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ORIGINAL ARTICLE

The Effects of Inaccurate Expectations on Experiences with Psychotherapy

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Abstract Inaccurate expectations have been shown to negatively affect patients' experiences with medical treatments; however, much less is known about the effects of inaccurate expectations on patients' experiences with psychotherapy. This may be particularly important at the current time because, while many cultural outlets depict either nondirective or psychodynamic therapy, the majority of empirically supported treatments are guided by cognitive behavioral theory. Two studies examined (1) current expectations for psychological treatment and (2) the effects of accurate versus inaccurate expectations on students undergoing either cognitive behavioral therapy (CBT) or nondirective therapy for nonclinical academic problems. Results from Study 1 suggest that people presenting for psychotherapy may be unlikely to expect the specific tasks and goals common to many CBTs. Results from Study 2 demonstrate negative effects of inaccurate expectations on affective reactions to treatment regardless of the type of treatment received. The implications for dissemination of empirically supported CBTs are discussed.

Keywords Treatment expectations · Cognitive behavioral therapy · Empirically supported treatments

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Introduction

Many of the current empirically-supported treatments (ESTs) for psychological disorders or behavioral problems involve cognitive and/or behavioral therapy (Chambless et al. 1998); however, the depiction of effective psychotherapy in popular culture outlets (i.e., television, movies, literature) seems to overwhelmingly reference nondirective or psychodynamic types of therapeutic interventions. Thus, it is likely that clients presenting for psychological treatment will be expecting nondirective or psychodynamic treatment. This conflict, while largely ignored in the psychotherapy literature, seems likely to negatively affect an individual's perception of and outcomes with an otherwise potentially effective treatment. That is, research suggests that experience is determined by the expectations an individual brings to the situation as well as the specifics of the situation itself (Kirsch 1999). This is well established for affective and behavioral reactions to situations ranging from specific sensory stimuli (Anderson and Pennebaker 1980) to complex social interactions (Burgoon et al. 1995; Darley and Fazio 1980).

Importantly, it appears that not only is the specific content of one's expectation (e.g., pleasure versus pain), relevant, the *accuracy* of the expectation also seems to play an important role in determining one's affective experience and behavioral reactions. For example, Johnson (1973) tested what she called the incongruency hypothesis by subjecting participants to ischemic pain in order to simulate a painful medical procedure. Half of the participants were given a detailed, accurate description of what to expect prior to the procedure. Half were given a more general description. Results indicated no differences between groups in terms of the physical sensations experienced during the procedure; however, the group given the more

accurate and detailed expectation reported less distress, particularly during the early period of the pain exposure.

Similarly, patients undergoing an endoscopic examination who were given accurate expectations about the sensations they would experience prior to the treatment experienced less distress and required less medication compared to patients who were given no expectation (Johnson and Leventhal 1974; Johnson et al. 1973). Although these studies compared more or less accurate expectations and accurate versus no information, Johnson and her colleagues more specifically focused on the incongruency hypothesis in a subsequent study (Johnson and Rice 1974). In this study, all participants were exposed to pain from an inflated blood pressure cuff. Some participants received an accurate expectation about what to expect—half of these subjects received partial information, the other half got more complete information, others received no expectation, and, importantly, some subjects were given inaccurate information regarding the procedures. Distress ratings from the partial and complete accurate expectations groups did not differ from one another. Similarly, the no information and inaccurate information group did not report significantly different levels of distress. However, the two accurate expectations groups did report significantly less distress upon exposure to the painful procedure than either the no expectation or the inaccurate expectation group.

Johnson and colleagues have also demonstrated that these findings generalize to males and females as well as children and adults (Johnson 1999). Moreover, results generalize to patients' ability to cope with medical procedures that last for an extended duration, a situation not unlike psychotherapy. For example, surgical patients who were given information leading to accurate expectations regarding their hospitalization had shorter hospital stays and quicker return to usual activities than those who were not given this information (Johnson et al. 1978). Additionally, patients who were fearful before the surgery also demonstrated better affective responses when provided with accurate information. Again, effects on functioning and negative affect were found for medical treatments (i.e., radiation therapy and chemotherapy) that were delivered over several weeks (Johnson 1996; Johnson et al. 1988).

