the apparent paucity of items which tap negative expectations (only 2 out of 53). The second issue relates to the fact that the scale used to rate items does not

increase in evenly graduated steps. Rather, two main response modes appear to be represented: either the non-endorsement of the item (i.e. 1 = not true); or the endorsement of the item at varying levels (i.e. 2 = slightly true, 7 = definitely true). The identification of these two specific issues strengthens the suspicion that Prospero's (1987) alternative conceptualisation of the EAC is inaccurate. However, in order to avoid the meting out of unjust criticism, the context and likely intention of Prospero's suggestion requires clarification.

Unlike the current study, Prospero's (1987) work was not concerned with assessing the impact of the affective valence of client expectations. Hence, the proposition that the short form of the EAC may measure positive and negative expectations emerged solely as a discussion point designed to illuminate some ambiguous results and guide future research efforts. The only support cited for this proposition was the observation of higher than expected intercorrelations among the EAC variables at pretest. This lead to speculation that a response bias was operating whereby individuals were prone to respond in a consistently positive (denoted by high scale values) or consistently negative (low scale values) manner to the items. However, these observations do not appear to constitute sufficient supporting evidence on their own, therefore, the focus of the current study was expanded in order to fill the conceptual holes which Prospero and Hardin et al. (1988) either failed to consider or chose to ignore.

7.4 Rationale for questioning Prospero's (1987) interpretation

The outcome of the rating procedure described in section 6.1 revealed that achieving consensus among raters was less difficult when isolating positive items than when identifying those which reflect the presence of neutral or negative expectations. When 73% inter-rater agreement was used as the threshold above which an item was considered positive, almost half of the entire item set (25 items) fell into this category. In contrast, the use of less stringent criteria was required in order to identify those items which could possibly reflect neutral or negative expectations (46 to 60% agreement to delineate 7 neutral items; and 46 to 54% agreement to identify only 2 negative items).

These results are inconsistent with Prospero's (1987) alternative interpretation of the EAC scores for the following reasons: Firstly, it appears that Prospero's interpretation uses total scale scores (ie. the cumulative value of items 1 to 53) to infer the presence of positive and negative expectations. For this perspective to be valid, each item would need to be of equivalent "positiveness" or "negativeness", otherwise the use of a cumulative score will obscure specific items which may be stronger indicators of the valence of the client's expectations. Also, all of the items would need to be either positive **or** negative in order to avoid the problem of individual items

cancelling each other out. The observed ratings indicate that neither of these requirements are met.

In addition to the low concordance between raters, an examination of the individual EAC items indicates that using cumulative scores to infer positiveness or negativeness is inappropriate. For instance, it is nonsensical to suggest that fully endorsing item 16 ("I expect to become better able to help myself in the future") reflects the same degree of positiveness or negativeness as fully endorsing item 50 ("I expect the counsellor to make me face up to the differences between how I see myself and how I am seen by others"). The first statement appears to reflect the positive expectation that the client will gain some tangible benefit from counselling, while the second one suggests that he or she may have to go through the potentially negative process of facing up to any personal inadequacies. Clearly, a high score on either of these items reflects the presence of qualitatively distinct expectations, and therefore, it would be imprudent to apply Prospero's (1987) interpretation.

Examination of the original factor analysis from which the EAC was developed also indicates that the use of cumulative scores to measure the affective valence of expectations is inadequate. Tinsley et al. (1980) delineate four distinct factors which will impinge on the counselling process, these are: personal commitment; facilitative conditions; counsellor expertise; and nurturance. When presenting an interpretation of client responses on items comprising factor 1, the personal commitment dimension, Tinsley et al. suggest that extremely high scores may indicate compulsive, perfectionist tendencies. In contrast, low scores may be characteristic of those who naively expect the counsellor to "cure" them without their having to exert any personal effort. Tinsley et al. also note that an extremely high score on factor 3, counsellor expertise, may indicate the presence of magical thinking by the client. These interpretations do not appear to be compatible with Prospero's suggested interpretation of high and low scores. In fact, a low score on the commitment dimension may indicate very positive client expectations.

Despite the problems cited above, the observation of clearly significant results for *hypothesis 1* indicates that the EAC does appear to measure the affective valence of client expectations in some way. The elucidation of this issue hinges on two factors: firstly, it is clear that any interpretation has to be consistent with what is already known about the EAC; and secondly, there is a need to address the semantic issues regarding the use of "positiveness" and "negativeness" as constructs.

7.5 Alternatives to Prospero's (1987) interpretation

Once the limitations of Prospero's (1987) treatment of the EAC were realised, it became necessary to adopt an alternative interpretation which would address the

problems cited above. The first option was to use the available ratings to isolate items which could be used as measures of "positiveness" or "negativeness". The delineation of two distinct scales to assess these constructs was precluded by the low level of rater agreement for items reflecting negative expectations. As mentioned above, items 23 and 32 gained 53.3 and 46.7% rater agreement respectively, however, for item 32, the same number of people ascribed it a neutral rating. Given these equivocal results it was decided to temporarily discard the negative and neutral items and focus on those which had received high level rater agreement for positiveness.

Using 73% rater agreement as the threshold, 25 items were identified as reflecting the presence of positive expectations (see section 6.2 for the specific items). However, because one of the primary aims of the current work was to explore the influence of both positive **and** negative expectations on counselling, it was necessary to investigate how these items could be used to assess negative end of the expectancy continuum. The anchors used on the rating scale prompted the suggestion that, if an item has been rated as positive and the client responds "Not true" (1), then this non-endorsement should reflect a negative expectation. For instance, for item 1: "I expect to like the counsellor", the client could either endorse the statement at different levels of agreement ranging from "Definitely true" (7), to "Slightly true" (2), or, they could disagree with the item and indicate 1: "Not true". By implication, indicating "Not true" infers that the client's expectation is that they will **not** like the counsellor, which appears to be a negative expectation. Hence it was decided to treat any non-endorsement of a positive item as an indicator of a negative expectation. Although it can not be determined, it is possible that Prospero (1987) had a similar rationale in mind when she suggested that lower scale scores indicated the presence of negative expectations. However, it seems inappropriate to use any more than the "Not true" response to determine negativeness because the remaining anchors all appear to indicate agreement with the item at some level.

Unfortunately, identifying those client's with negative expectations based on the number of times they responded "Not true" to a positive item yielded a cell size of only three. Two possible conclusions could be drawn from this, either: (a) most of the participants in the study did not hold negative expectations about the impending counselling experience; or (b) the scale used was assessing something other than negative expectations. Given the issues outlined above, it appears most parsimonious to assume option (b). That is, that the EAC distinguishes between client's on the basis of some criterion other than negative expectations.

7.6 The EAC as a measure of "confidence" of expectations

The nature of the response anchors used on the EAC lends some support to the view that total scale scores may be indicative of how **confident** the client feels about the accuracy of his or her expectations. Viewing the anchors in this manner suggests that responding with either "Not true" (1) or "Definitely true" (7) indicates high confidence in the accuracy of his or her expectations, while the intervening responses, "Slightly true" (2) to "Very true" (6), indicate varying levels of confidence. The main limitation of this perspective is that, if only high scores are treated as indicating highly confident expectations, the "Not true" response is ignored.

Fully exploring the ramifications of this particular perspective is beyond the scope of the current study and is therefore left as an issue for future research. However, displaying low confidence in the accuracy of the expectation may prove to have similar consequences to holding a negative expectation. Self-regulation theory suggests that any uncertainty about an impending event will result in anticipatory arousal (due to the "threat of the unknown"), while viewing an event in threatening or negative terms will elicit a similar response (Leventhal & Johnson, 1983). This could be bourne in mind for future research.

7.7 Low-positive versus negative expectations - a semantic issue

One of the main questions to emerge from the rating process outlined in section 6.3 regards the appropriateness of using the terms "positive" and "negative" to describe high and low scores on the EAC. There are a number of arguments for discarding Prospero's (1987) interpretation, and introducing the terms "high-positive" and "low-positive" (negative) expectations: Firstly, the identification of only two possible negative items versus the relative abundance of positive items strongly suggests that the EAC measures the **positive** end of the expectancy continuum. Secondly, given that a low score may still reflect agreement with an item, but at a low level of confidence, it may be premature to use the "negative" label without further empirical investigation. Finally, the use of the words "positive" and "negative" in the vernacular may have different connotations when used to describe expectations about counselling. For instance, on face value, a high score on the confrontation subscale (eg. item 52: "I expect the counsellor to point out the differences between what I am and what I want to be") could be viewed as indicating the presence of negative expectations. However, if the client believed that such a scenario would be beneficial in the long run, the response pattern may actually reflect benign or even positive expectations.

The fact that these issues can only be raised but not clarified by the current work presents a semantic problem. The outcome of the rating process suggests that the use of the term "negative" is premature, but there is no clear alternative which will permit

the efficient communication of the results. Although it is likely that any future definition of "positive" and "negative" expectations will be closely linked to the concept of client "preferences" (see: Ziemelis, 1974; Duckro et al., 1979; Tinsley et al., 1988) it is not possible to provide such a definition here. Therefore, in the interests of clarity, the following discussion of the theoretical implications of the results uses the term "negative" expectations. However, this is done with the understanding that future research may reveal that low scores on the EAC may reflect something other than negative expectations.

7.8 Theoretical implications of the results

Whereas *hypothesis 1* was primarily oriented toward challenging the congruency hypothesis, the remaining four hypotheses focussed specifically on investigating the applicability of self-regulation theory and the attentional-bias model to the counselling situation. As noted above, the interpretation of the results is tempered by the limitations of the EAC, however, it is possible to draw a number of modest conclusions from the available data. The following is a discussion of the results observed for each hypothesis, with an emphasis on establishing connections between these findings and the two theoretical perspectives outlined in the introduction.

Before discussing the specific results for *hypothesis 2* it is appropriate to reiterate the theoretical rationale from which the hypotheses were drawn. Both self-regulation theory (Leventhal & Johnson, 1983) and the attentional-bias model (Mathews & MacLeod, 1985) postulate that there is a direct link between elevations in state anxiety and viewing environmental events in threatening terms. Self-regulation theory predicts that negative or threatening expectations will produce distress because the individual will base the cognitive representation (schema) of the impending event on prior emotionally laden memories. That is, while trying to predict the likely sequence of events, the individual will be reminded of previous negative experiences and the recall of these memories will be accompanied by the associated negative mood state (Bower, 1981). Hence, the individual will enter the counselling situation in a state of cognitive and autonomic arousal. Following on from this, the attentional-bias model infers that the client entering the counselling situation with a negative schema activated, will preferentially attend to the cues in the environment which are congruent with that schema. This preferential processing of threat cues will lead to an increase in state anxiety and will render the client less able to concentrate on the important aspects of therapy.

These two paradigms predict that the presence of accurate positive expectations will result in reduced post-session state anxiety. Self-regulation theory suggests that this is because the individual is prevented from tainting the current experience by

accessing memories which are closely linked with negative emotions. The attentional-bias model infers that the activation of a positive schema will preclude the processing of threat cues until they reach an intensity or threshold above which some form of reaction is prudent and adaptive (Mathews, 1990).

7.9 The consequences of confirming positive versus negative expectations

Hypothesis 2 predicted that client's who had negative expectations which were confirmed would display greater post-session state anxiety than client's who experienced the confirmation of positive expectations. However, the results failed to reach significance, and an examination of the mean post-session anxiety scores indicates that there was no difference between the positive and negative expectation groups. Three explanations can be offered for these results, either: (a) the sample size was too small to detect any effect; (b) the EAC did not adequately measure negative expectations; or (c) the valence of client expectations has no effect on state anxiety.

The first explanation is posited because the use of median splits meant that the active data set was immediately halved to eliminate those clients who experienced low confirmation, and then split again to differentiate between those who displayed negative versus positive expectations. This resulted in cell sizes as low as eight which raises the question of whether the sample was too small to detect an effect. However, the fact that there was no between group difference in the post-session anxiety scores strongly suggests that increasing the cell numbers would not have yielded dramatically different results. Therefore, the first explanation is discarded.

The most plausible reason for the observed results is that the limitations of the EAC precluded the adequate differentiation of those clients who held truly "negative" expectations. For the hypothesis to adequately test the applicability of both self-regulation-theory and the attentional-bias model, it was necessary to distinguish between those clients who entered the counselling with a non-threatening schema from those who held a threatening schema. These two cognitive representations of the counselling situation were operationalised as "positive" and "negative" expectations. However, if low EAC scores indicate something other than negative expectations, it is possible that the subjects were being sorted on the basis of some unknown factor - possibly "positiveness". This raises the question of whether "positiveness" varies independently of "negativeness".

Pursuing this line of reasoning has important implications for future research, however, it is imperative that the speculative nature of these suggestions is acknowledged and that they are treated with caution until supported by empirical evidence. Up until this point the current study has assumed that the valence of client

expectations varies along a continuum from negative to positive, with the EAC measuring those expectations which lie at the positive end of the continuum. If this representation is valid, and if negative expectations result in increases in state anxiety (which the empirical evidence from the self-regulation research indicates that they do), then it is logical to assume that increases in state anxiety will occur as client expectations move further along the expectancy continuum from positive to negative. However, this pattern was not observed in the current study; clients with confirmed negative expectations showed no more state anxiety than clients who had confirmed positive expectations. This raises the question of whether positive and negative expectations do in fact represent the extremes of a single dimension, or, alternatively, are they two distinct constructs which vary independently at different levels? Fully exploring this is beyond the scope of the current work, but by raising the issue it is hoped that it will be examined more extensively by future researchers.

The final explanation offered above for the non-significant results suggested that no relationship exists between state anxiety and the affective valence of client expectations. However, accepting this view does not appear to be a viable option given that evidence in the medical psychology literature (eg. Johnston, 1986) strongly supports the presence of a relationship.

In conclusion, it is difficult, if not impossible to infer the consequences of confirming positive or negative expectations from the results of the current study. It appears that explicating the nature of this relationship hinges on: (a) the development of an appropriate measure of negative expectations; and (b) investigating whether positive and negative expectations represent poles on a single continuum or separate components of the overall construct "client expectations". What the results do suggest is that confirming positive expectations results in equivalent levels of post-session state anxiety for first time counselling clients. This finding is consistent with the work of Ziemelis (1974) who found that fostering neutral or positive expectations about counselling had similar favourable effects, while the induction of negative expectations had a detrimental effect.

7.10 The relationship between trait anxiety and negative expectations

One of the recurrent themes of research using the attentional-bias model is that susceptibility to generalised anxiety disorder is attributable to a stable personality characteristic which is expressed in terms of a hypervigilance to threat cues. Some authors have found that the inability to screen out threat-related material is closely associated with **trait** anxiety (MacLeod & Mathews, 1988; Mogg, Mathews, & Weinman, 1989) while other research suggests that the individual's level of **state** anxiety is most influential (Mathews & MacLeod, 1985). However, an interactive

explanation has also been postulated whereby an innate hypersensitivity to threatening material exacerbates increases in state anxiety under stressful circumstances (Mathews et al., 1990; Mathews, 1990). Therefore, it is still unclear which specific factor, if any, is most influential in the emergence and maintenance of episodes of worry and anxiety.

In the context of the current study, it was considered that the presentation of predominantly negative expectations could be used to operationalise susceptibility to threat-related environmental cues. The rationale behind this was that the presence of negative expectations most probably indicates that the client is entering the counselling situation with an active danger schema (a threatening cognitive representation of the event). Clarifying the nature of the relationship between trait anxiety, negative expectations and counselling process has potential benefits for clinical practice in that clinicians may be able to use a trait anxiety measure to screen those clients who require additional reassurance before the commencement of therapy.

Hypothesis 3 was based on the assumption that, if the preferential processing of threat cues is attributable to the influence of an enduring cognitive characteristic, there should be a positive correlation between trait anxiety and negative expectations. A median split of EAC scores was used to delineate those client's who held negative expectations and trait anxiety was measured using the STAI-Y2[1]. The results indicate that there was a relationship in the expected direction ($r = -.40$) but this was non-significant. In addition to this, the strength of the relationship between trait anxiety and **negative** expectations was greater than the non-significant relationship observed for client's with **positive** expectations ($r = -.20$).

A number of factors impinge on the interpretation of these findings. Firstly, as mentioned in section 5.4, an administrative error meant that incorrect anchors were used on the trait anxiety scale and thus it is unclear how this effected the validity of the instrument. Secondly, there may have been too few subjects, resulting in insufficient power. Thirdly, the inability of the EAC to measure negative expectations must be acknowledged. Finally, because the measures in the current work were only administered to a clinical sample, there is no opportunity to see whether the observed pattern differs from that of a normative sample.

The exploratory nature of this hypothesis and the presence of the complicating factors mentioned above suggest caution in drawing conclusions from the available data. Therefore, further explication of the relationship between trait anxiety and negative expectations about counselling is left for future research. However, it is possible to raise one final point regarding the applicability of this model to the investigation of expectations about counselling. Because most of the work in the attentional-bias literature is concerned with providing an etiological explanation for

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[1] STAI-Y2: State-Trait Anxiety Inventory, Version Y, (trait scale) (Spielberger, 1983).

generalised anxiety disorder it could be argued that applying the model to the investigation of other anxiety states is inappropriate. However, recent empirical findings indicate that it is getting more difficult to assume that sensitivity to threat cues is idiosyncratic to those individuals who are prone to generalised anxiety disorder. For instance, McNally, Riemann, and Kim (1990) found that the selective processing of threatening material is also evident panic disorder patients. Hence, it is possible that this information processing style may be an integral part of any anxiety state, including pretherapeutic anxiety.