These findings, especially those pertaining to potentially distressful treatments that take place over a significant time period, appear likely to be relevant to patients undergoing psychological treatment. Although the findings on providing accurate expectations are well established in the medical field, the application of these findings to psychotherapy has been somewhat limited. Thus, despite the potentially important impact of clients' expectations when entering psychological treatment, we currently know very little about what people expect when seeking treatment, whether these expectations are accurate for any given psychological intervention, and whether these expectations affect perceptions of the treatment or treatment outcome. The extant literature on psychotherapy expectations does suggest that accurate expectations can be developed using relatively efficient and straightforward interventions such as audiotaped or videotaped information (Day and Reznikoff 1980a, b; Tinsley et al. 1988; Zwick and Attkisson 1985). However, some research (e.g., Hardin et al. 1988) has suggested that pretherapy expectations are not different for those who complete therapy and those who terminate early; on the other hand, this research has not considered the accuracy of the expectations. In other words, whether one enters therapy expecting the therapist to be active or passive may not be as important as whether these expectations are congruent with the treatment.

In fact, correlational studies have found that clients with more congruent expectations are less likely to terminate treatment prematurely (Day and Reznikoff 1980b; Hansen et al. 1992; Rabin et al. 1985). Further, using an experimental design, Reis and Brown (2006) found that prepared clients (i.e., those who viewed a videotaped introduction to psychotherapy) were less likely to prematurely terminate their treatment than unprepared clients. However, these results are difficult to interpret in that, although the authors suggest that the videotaped preparation was designed to increase the accuracy of patient expectations, the content of the videotape also included direct instruction on behaviors that themselves may have produced decreased dropout (e.g., telling clients to be active in the therapy process and to tell the therapist if they are unhappy with him/her). Moreover, the degree to which the therapy received was consistent with the expectations given was not manipulated or measured. Additional studies have found that prepared clients have better outcomes (Zwick and Attkisson 1985) and missed fewer appointments (Day and Reznikoff 1980a); however, effects on treatment satisfaction have been mixed. Importantly, satisfaction or positive affect during treatment may serve to motivate clients to attend therapy sessions and adhere to treatment recommendations by serving as positive reinforcement (Annesi 2005). Therefore, while studies of psychological treatments suggest, similar to the medical literature, that clients should be more likely to complete a treatment when their expectations are congruent with the tasks and goals of the treatment, additional research is needed that uses an experimental method and that assesses outcomes in addition to dropout.

Timely data on these issues are particularly important given the relatively recent movement to identify and disseminate ESTs. That is, while ESTs should arguably represent the first line of treatment in everyday clinical practice, if these treatments are not what clients are expecting, their effects may be somewhat diminished or they may be viewed less favorably, possibly leading to

higher rates of dropout. Therefore, the goals of the current study were twofold. The first goal was to examine current expectations about psychotherapy and to determine whether current expectations are consistent with either a cognitive behavioral approach to psychological treatment or other approaches. The second goal was to examine whether clients' expectations about treatment affect perceptions of the treatment and treatment outcome.

Study 1

Method

Participants

Participants were 92 students enrolled in an introductory psychology class in a large, Midwestern University. Students participated early in the semester before covering theories of psychopathology or psychotherapy in their coursework. The mean age of participants was 19.23 years ($SD = 1.63$ years) and the majority (58%, $N = 53$) of participants were female. The sample was drawn from a mostly Caucasian group of students. This was primarily a treatment naïve sample; 78 students (85%) reported no previous therapy experience while 8 students (9%) reported they had been in therapy at some point prior to their participation in the study [6 students (7%) failed to answer this question]. Students received course credit for their participation.

Procedures

Participants were informed that the study was investigating ideas about therapy, and that they would be completing questionnaires about their perceptions of therapy. After consent was obtained, participants filled out the questionnaires described below.

Measures

Participants completed a demographics form and a questionnaire designed to elicit participants' perceptions of therapy. This questionnaire posed three open-ended questions: "What does a therapist do during a typical therapy session?," "What would someone going to therapy be expected to do?," and "What is therapy like (i.e., what happens in therapy)?" and allowed for participants to list up to three responses for each question.

Coding of Responses

Two undergraduate coders reviewed participants' responses and listed all unique statements. (Due to redundancy in responses both within and across participants, the total number of *unique* responses was less than the total number of participants.[1]) Two of the resulting responses were deleted because they were too vague to convey any specific meaning. The remaining responses were coded by the first author (LDS), a licensed psychologist with over 12 years of experience, and a graduate student in clinical psychology who was unfamiliar with the hypotheses of the study. Responses were coded as being either: (1) central to CBT (i.e., more like CBT than treatments guided by another theory); or (2) nonspecific or typical of treatment guided by another theoretical orientation. The two coders agreed on the coding of 42 of 43 (98%) of participants' responses to the question, "What does a therapist do during a typical therapy session?" The one disagreement was resolved through discussion. Similarly, of the 48 responses to the question, "What would someone going to therapy be expected to do?" the two coders agreed on 45 of 48 responses (94%). Consensus was again reached on the three disagreements through discussion. Participants provided 57 responses to the question, "What is therapy like (i.e., what happens in therapy)?" The two coders agreed on 56 (98%) of these responses, and reached consensus on the one disagreement through discussion.

Results and Discussion

Of the 43 unique responses given in response to the question, "What does a therapist do during a typical therapy session?" 3 responses (7%) were judged to be typical of CBT. The remaining 40 responses (97%) were either more typical of treatment delivered from another theoretical perspective or were not specific to any particular type of treatment. The three responses typical of CBT and examples of the remaining responses can be seen in Table 1. In response to the question concerning clients' behavior in psychological treatment, participants gave a total of 48 unique responses; examples can be seen in Table 2. Of these, the majority (96%, 46 responses) were either not specific to any theoretical orientation or were typical of treatment from a theoretical orientation other than CBT. Only 2 responses (4%) reflected client behaviors that were specific to those behaviors expected of clients in CBT. Similarly, participants gave a total of 56 unique responses when queried about their beliefs about what is expected in psychotherapy in general, examples can be seen in Table 3. Again the vast majority of responses (98%, 55 responses) were not typical of CBT.

[1] Responses given by those who had previous therapy experience (and those who did not indicate whether they had previous therapy experience) were duplicated in responses given by the treatment naive students; therefore, no distinction is made between these groups when reporting results.

Table 1 Responses to "What does a therapist do during a typical therapy session?"

Responses specific to CBT	Examples of nonspecific responses
Directs patient's thoughts in the direction they need to be in	Helps the patient talk everything out
Attempts to change the way the brain interprets problems	Sits behind something so the patient does not see their facial expressions
Has patient do body or mind exercises	Tries to put the patient in a better mind-set
	Gives advice
	Listens
	Helps the patient realize the true cause of their problem
	Asks questions to see if the patient's problems have come from childhood

Table 2 Responses to "What would someone going to therapy be expected to do?"

Responses specific to CBT	Examples of nonspecific responses
Face their fears	Answer questions
Be monitored on their path to their goal	Talk freely and listen to advice
	Learn why they feel the way they do
	Dig deep into their emotions
	Stay positive
	Talk about their relationship with family or friends
	Listen to the therapist

Table 3 Responses to "What is therapy like (e.g., what happens in therapy)?"