7.11 Negative expectations and adherence to treatment

Hypothesis 4 focussed on the role that negative pretherapy expectations play in determining premature termination of treatment. A suggestion made by Howard Tinsley (1986, cited in Heesacker & Heppner, 1988) was primarily responsible for the inclusion of this hypothesis in the current work. Tinsley suggested that the confirmation of a negative expectation may take less time than the disconfirmation of a positive one due to the operation of a memory or processing bias which favours negative information. The links between this speculative statement and the attentional-bias model were immediately recognised and *hypothesis 4* represents an attempt to submit the idea to empirical investigation.

For *hypothesis 4* to be supported, those clients who displayed negative expectations which were confirmed should have failed to keep their next scheduled appointment more often than other client groups. However, no support was found for this hypothesis.

In the light of prior research, there are a number of interpretations which could be applied to these results. Firstly, the finding is consistent with the conclusions drawn by Baekeland and Lundwall (1975). After completing a review of the premature termination literature, these authors emphatically stated that "...discrepant expectations about treatment promote dropping out" (p. 758). Therefore, in the context of the current study it could be inferred that, although the clients' expectations were negative, the fact that they were confirmed prevented premature disengagement from treatment. However, as Duckro et al. (1979) point out, Baekeland and Lundwall based their assertions on the results of only six studies, five of which were published before 1966.

There is no obvious theoretical or empirical basis on which it could be argued that confirming an individual's expectation that something negative is about to happen to them will increase the likelihood that they will return to that aversive situation. The only comparable health related example is the situation where an individual goes to the dentist with a sore tooth and the negative expectation that they will have to undergo some painful procedure to alleviate the discomfort. Under these circumstances it is

likely that the individual will endure the aversive intervention because prior experience assures them that the consequences of not seeking treatment are potentially more undesirable. However, first time counselling clients lack a precedent which will assure them that any discomfort in the short term will be balanced by improvement in the long term, therefore it is most likely that the confirmation of negative expectations will prompt the individual to avoid the counselling situation.

In addition to questioning the findings on a logical basis, recent applied research and theoretical developments support the view that the results of *hypothesis 4* were aberrant. In direct support of the proposed effect, Heesacker and Heppner (1988) found that client's who terminated prematurely displayed less favourable expectations than those who adhered to treatment. Similarly, Hynan (1990) found that early terminators tended to disengage due to **negative** experiences while late terminators left because of improvement attributed to the therapeutic process.

The most parsimonious explanation for the unexpected results of *hypothesis 4* is that the cell sizes for each client group were simply too small to detect an effect. This explanation appears particularly valid when it is noted that for each group as many as half the clients did not have a second appointment scheduled. This meant that for the low confirmation of high positive expectations group the cell numbers were reduced from 8 to 4, while for the remaining three groups the numbers dropped from 9 to 5. It is also possible that those who failed to attend their second appointment did so because they had improved sufficiently after the first session. This explanation is indirectly supported by the results of a study by Noonan (1973) who found that 35% of clients said they did not keep their first appointment at a university based psychiatric outpatient clinic did so because they felt that they had improved sufficiently so that treatment had become unnecessary.

In conclusion, the availability of only a small data set to test hypothesis 4 makes it impossible to draw any firm conclusions from the observed results. Further research using larger sample sizes and improved measures is needed before the relationship between negative expectations and adherence to treatment can be fully understood.

7.12 The effects of disconfirming negative expectations

Hypothesis 5 sought to explore whether the negative effects of experiencing disconfirmation of expectations were negated by the positive effects of having a more desirable experience. The attentional-bias model predicts that those individuals who enter a novel situation with negative expectations which are then disconfirmed will display a reduction in state anxiety (Mathews, 1990). Self-regulation theory predicts that an incompatibility between what is expected and what is experienced will lead to increased distress which will persist until the individual forms an accurate schema of

the event (Leventhal & Johnson, 1983). This gives rise to the situation where the attentional-bias model predicts that disconfirmation of negative expectations should **reduce** state anxiety because they are unable to identify threat cues, while self-regulation theory infers that disconfirmation will result in **increased** arousal because the novelty of the situation will hinder the individual's ability to select an appropriate coping response. Because there is no prior research into this issue it was not possible to infer the relative magnitude of each of these effects. Hence, the suggestion that they would cancel each other out was purely exploratory.

The presence of a significant 32% reduction in state anxiety for clients who had their negative expectations disconfirmed indicates that *hypothesis 5* was not supported. As with all of the preceding hypotheses a number of explanations can be offered for the results. For example, the obligatory caution regarding the limitations of the EAC is also applicable in this instance. However, in order to prevent this explanation from becoming a panacea, it is important that other avenues are investigated. For instance, the observed findings are consistent with the *habituation hypothesis* forwarded by Howard Leventhal (in Leventhal & Johnson, 1983; Leventhal et al., 1989). This suggests that the provision of accurate, objective information prior to a stressful event will increase the depth of processing beyond the immediate emotional reaction, which will facilitate the rapid formation of a schema of the noxious stimulus. This will then lead to the diminution of it's novelty and/or activating power. Leventhal et al. (1989) note that, for habituation to occur, the individual must actively encounter the aversive event. Therefore, it appears possible that actual exposure to the counselling environment may have been sufficient to reduce it's activating power and subsequent attenuation of state anxiety. This habituation was reflected in significant reductions in state anxiety across all of the client groups. If this suggestion is supported by future research, it will have important implications for investigations into the effects of preparation for psychotherapy.

Tinsley et al. (1988) completed an extensive review of the literature dealing with the manipulation of client expectations prior to counselling and drew the following conclusion: "Until important relations have been documented between clients' expectancies and important aspects of the therapeutic process and outcome, concern about how to manipulate expectancies appears premature" (p.106). Therefore, if one of the main aims of preparation is to make the client feel more at ease during counselling, the results observed for *hypothesis 5* indicate that simply attending the first session is sufficient to effect a reduction in state anxiety. Other research also indicates that simple exposure to therapy will reduce state anxiety. For instance, Deane (1991) used a 10 minute videotape to prepare clients for psychotherapy and found that those who saw the video reported less state anxiety and displayed more accurate expectations prior to the

first session than the non-treatment groups. However, these effects disappeared at two-month follow-up. The results of the current work extend this finding and suggest that it may take **only one session** with the counsellor for any preparation effects to disappear.

Two main conclusions can be drawn from the results of *hypothesis 5*: Firstly, it appears that the magnitude of the effects predicted by the attentional-bias and self-regulation models are not equivalent and therefore do not cancel each other out. Secondly, the findings are most consistent with the *habituation hypothesis* which predicts that exposure to a novel situation will lead to the formation of an accurate schema which will ameliorate the emotional response to any aversive stimulus (Leventhal & Johnson, 1983; Leventhal et al., 1989). Concurrent support for this is presented by Spielberger (1983) who notes that reductions from pre-test measures of state anxiety are common once individuals have directly experienced a stressful event.

7.13 The integration of self-regulation theory and the attentional-bias model

The current study was founded on two core objectives: (a) challenging of the congruency hypothesis; and (b) the introduction of relevant theory to the exploration of client expectations about counselling. In achieving the second objective, self-regulation theory (Leventhal & Johnson, 1983) and the attentional-bias model (Mathews & MacLeod, 1985) were used to guide the formulation and interpretation of the experimental hypotheses. It is appropriate at this point to reiterate the common ground which points to the compatibility and mutuality of these two theories.

Firstly, in their discussion of the role that cognitive styles play in the processing of incoming stimuli and the subsequent emotional reactions to those stimuli, Mathews and MacLeod (1985) state that danger schemata "...may be plausibly argued to arise from the past experiences of danger events" (p. 563). This view is echoed in the self-regulation literature which infers that, when placed in a stressful situation, an individual will attempt to construct a cognitive representation (a schema) of that situation based on prior experiences (Leventhal & Johnson, 1983).

A major benefit of integrating the two paradigms is that the attentional-bias model extends under-developed aspects of self-regulation theory. For example, when explaining the effects of preparatory information on recovery from stressful medical procedures, Leventhal (in Leventhal & Johnson, 1983) suggests that the accessing of "danger schemata" may occur at a preconscious level and therefore, may be beyond the control of the individual. This idea is developed more fully by authors working in the attentional-bias field (eg. Mathews & MacLeod, 1985; MacLeod & Mathews, 1991) who have found that the preferential processing of threat cues is unavoidable for some

individuals when they are placed in a situation which requires the selective screening of benign and threatening information.