Responses specific to CBT	Examples of nonspecific responses
Coping skills are suggested	Release of emotional stress
	Therapist finds out exactly what the problem is
	Patient talks about how they feel
	Therapist helps the client with closure
	Patients get in touch with what they are truly feeling
	Therapist analyzes client responses
	Patients understand themselves better
	Therapist tells patient what to do

These results suggest that the general population may not expect the specific tasks of typical CBT interventions when entering psychotherapy. In fact, many of participants' statements suggest that they expect psychotherapy to more like a nondirective social interaction than like treatment delivered from any specific theoretical orientation. Those expectations that are consistent with a particular theoretical orientation appear to more consistent with psychodynamic therapy or traditional psychoanalysis. Although this may not be surprising given the popular depiction of psychotherapy in our culture and limited public education regarding effective psychological treatment, it does suggest that clients participating in most current ESTs will start treatment with inaccurate expectations. Extant research suggests that these expectations could negatively affect clients' affective experiences in treatment and may also affect dropout and treatment outcome (e.g., Day and Reznikoff 1980a). However, in regard to psychological treatments, much of this research is correlational. Therefore, in Study 2 participants' expectations for treatment were manipulated in order to examine the effects on affective reactions and treatment outcome and dropout.

Study 2

Methods

Participants

All participants were undergraduate students enrolled in an introductory psychology class in a large, Midwestern University. A total of 94 participants (approximately 39% males and 62% females) participated in a screening session and agreed to take part in the treatment phase of the study. During the screening, participants completed the measures described below and an expectation manipulation was conducted. Of the 94 participants who signed up for treatment, 63 (67%) attended the first session. Analyses reported below are for the final sample of 63 participants.

The average age of the final sample was 19.52 years ($SD = 3.44$ years). The majority of participants were female (61%) and Caucasian 81%; 9% were Asian Americans, 8% were African Americans, and 2% were from other ethnic backgrounds. No significant differences were found between the final sample (i.e., those participants who attended session one) and the screened sample in terms of age $t\ (43.1)^2 = 0.77\ P > .05$, sex $\chi^2\ (1) = 0.37\ P > .05$,

[2] The Welch-Satterthwaite solution, with adjusted degrees of freedom, is reported because the variances for the two groups were determined to be significantly different. This is due to the influence of

ethnicity χ^2 (4) = 5.78, $P > .05$, or expectation condition χ^2 (1) = 0.65, $P > .05$, or affective reactions in response to the treatment described in the expectation manipulation (expected helpfulness of treatment: $t[92] = 0.41$, $P > .05$, how pleasurable treatment was expected to be: $t[92] = 1.15$, $P > .05$, or how enjoyable treatment was expected to be t [92] = 0.78, $P > .05$).

Measures

Pre-treatment Measures Participants filled out a demographics form and a questionnaire created for the current study which asked them to predict how helpful, enjoyable, and successful the therapy sessions might be (e.g., "How pleasant do you think participating in the therapy group will be?"). Participants rated their responses on a seven-point Likert scale (1 = *not at all helpful/enjoyable/pleasant*; 7 = *extremely helpful/enjoyable/pleasant*).

Treatment Questionnaire After each therapy session, participants completed questionnaires created to assess perceptions of session helpfulness, enjoyability, and pleasantness. Responses were again rated on a seven-point Likert scale (1 = *not at all* helpful/enjoyable/pleasant; 7 = *extremely helpful/enjoyable/pleasant*).

Posttreatment Interview After all therapy sessions concluded, participants were telephoned and asked to again rate their affective reactions to the therapy. Responses were on a seven-point Likert scale, with higher numbers indicating greater helpfulness and satisfaction. In addition they were asked to describe their progress and based on this description the interviewer rated outcome on a 5-point scale (1 = *no progress*; 5 = *goal met*).

Procedures

Participants were told they were participating in a study about psychotherapy, in which they would be shown a short video detailing current methods of treatment and then given questionnaires about what they saw. They were also told that they would have the opportunity to sign up for therapy sessions, similar to those described in the video, which would focus on nonclinical academic problems (e.g., procrastination). Two brief videos (i.e., less than 5 min) were created for the current study, one describing group therapy from a cognitive-behavioral standpoint and one describing group therapy from a nondirective, supportive standpoint. Groups of participants were randomly assigned to view either the CBT or nondirective video, and then completed questionnaires in which they predicted the therapy's helpfulness, pleasantness, and enjoyability. At this time, they were also asked to identify a particular academic goal they wanted to work toward in therapy. After completion of the questionnaires, those who wished to participate in therapy sessions were randomly assigned to either the CBT treatment condition or the nondirective treatment condition. This assignment resulted in 19 participants who had viewed the video describing CBT being assigned to the CBT treatment (accurate expectations), 13 participants who had viewed the video describing CBT were assigned to the nondirective treatment (inaccurate expectations), 17 participants who had viewed the video describing the nondirective therapy were assigned to the nondirective treatment (accurate expectations), and 14 participants who had viewed the video describing the nondirective therapy were assigned to CBT treatment (inaccurate expectations).

After each therapy session, participants completed the treatment questionnaire described above. Attendance was also recorded following each session. Approximately 1–2 weeks after all therapy sessions concluded, participants were contacted by phone for the posttreatment interview and debriefing. During the debriefing, the expectation manipulation was explained, and all questions were answered.

Therapy Therapy sessions focused on nonclinical, academic problems (e.g., procrastination). Participants requesting therapy for other concerns were given appropriate referrals. Therapy sessions were held once per week for 3 weeks, and were 50 min long. CBT groups focused on psychoeducation, identifying and challenging distorted and maladaptive cognitions, and on creating and implementing a system of reinforcers and punishers for target behaviors. Nondirective groups focused on providing a supportive environment for group members to discuss their concerns. Therapists conducting the nondirective treatment refrained from discussing cognitive and behavioral strategies and deflected direct queries for advice or suggestions back to the group.

Therapists Therapists for the study were five graduate students in clinical psychology (4 females, 1 male). Each therapist ran at least one CBT group and one nondirective group. All therapists had completed training in CBT and nondirective therapy group procedures, and were supervised by a licensed psychologist.

Treatment Integrity Two sessions for each therapist were coded by two raters—one CBT session and one nondirective session. The session number (i.e., first, second, or

Footnote 2 continued
two outliers in the group of participants who did not attend the first therapy session.

third) was randomly selected. Raters rated the degree to which the therapist engaged in the behaviors as proscribed by the relevant treatment manual using a likert scale ranging from 1 ("not at all") to 5 ("extensively"). Inter-rater reliability was assessed using Pearson product moment correlations (r) and intraclass correlation coefficients (ICC). Reliability of raters was in the moderate range for both the CBT sessions and the nondirective sessions (r = 0.69, ICC = 0.63; r = 0.64, ICC = 0.57, respectively). When adherence ratings were averaged across judges and therapists the average adherence rating for CBT sessions was 4.65 and the average adherence rating for nondirective sessions was 4.73, suggesting that therapists followed the treatment manuals and the manipulation was successful.

Results and Discussion

Affective Reactions

No significant differences in affective reactions to the CBT and nondirective videotapes were found for the 63 participants who attended the first session. More specifically, prior to treatment, participants who viewed the CBT videotape and those who viewed the nondirective videotape did not differ in how helpful they perceived the therapies to be (t [54.2] = 0.41, $P > .05$), how pleasant they perceived the therapies to be (t [61] = 0.52, $P > .05$), or how enjoyable they perceived the therapies to be (t [61] = 0.29, $P > .05$).