Another link between the two models concerns the consequences of displaying and active "danger schema". Considerable research using self-regulation theory indicates that viewing an impending event in threatening terms increases distress and slows recovery (Johnson, 1973; Johnson & Leventhal, 1974; Leventhal et al., 1979; Leventhal & Johnson, 1983; Johnson et al., 1989). The attentional-bias model also indicates that adopting a negative cognitive set will increase state anxiety and make the individual more distractable. Hence, in the case of recovery from stressful medical procedures, recovery may be hampered by the presence of the physiological and biochemical correlates of anxiety and the fact that distressed patients may be unable to fully attend to the advice offered by health professionals. Similarly, anxious counselling clients may not concentrate sufficiently during the initial session to gain maximum benefit from the encounter.

As mentioned above, one of the primary aims of the current work was to use these models to guide the formulation and interpretation of the hypotheses. The concerns regarding the utility of the EAC as a measure of negative expectations makes it unwise to present a summary analysis of the theoretical interpretations of hypotheses 2 to 5. However, the presence of a significant interaction effect between confirmation and positiveness of expectations on post-session state anxiety (*hypothesis 1*) can easily be interpreted in terms of both the attentional-bias model and self-regulation theory. Figure 6.1 indicates that, as predicted by self-regulation theory, those who entered counselling with non-threatening (positive) expectations which were accurate experienced a significant decline in state anxiety. Meanwhile, in support of the attentional-bias model, those who entered with an active danger schema (negative expectations) displayed heightened anxiety which persisted at post-session measurement.

7.14 Clinical implications of the current research

The main clinical implication of the current study is that effecting a reduction in state anxiety among first time clients is not simply a matter of meeting their expectations. Rather, the results to *hypothesis 1* indicate that attention must also be paid to the affective valence of those expectations. Future research into preparation for psychotherapy may reveal that the most efficacious way of effecting reductions in state anxiety is to focus on the disconfirmation of negative expectations (see Ziemelis, 1974, for a more extensive discussion of this issue).

Despite the fact that reducing client anxiety has important consequences regarding the establishment of rapport and the minimising of an avoidance or fear

response (Kushner & Sher, 1989), it is not suggested that the negative aspects of therapy should be glossed over. Research into coping with stress indicates that rejection or blunting is effective as a short term strategy, but when the stressor is present for an extended period or is recurrent (as is the case with many psychological problems), directing attentional resources toward the stressor is most beneficial (Weinberger, Schwartz, & Davidson, 1979; Mullen & Suls, 1982; Leventhal et al., 1989). Therefore, it remains to be determined how best to balance the allaying of clients' fears about the counselling situation against the need to acknowledge the unpleasant aspects of the therapeutic process.

Finally, a subsidiary finding to emerge from this study regards the difference in expectations displayed by the New Zealand student sample compared to the North American sample described by Hardin et al. (1988). The fact that the participants in the current study displayed consistently lower scale scores and lower overall scores may indicate the presence of an as yet undefined cultural influence. The close examination of this issue was outside of the scope of the current study but it is hoped that the inclusion of this data will provide a point of comparison any future investigation in this area.

CHAPTER EIGHT

Summary and Conclusions

8.1 Summary of the present research

Many researchers have asserted that failing to meet client expectations about counselling is detrimental to both counselling process and outcome. This has been assumed despite the presence of equivocal results and the absence of theory. In response, the current study proposed that it is not enough to only examine confirmation of expectations, and proceeded to investigate the role that positive and negative expectations play in determining anxiety about counselling. Theory from related areas was introduced to guide the research and a recommended measure of positive versus negative expectations was selected. However, the suspicion that the measure was less valid than previous authors suggested was supported by a preliminary investigation of the scale. The outcome of the subsequent rating process influenced the testing and interpretation of the results, but the negative effects of this were balanced by the methodological contribution that was made. The results clearly indicated that positiveness and confirmation interact to produce increases in state anxiety. That is, confirmation of positive expectations reduces state anxiety after the first counselling session while confirmation of negative expectations results in the maintenance of higher levels of state anxiety. This finding suggests that future research into preparation for psychotherapy should take account of the affective valence of the expectations displayed by the client.

8.2 Specific implications of the present research

The most important implications of the current work are that: (a) treating client expectations as unitary construct is inappropriate as this fails to acknowledge that disconfirmation of a negative expectation may actually be beneficial to the therapeutic process; (b) contrary to the untested assertions of Hardin et al. (1988) and Prospero (1987), the EAC in it's current form does not represent a useful measure of negative expectations; and (c) the integration of self-regulation theory (Leventhal & Johnson, 1983) and the attentional-bias model (Mathews & MacLeod, 1985) presents a promising avenue of theoretical investigation for future research into the role of expectations about counselling.

8.3 Recommendations for future research

The finding that confirmation of positive expectations results in a reduction in state anxiety has important implications for research into preparation for psychotherapy, particularly regarding the type of expectations that should be fostered. While previous

efforts have focussed on establishing accurate expectations, it may be necessary to emphasise the positive aspects of the therapeutic process in order to establish a reliable effect. There is also a need to clarify how elevated levels of state anxiety influence therapeutic process and outcome. Wells et al. (1986) indicate that increased preoperative state anxiety results in slower post-surgical recovery and increased analgesic use among patients. Also, the attentional-bias model predicts that increases in state anxiety will make the individual more distractable which may reduce their ability to attend fully to therapy. Future research should explore the relationship between expectations, state anxiety, and outcome variables such as speed of recovery and adherence.

The limitations of the EAC mean that the specific influence of negative expectations can not be established by the current work. Addressing this issue will involve the development of a valid and reliable method of quantifying positive **and** negative expectations. The preliminary analysis of the EAC presented in the current study indicates that it may yield a number of the items which could be used to assess positive expectations. Tinsley and Westcot (1990) present a methodology which could be adapted to investigate this issue more fully.

Because theory has largely been neglected in the development of the expectations about counselling literature a lot of work remains to be done. It appears that both the attentional-bias model and self-regulation theory have a lot to offer our understanding of the way first time counselling clients behave. However, it would be foolish to suggest that these are the only applicable models. Another potential model is control theory (Carver & Scheier, 1982; 1988) which is widely used in personality-social, health, and clinical psychology. This may be particularly appropriate for investigating the effects of disconfirmation on premature termination of treatment as it infers that a large discrepancy between what is experienced and the individual's internal point of reference (their expectation) may prompt disengagement or avoidance of the situation.

8.4 Concluding comments

It is appropriate to conclude by reflecting on the reasons for conducting research into client expectations about counselling. The work of Bordin (1955) aimed to highlight the need for clinicians to be sensitive to the expectations and perceptions of the client so that "...the mood of the quiet smile is not responded to with boisterous laughter" (p. 18). Almost forty years later, the literature dealing with client expectations about counselling is still very much in the early stages of it's development. It is hoped that by introducing a new theoretical perspective and demonstrating the influence of the valence of client expectations, the current work will encourage further developments which can be used to benefit the consumers of psychological services.

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APPENDIX A

EXPECTATIONS ABOUT COUNSELLING

QUESTIONNAIRE 1.

Directions

You are about to see a counselling psychologist for your first interview. We would like to know just what you think counselling will be like. On the following pages are statements about counselling. In each instance you are to indicate what you expect counselling 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 box to the right of the statements. For each statement, write the number which most accurately reflects your expectation.

Your responses will be kept in the strictest confidence, they will be combined with the answers of others like yourself and reported only in the form of group averages. Your participation, however, is voluntary. If you do not wish to participate in this research, just hand the questionnaire back to the person in charge.

When you are ready to begin, answer each question as quickly and as accurately as possible. Please finish each page before going to the next.

NOW TURN THE PAGE AND BEGIN.

1	2	3	4	5	6	7
Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

I EXPECT TO...

1.	Like the counsellor.	
2.	Gain some experience in new ways of solving problems within the counselling process.	
3.	Openly express my emotions regarding myself and my problems.	
4.	Take responsibility for making my own decisions.	
5.	Talk about my present concerns.	
6.	Get practice in relating openly and honestly to another person within the counselling relationship.	
7.	Enjoy my interviews with the counsellor.	
8.	Practice some of the things I need to learn in the counselling relationship.	
9.	Get a better understanding of myself and others.	
10.	Stay in counselling for at least a few weeks, even if at first I am not sure it will help.	
11.	See the counsellor for more than three interviews.	
12.	Enjoy being with the counsellor.	
13.	Stay in counselling even though it may be painful or unpleasant at times.	
14.	Contribute as much as I can in terms of expressing my feelings and discussing them.	
15.	Find that the counselling relationship will help the counsellor and me identify problems on which I need to work.	
16.	Become better able to help myself in the future.	
17.	Feel safe enough with the counsellor to really say how I feel.	
18.	Improve my relationships with others.	
19.	Ask the counsellor to explain what he or she means whenever I do not understand something that is said.	
20.	Work on my concerns outside the counselling interviews.	

PLEASE TURN OVER...