To assess participants' change in affective reactions (i.e., helpfulness, pleasantness, enjoyableness) upon exposure to psychotherapy, difference scores were computed subtracting participants' affective reaction after viewing the videotape from their affective reaction after each session and at posttreatment. This was done to isolate the affective reaction to the psychotherapy condition from the affective reaction to the expectation manipulation. These change scores then served as the dependent variables in 2 × 2 between participants, factorial ANOVAs (Expectation Condition: CBT/Nondirective; Treatment Condition: CBT/Nondirective) to test the hypothesis that participants would have a more positive reaction to psychotherapy, regardless of the specific type of therapy, when the treatment they received was consistent with what they had been told to expect.

Early Reactions In terms of participants' early perceptions of the helpfulness of treatment (i.e., perceptions after session one) there was no main effect for treatment condition (F [1, 55] = 1.82, $P > .05$) or for expectation condition (F [1, 55] = 1.01, $P > .05$). As hypothesized, there was however, a significant Treatment Condition × Expectation Condition interaction, F (1, 55) = 6.30, $P < .05$. As can be seen if Fig. 1, participants who had been expecting nondirective therapy and received CBT therapy viewed their first session as somewhat less helpful than they had expected before starting treatment; however, the participants who were expecting nondirective therapy and who received nondirective therapy viewed the first session as slightly more helpful than originally expected. This pattern was reversed for the participants who were expecting CBT. These participants viewed the CBT session as more helpful and the nondirective session as less helpful.

This same pattern can be seen in participants' perceptions of the pleasantness of the first session. More specifically, no main effect was found for treatment condition (F [1, 55] = 1.93, $P > .05$) or for expectation condition (F [1, 55] = 0.54, $P > .05$); however, a significant Treatment Condition × Expectation Condition interaction was revealed (F [1, 55] = 18.61, $P < .01$). Again, as can be seen in Fig. 2, participants' perceptions of the pleasantness of the session were more positive when the type of treatment they received was consistent with the expectation they were given.

When participants were asked about how enjoyable the first session was, a similar pattern emerged. No main effect for treatment condition was found, F (1, 55) = 2.76, $P > .05$. However, a significant main effect for expectation condition (F [1, 55] = 4.36, $P < .05$) was found, with participants in the nondirective treatment expectation condition viewing the first session as more enjoyable than expected as compared to the participants who were expecting CBT ($M = 0.73$, $SD = 1.01$; $M = 0.24$, $SD = 1.18$, respectively). However, this main effect was qualified by a significant Treatment Condition × Expectation Condition interaction, F (1, 55) = 5.84, $P < .05$. As can be seen in Fig. 3, again participants viewed the first

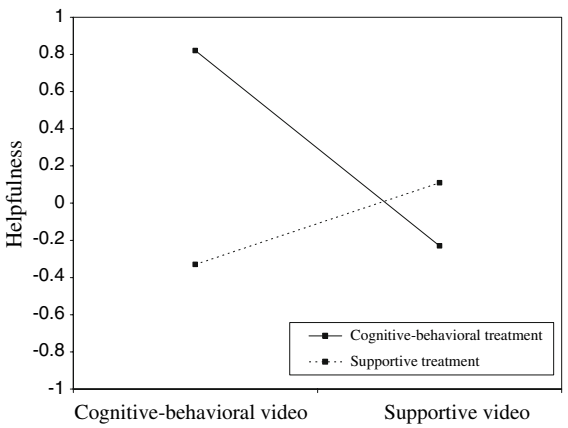

Fig. 1 Early perceptions of therapy helpfulness among matched and nonmatched participants