1	2	3	4	5	6	7
Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

The following questions concern your expectations **about the counsellor.**

I EXPECT THE COUNSELLOR TO...

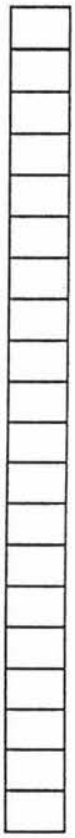
21.	Explain what's wrong.	
22.	Help me identify and label my feelings so I can better understand them.	
23.	Tell me what to do.	
24.	Know how I feel even when I cannot say quite what I mean.	
25.	Know how to help me.	
26.	Help me identify particular situations where I have problems.	
27.	Give encouragement and reassurance.	
28.	Help me to know how I am feeling by putting my feelings into words for me.	
29.	Be a "real" person not just a person doing a job.	
30.	Help me discover what particular aspects of my behaviour are relevant to my problems.	
31.	Inspire confidence and trust.	
32.	Frequently offer me advice.	
33.	Be honest with me.	
34.	Be someone who can be counted on.	
35.	Be friendly and warm towards me.	
36.	Help me solve my problems.	
37.	Discuss his or her own attitudes and relate them to my problem.	
38.	Give me support.	
39.	Know how I feel at times, without having to speak.	
40.	Be able to determine what is the matter with me.	
41.	Respect me as a person.	
42.	Discuss his or her experiences and relate them to my problems.	
43.	Praise me when I show improvement.	
44.	Make me face up to the differences between what I say and how I behave.	
45.	Talk freely about himself or herself.	
46.	Have no trouble getting along with people.	
47.	Like me.	
48.	Be someone I can really trust.	
49.	Like me in spite of the bad things that he or she knows about me.	
50.	Make me face up to the differences between how I see myself and how I am seen by others.	
51.	Be someone who is calm and easygoing.	
52.	Point out to me the differences between what I am and what I want to be.	
53.	Get along well in the world.	

PLEASE TURN OVER...

1	2	3	4
Not at all	Somewhat	Moderately so	Very much so

In addition to gaining an understanding of what you **expect** from counselling, we would also like to find out how you **feel about seeing a counselling psychologist.** A number of statements which people have used to describe themselves are given below. Read each statement and then record the appropriate number in the box to indicate how you feel **right now**, that is, **at this moment.** There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your feelings best. The rating scale we would like you to use is printed directly above.

54. I feel calm.
55. I feel secure.
56. I am tense.
57. I feel strained.
58. I feel at ease.
59. I feel upset.
60. I am presently worrying over possible misfortunes.
61. I feel satisfied.
62. I feel frightened.
63. I feel comfortable.
64. I feel self-confident.
65. I feel nervous.
66. I am jittery.
67. I feel indecisive.
68. I am relaxed.
69. I feel content.
70. I am worried.
71. I feel confused.
72. I feel steady.
73. I feel pleasant.



PLEASE TURN OVER...

1	2	3	4	5
Not at all				Very much.

This inventory is a way of studying people's reactions to coming to see a counselling psychologist. Below are some common types of reactions and feelings. Please record the number which indicates how much you are experiencing these reactions and feelings **right now.** The rating scale we would like you to use is printed directly above.

74. Heart beats faster. ☐
75. Get an "uneasy feeling". ☐
76. Emotions disrupt action. ☐
77. Become immobilised. ☐
78. Want to avoid situation. ☐
79. Perspire. ☐
80. Mouth gets dry. ☐

PLEASE TURN OVER...

1	2	3	4
Not at all	Somewhat	Moderately so	Very much so

We would also like to find out how you feel at other times, when you are not visiting a counselling psychologist. A number of statements which people have used to describe themselves are given below. Read each statement and then record the appropriate number in the box to indicate how you **generally feel.** There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe **how you generally feel.** The rating scale we would like you to use is printed directly above.

81. I feel pleasant
82. I feel nervous and restless
83. I feel satisfied with myself.
84. I wish I could be as happy as others seem to be.
85. I feel like a failure.
86. I feel rested.
87. I am "calm, cool, and collected".
88. I feel that difficulties are piling up so that I cannot overcome them.
89. I worry too much over something that really doesn't matter.
90. I am happy.
91. I have disturbing thoughts.
92. I lack self-confidence.
93. I feel secure.
94. I make decisions easily.
95. I feel inadequate.
96. I am content.
97. Some unimportant thought runs through my mind and bothers me.
98. I take disappointments so keenly that I can't put them out of my mind.
99. I am a steady person.
100. I get in a state of tension or turmoil as I think over my recent concerns and interests.

Please answer the following questions about yourself. This information will only be used in combining your results with those of other people like you. Please indicate your response by **circling the number of the answer** which you wish to give.

What is your present year at university ?

1. 1
2. 2
3. 3
4. 4
5. 5
6. Other (please indicate) : ____

How old are you ?

1. 17 to 20 years old.
2. 21 to 23 years old.
3. 24 to 30 years old.
4. 31 to 40 years old.
5. 41 to 50 years old.
6. 51 to 60 years old.
7. 61 years or older.

Are you male or female ?

1. Female.
2. Male.

Have you ever been to see a professional counsellor before this visit?

1. Yes.
2. No.

Of what race do you consider yourself to be a member ?

1. Maori.
2. Pacific Islander.
3. Asian.
4. Pakeha.
5. Other (please indicate): _____

STOP

Please check to see that you have answered all of the questions and return the questionnaire booklet and the answer sheets to the person in charge. Thankyou very much for taking the time to participate in the first part of this study. **Please remember that you will be asked to fill out an almost identical (but slightly shorter) questionnaire at the conclusion of your first session with the counsellor.**

APPENDIX B

EXPECTATIONS ABOUT COUNSELLING

QUESTIONNAIRE 2.

Directions

You have just seen a counselling psychologist for your first interview. We would now like to find out if your expectations about counselling have changed in any way. Please indicate what you expect from counselling **now that you have completed your first session.** For each statement, write the number which most accurately reflects your expectation.

Your responses will be kept in the strictest confidence and your answers will be combined with the answers of others like yourself and reported only in the form of group averages. Your participation, however, is voluntary. If you do not want to participate in this part of the research, just hand the questionnaire back to the person in charge.

When you are ready, answer each question as quickly and as accurately as possible. Please finish each page before going to the next.

NOW TURN THE PAGE AND BEGIN.

1	2	3	4	5	6	7
Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

I EXPECT TO...

1.	Like the counsellor.	
2.	Gain some experience in new ways of solving problems within the counselling process.	
3.	Openly express my emotions regarding myself and my problems.	
4.	Take responsibility for making my own decisions.	
5.	Talk about my present concerns.	
6.	Get practice in relating openly and honestly to another person within the counselling relationship.	
7.	Enjoy my interviews with the counsellor.	
8.	Practice some of the things I need to learn in the counselling relationship.	
9.	Get a better understanding of myself and others.	
10.	Stay in counselling for at least a few weeks, even if at first I am not sure it will help.	
11.	See the counsellor for more than three interviews.	
12.	Enjoy being with the counsellor.	
13.	Stay in counselling even though it may be painful or unpleasant at times.	
14.	Contribute as much as I can in terms of expressing my feelings and discussing them.	
15.	Find that the counselling relationship will help the counsellor and me identify problems on which I need to work.	
16.	Become better able to help myself in the future.	
17.	Feel safe enough with the counsellor to really say how I feel.	
18.	Improve my relationships with others.	
19.	Ask the counsellor to explain what he or she means whenever I do not understand something that is said.	
20.	Work on my concerns outside the counselling interviews.	

PLEASE TURN OVER...

1	2	3	4	5	6	7
Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

The following questions concern your expectations **about the counsellor.**

I EXPECT THE COUNSELLOR TO...

21.	Explain what's wrong.	
22.	Help me identify and label my feelings so I can better understand them.	
23.	Tell me what to do.	
24.	Know how I feel even when I cannot say quite what I mean.	
25.	Know how to help me.	
26.	Help me identify particular situations where I have problems.	
27.	Give encouragement and reassurance.	
28.	Help me to know how I am feeling by putting my feelings into words for me.	
29.	Be a "real" person not just a person doing a job.	
30.	Help me discover what particular aspects of my behaviour are relevant to my problems.	
31.	Inspire confidence and trust.	
32.	Frequently offer me advice.	
33.	Be honest with me.	
34.	Be someone who can be counted on.	
35.	Be friendly and warm towards me.	
36.	Help me solve my problems.	
37.	Discuss his or her own attitudes and relate them to my problem.	
38.	Give me support.	
39.	Know how I feel at times, without having to speak.	
40.	Be able to determine what is the matter with me.	
41.	Respect me as a person.	
42.	Discuss his or her experiences and relate them to my problems.	
43.	Praise me when I show improvement.	
44.	Make me face up to the differences between what I say and how I behave.	
45.	Talk freely about himself or herself.	
46.	Have no trouble getting along with people.	
47.	Like me.	
48.	Be someone I can really trust.	
49.	Like me in spite of the bad things that he or she knows about me.	
50.	Make me face up to the differences between how I see myself and how I am seen by others.	
51.	Be someone who is calm and easygoing.	
52.	Point out to me the differences between what I am and what I want to be.	
53.	Get along well in the world.	

PLEASE TURN OVER...

1	2	3	4
Not at all	Somewhat	Moderately so	Very much so

A number of statements which people have used to describe themselves are given below. Read each statement and then record the appropriate number in the box to indicate how you feel **right now**, that is, **at this moment.** There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your feelings best. The rating scale we would like you to use is printed directly above.

54. I feel calm.
55. I feel secure.
56. I am tense.
57. I feel strained.
58. I feel at ease.
59. I feel upset.
60. I am presently worrying over possible misfortunes.
61. I feel satisfied.
62. I feel frightened.
63. I feel comfortable.
64. I feel self-confident.
65. I feel nervous.
66. I am jittery.
67. I feel indecisive.
68. I am relaxed.
69. I feel content.
70. I am worried.
71. I feel confused.
72. I feel steady.
73. I feel pleasant.

PLEASE TURN OVER...

1	2	3	4	5
Not at all				Very much.

Please record the number which indicates how much you are experiencing the following reactions and feelings **right now.** The rating scale we would like you to use is printed directly above.

74. Heart beats faster. ☐
75. Get an "uneasy feeling". ☐
76. Emotions disrupt action. ☐
77. Become immobilised. ☐
78. Want to avoid situation. ☐
79. Perspire. ☐
80. Mouth gets dry. ☐

PLEASE TURN OVER...

STOP

Thank you for participating in this study. Should you wish to have the overall findings communicated to you, a summary sheet will be availiable at the counselling centre from the 1st of February 1992. Thank you again for your help, please hand all of the materials back to the person in charge.

APPENDIX C

Subscales of the EAC

Scale	*Items*
Motivation	10, 11, 13
Responsibility	4, 5, 19, 20
Confrontation	44, 50, 52
Empathy	24, 28, 39
Nurturance	27, 38, 43
Attractiveness	1, 7, 12
Tolerance	46, 51, 53
Concreteness	22, 26, 30
Outcome	9, 16, 18
Openness	3, 14, 17
Acceptance	35, 47, 49
Directiveness	21, 23, 32
Genuineness	29, 33, 41
Self-disclosure	37, 42, 45
Expertise	25, 36, 40
Trustworthiness	31, 34, 48
Immediacy	2, 6, 8, 15

APPENDIX D

EXPECTATIONS ABOUT COUNSELLING QUESTIONNAIRE 3.

On the following pages are some statements which reflect some of the expectations that people display before they enter counselling. We are interested in finding out whether some people display predominantly positive or negative expectations about counselling and in order to do that we must first determine which statements reflect positive expectations and which ones reflect negative expectations. We would like you to read each statement and indicate whether you think agreeing with that statement reflects a positive or negative expectation. Please indicate "P" if you think the statement is positive, "N" if you think it is negative, and "O" if you think that the statement is neutral. (eg. for item 1: "I expect to like the counsellor" if you think that agreeing with that statement reflects a positive expectation - indicate with a "P").

P = POSITIVE O = NEUTRAL N = NEGATIVE

I EXPECT TO...

1. Like the counsellor.
2. Gain some experience in new ways of solving problems within the counselling process.
3. Openly express my emotions regarding myself and my problems.
4. Take responsibility for making my own decisions.
5. Talk about my present concerns.
6. Get practice in relating openly and honestly to another person within the counselling relationship.
7. Enjoy my interviews with the counsellor.
8. Practice some of the things I need to learn in the counselling relationship.
9. Get a better understanding of myself and others.
10. Stay in counselling for at least a few weeks, even if at first I am not sure it will help.
11. See the counsellor for more than three interviews.
12. Enjoy being with the counsellor.
13. Stay in counselling even though it may be painful or unpleasant at times.
14. Contribute as much as I can in terms of expressing my feelings and discussing them.
15. Find that the counselling relationship will help the counsellor and me identify problems on which I need to work.
16. Become better able to help myself in the future.
17. Feel safe enough with the counsellor to really say how I feel.
18. Improve my relationships with others.
19. Ask the counsellor to explain what he or she means whenever I do not understand something that is said.
20. Work on my concerns outside the counselling interviews.

The following questions concern your expectations **about the counsellor.**

I EXPECT THE COUNSELLOR TO...

21. Explain what's wrong.
22. Help me identify and label my feelings so I can better understand them.
23. Tell me what to do.
24. Know how I feel even when I cannot say quite what I mean.
25. Know how to help me.
26. Help me identify particular situations where I have problems.
27. Give encouragement and reassurance.
28. Help me to know how I am feeling by putting my feelings into words for me.
29. Be a "real" person not just a person doing a job.

P = POSITIVE O = NEUTRAL N = NEGATIVE

30.	Help me discover what particular aspects of my behaviour are relevant to my problems.	
31.	Inspire confidence and trust.	
32.	Frequently offer me advice.	
33.	Be honest with me.	
34.	Be someone who can be counted on.	
35.	Be friendly and warm towards me.	
36.	Help me solve my problems.	
37.	Discuss his or her own attitudes and relate them to my problem.	
38.	Give me support.	
39.	Know how I feel at times, without having to speak.	
40.	Be able to determine what is the matter with me.	
41.	Respect me as a person.	
42.	Discuss his or her experiences and relate them to my problems.	
43.	Praise me when I show improvement.	
44.	Make me face up to the differences between what I say and how I behave.	
45.	Talk freely about himself or herself.	
46.	Have no trouble getting along with people.	
47.	Like me.	
48.	Be someone I can really trust.	
49.	Like me in spite of the bad things that he or she knows about me.	
50.	Make me face up to the differences between how I see myself and how I am seen by others.	
51.	Be someone who is calm and easygoing.	
52.	Point out to me the differences between what I am and what I want to be.	
53.	Get along well in the world.	

APPENDIX E

ADHERENCE FORM

Code Number: _____

Date: _____

Problem type: Personal / Social / Emotional. _____

Study _____

Vocational. _____

Other _____

Was a second appointment scheduled?

Yes: _____

No: _____

Was the second appointment kept?

Yes: _____

No: _____

APPENDIX F

Research Project on Expectations and Feelings of People Entering Counseling.

I am currently interested in finding out how people feel and what they expect when they first see a psychologist or counselor. Previous research has indicated that gaining an understanding of these things will help psychologists to best serve the needs of their clients. Your participation in this study will allow the gathering of data that should ultimately allow practicing psychologists to enhance the assistance they can offer their clients.

Should you choose to participate, you will be required to fill out two questionnaires. The first questionnaire measures what you expect to happen in your first session with the counselor and also records some of the feelings you may be experiencing. The second questionnaire is almost identical to the first (it is slightly shorter) and is filled out immediately after the first session. By giving you the questionnaire a second time I can determine whether your feelings or expectations about seeing a counselor have changed in any way. It should take you about twenty minutes to fill out the first questionnaire and about fifteen minutes to complete the second. The information you provide will be grouped with other data, analysed and then used to help clients in the future.

All of the responses you give will be **strictly confidential.** You will be identified by a number only and your individual data will only be seen by the researcher. You are able to drop out of the study at any point.

As psychologists we are committed to providing the client with the best service possible. By gaining a thorough understanding of the feelings and expectations of new clients we can modify our behaviour as necessary to enhance the therapeutic process.

Your participation in this study would be greatly appreciated, however you are under no pressure or expectation to comply.

Yours sincerely,

Hamish McLeod
Researcher.

CONSENT FORM

What would I be expected to do?

You will be asked to complete two questionnaires that record your expectations and feelings about seeing a counsellor. One questionnaire is filled out immediately **before** your first session and one is filled out immediately **after** your first session. This should take around thirty-five minutes of your time **in total.**

What can I expect from the researcher?

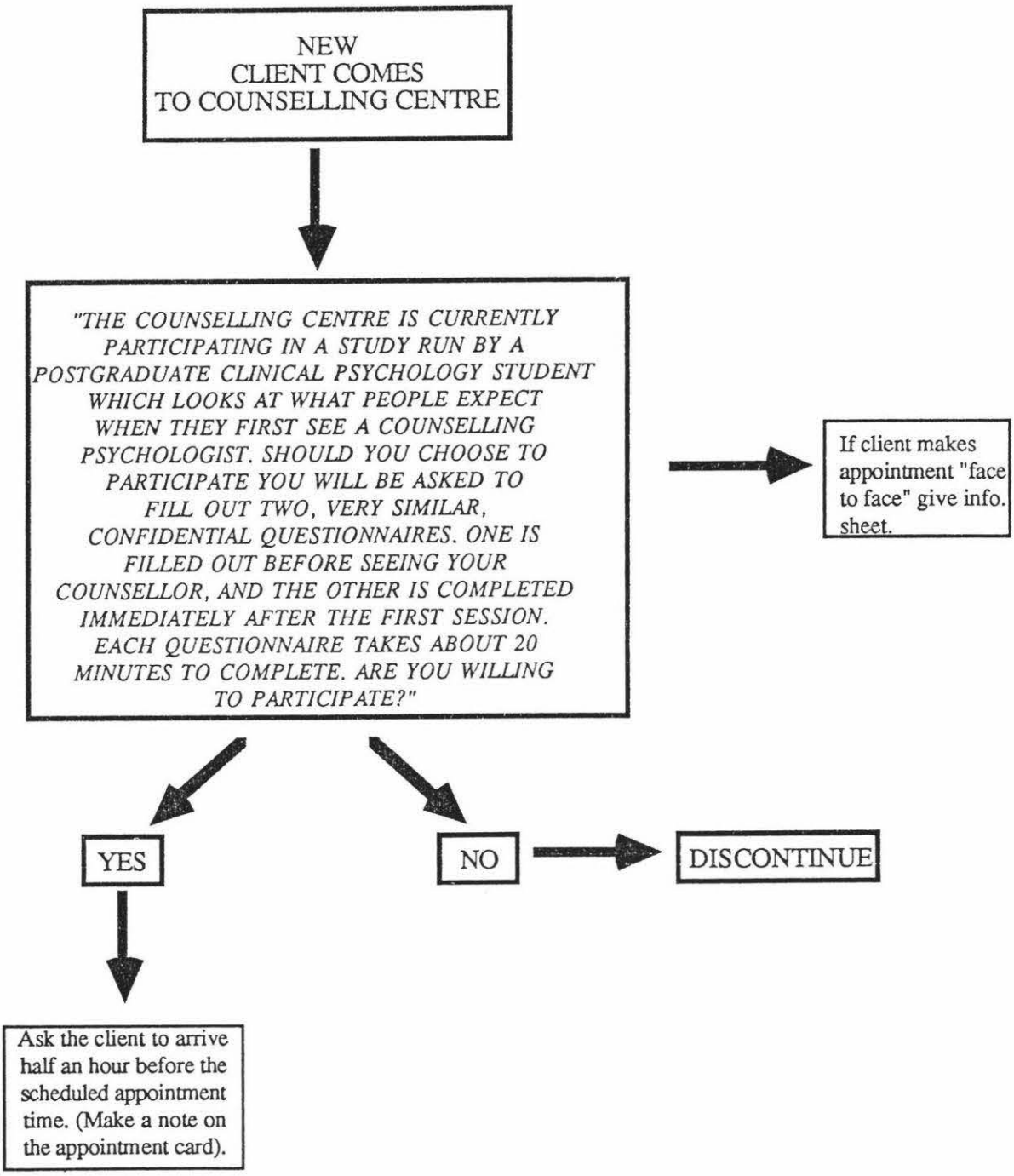
- All participants have the right to withdraw from the study at any time.
- Confidentiality is protected at all times. All questionnaires are identified by a code number only and are only seen by the researcher. It will not be possible to identify individuals in any published reports.

The details of the study have been adequately explained to me, and I wish to participate under the conditions set above.

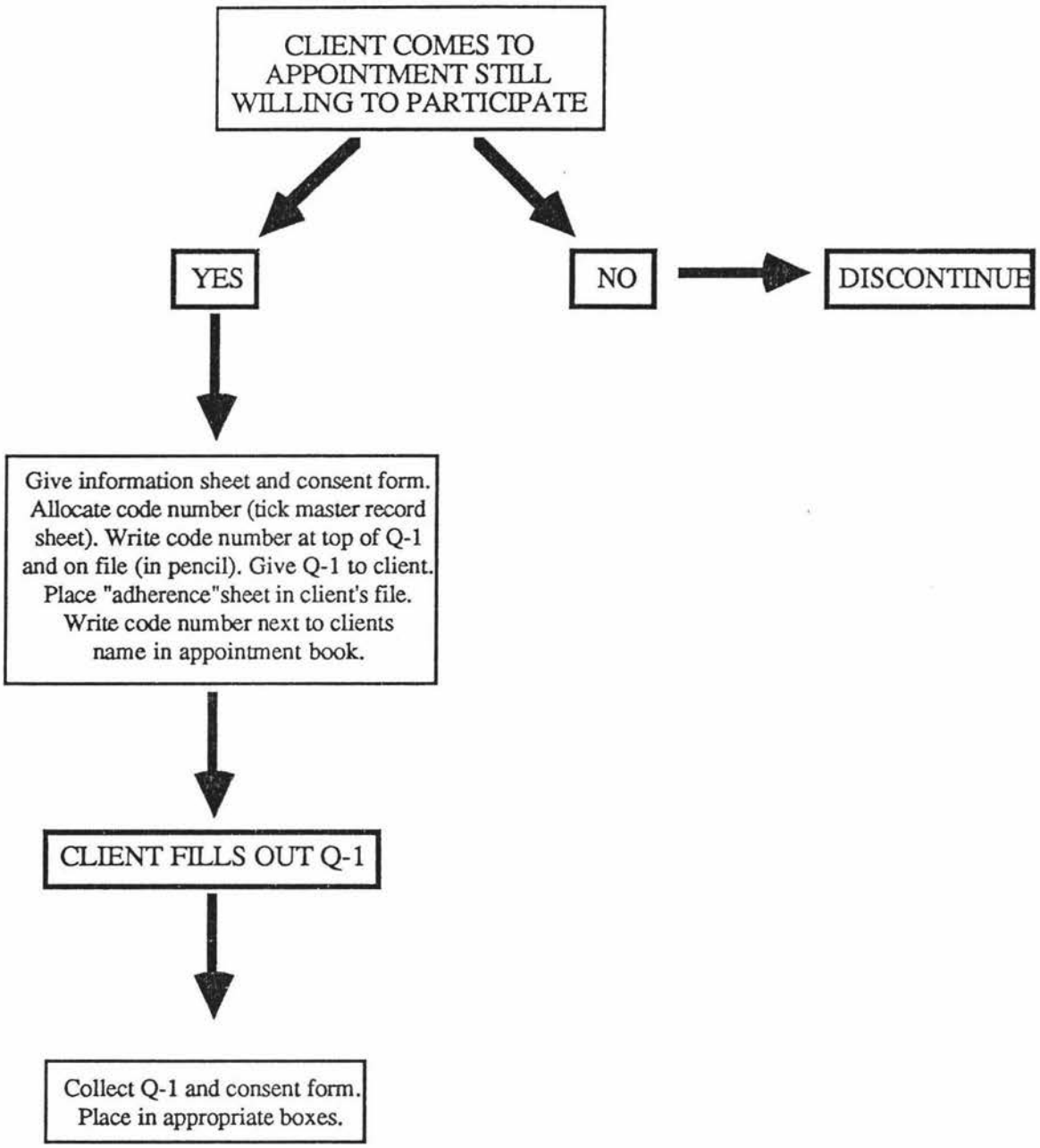
Signature of participant: _____ Date: _____

APPENDIX G

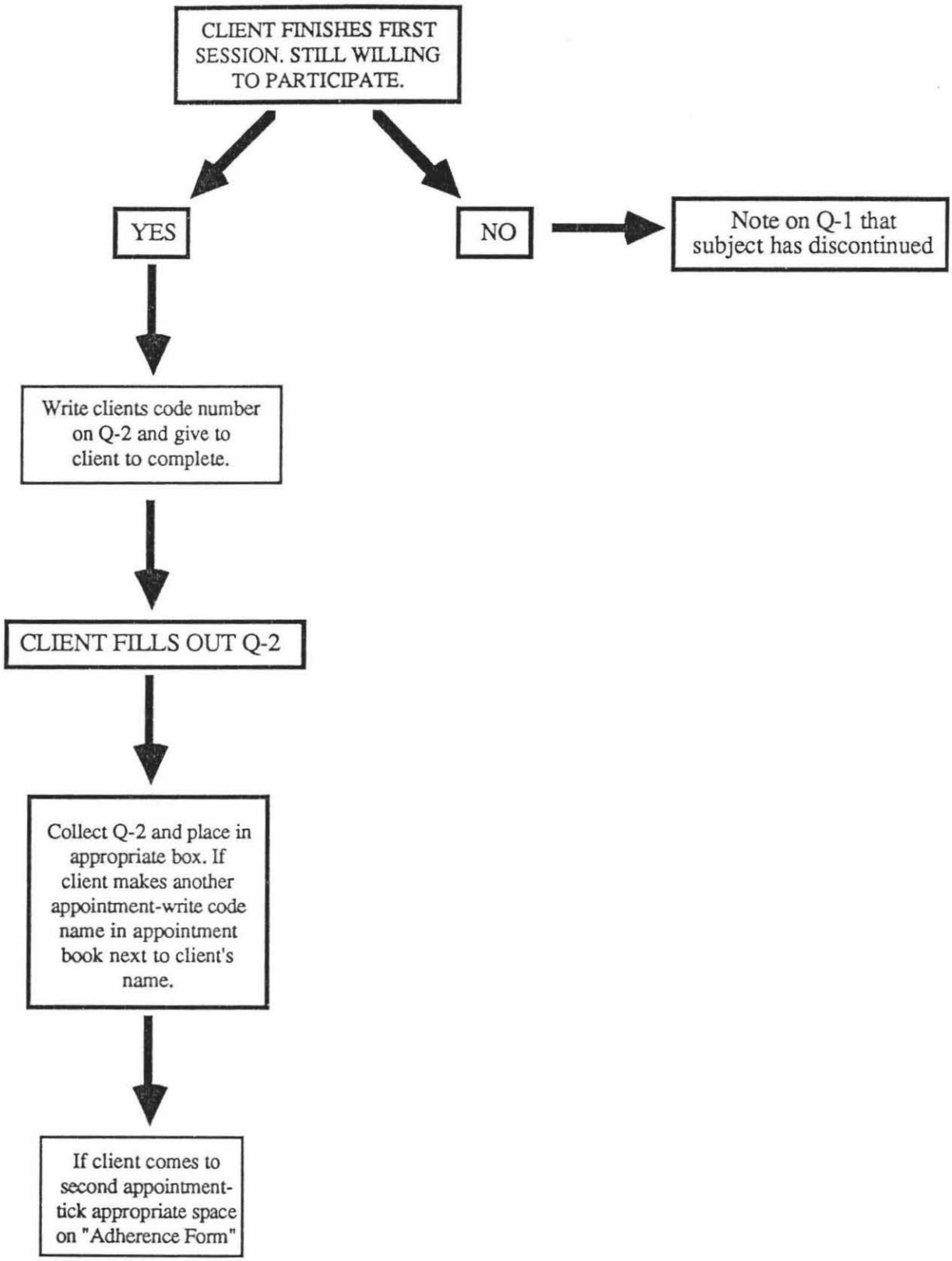
Instructional Flowchart



TIME BETWEEN MAKING APPOINTMENT AND COMING TO SESSION



CLIENT ENTERS FIRST SESSION.



APPENDIX H

Counsellor Consent Form

Research Project on Expectations and Feelings of People Entering Counselling.

I am currently interested in the types of expectations first time counselling clients display and the influence of these expectations on state anxiety. I intend to measure client expectations immediately before and after their first session and then relate the valence of their expectations (i.e. predominantly positive or negative) to their levels of state anxiety. I also intend to ascertain whether either of these variables influence subsequent adherence to treatment.

Your part in the current study would involve the completion of a short data sheet (attached) which records client problem type and whether or not a second appointment was scheduled.

If you are willing to participate, please sign below.

Yours sincerely,

HAMISH MCLEOD.

CONSENT FORM.

My role in the current study has been adequately explained to me and I am willing to participate.

Signature of participant: _____ Date: _____

APPENDIX I

Miscellaneous Tables

Table A1: *Mean scale scores and standard deviations for the current study, and comparison of internal consistency reliability coefficients (Cronbach's alpha) for the current study and Tinsley et al.'s (1980) original sample.*

EAC Subscale	*M*	*SD*	Scale Reliability (Current study)	Scale Reliability (Tinsley et al, 1980)
Openness	5.50	0.98	.74	.84
Responsibility	5.80	0.64	.64	.79
Motivation	3.95	1.49	.75	.82
Attractiveness	4.37	1.16	.79	.80
Expertness	4.70	1.29	.78	.80
Trustworthiness	5.58	1.13	.80	.86
Tolerance	4.75	1.23	.75	.84
Directiveness	3.41	1.59	.83	.80
Empathy	3.75	1.52	.78	.82
Nurturance	5.12	1.36	.80	.81
Genuineness	6.13	1.05	.85	.82
Acceptance	4.63	1.43	.78	.88
Self-disclosure	3.70	1.62	.81	.83
Confrontation	4.83	1.53	.88	.86
Immediacy	4.73	1.26	.67	.77
Concreteness	4.86	1.19	.54	.82
Outcome	5.10	1.45	.78	.89

Notes. *N.B.:* Current study - short form of the EAC (53 items); Tinsely et al. - original item set (135 items).

Table A2: % agreement on ratings of each item for positiveness, neutrality and negativeness by independent raters (n=15).

Item	Positive	Neutral	Negative
9	100*		
16	100*		
18	100*		
2	93.3*	6.7	
17	93.3*	6.7	
27	93.3*	6.7	
3	86.6*	6.7	6.7
4	86.6*	13.3	
25	86.6*	13.3	
33	86.6*	6.7	6.7
1	80*	20	
5	80*	13.3	6.7
19	80*	20	
22	80*	20	
26	80*	20	
31	80*	20	
34	80*	20	
41	80*	6.7	13.3
6*	78.5*	21.4	
8	73.3*	26.7	
13	73.3*	13.3	13.3
15	73.3*	20	6.7
35	73.3*	20	6.7
38	73.3*	26.7	
48	73.3*	26.7	
12	66.6	26.7	6.7
14	66.6	26.7	6.7
20	66.6	33.3	
29	66.6	33.3	
36	66.6	20	13.3
43	66.6	33.3	
30	60	40	
44	60	26.7	13.3
7	53.3	40	6.7
40	53.3	26.7	20
47	53.3	40	6.7
49	53.3	46.7	
51	53.3	40	6.7
10	46.7	46.7	6.7
11	46.7	53.3**	
24	40	46.7	13.3
28	40	33.3	26.7
39	40	26.7	33.3
46	40	60**	
50	40	33.3	26.7
52	33.3	40	26.7
21	26.7	33.3	40
45	26.7	60**	13.3
53	26.7	60**	13.3
23	13.3	33.3	53.3***
32	6.7	46.7**	46.7***
37	6.7	60**	33.3
42	6.7	60**	33.3

Notes. *treated as positive; **treated as neutral; ***treated as negative.

Table A3: *Pearson correlation matrix of EAC scale scores for first-time counselling centre clients (n=33).*

EAC Subscale	Open	Resp	Motiv	Attr	Exp	Trust	Toler	Direct	Emp	Nurt	Gen	Acc	SelfD	Conf	Imm	Conc	Out
Openness	1.00																
Responsibility	.48*	1.00															
Motivation	.08	.08	1.00														
Attractiveness	.47*	.20	-.04	1.00													
Expertness	.03	.25	-.05	.12	1.00												
Trustworthiness	.40	.60**	.60	.18	.52**	1.00											
Tolerance	.37	.11	.17	.29	.47*	.44*	1.00										
Directiveness	-.01	.15	-.17	-.03	.57**	.26	.22	1.00									
Empathy	-.15	-.06	.09	.07	.62**	.31	.28	.63**	1.00								
Nurturance	.25	.38	.27	.07	.66**	.77**	.57**	.43*	.56**	1.00							
Genuineness	.29	.56**	.07	.38	.46*	.78**	.42*	.15	.23	.55**	1.00						
Acceptance	.34	.32	.15	.37	.65**	.66**	.75**	.39	.35	.68**	.61**	1.00					
Self-disclosure	.43*	.19	.00	.33	.54**	.45*	.78**	.44*	.38	.60**	.42	.74**	1.00				
Confrontation	.01	.24	.47*	.05	.37	.57**	.43*	.17	.40*	.67**	.37	.40	.39	1.00			
Immediacy	.30	.33	.46*	.55**	.36	.22	.24	.24	.29	.27	.23	.41*	.29	.36	1.00		
Concreteness	.29	.54**	.17	.17	.70**	.58**	.35	.58**	.55**	.71**	.40*	.48*	.56**	.54**	.52*	1.00	
Outcome	.32	.21	.67**	.36	.11	.36	.38	-.08	.05	.30	.19	.45*	.20	.45*	.73**	.21	1.00

Notes. * $p < .01$; ** $p < .001$

Table A4: *Comparison of means and standard deviations on the STAI trait scale for participants in the current study (clients with positive and negative expctations) and normative data from Spielberger (1983) (male neuropsyciatric (NP) patients and general medical and surgical (GMS) patients with psychiatric complications).*

		Trait Anxiety	
	N	Mean	SD
Neg. Expectations	19	51.32	13.62
Pos. Expectations	19	54	9.34
NP Patients			
Anxiety reaction	60	48.08	10.65
Depressive reaction	28	53.43	12.91
GMS Patients (psychiatric)	34	44.62	14.12

Notes. STAI: State-Trait Anxiety Inventory