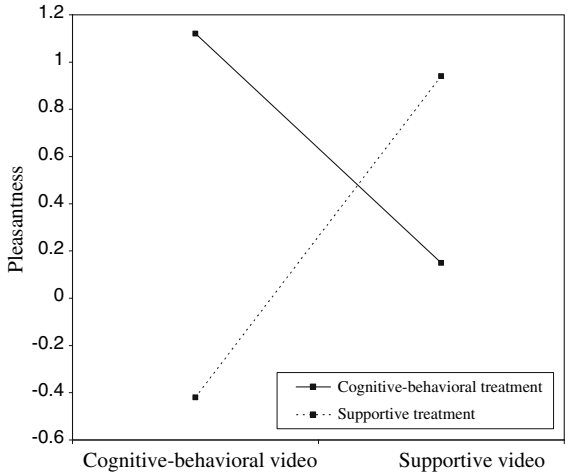

Fig. 2 Early perceptions of therapy pleasantness among matched and nonmatched participants

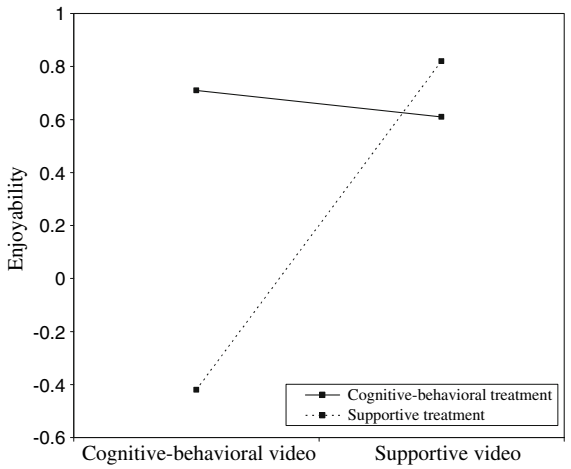

Fig. 3 Early perceptions of therapy enjoyability among matched and nonmatched participants

session more positively when the treatment they received was consistent with the expectation they were given.

Late Reactions In general, findings on participants' affective reactions later in treatment (i.e., after session three and at posttreatment) were similar to those seen early in treatment. More specifically, in terms of perceptions of helpfulness of session three, no main effect was found for treatment condition or expectation condition (F [1, 31] = 0.85, $P > .05$; F [1, 31] = 0.15, $P > .05$, respectively); however, a trend was noted for the Treatment Condition × Expectation Condition interaction, F (1, 31) = 3.94, $P = .056$. Again, participants rated the session as more helpful when their expectation was consistent with the treatment regardless of the type of treatment they received (see Fig. 4).

No significant main effects on perceived pleasantness were found for treatment condition, F (1, 31) = 0.47,

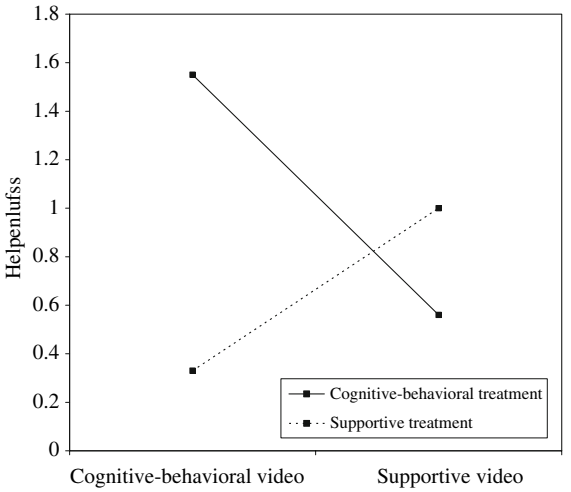

Fig. 4 Later perceptions of therapy helpfulness among matched and nonmatched participants

$P > .05$. A significant main effect for expectation condition was revealed F (1, 31) = 4.77, $P < .05$, with those participants expecting nondirective therapy viewing session three as more pleasant than expected than those who were expecting CBT therapy ($M = 1.20$, $SD = 1.15$; $M = 0.50$, $SD = 1.67$, respectively). However, this main effect was qualified by a significant Treatment Condition × Expectation Condition interaction, F (1, 31) = 14.62, $P < .01$. Inspection of this interaction (see Fig. 5) reveals that those participants who were expecting CBT perceived the third session of treatment to be more pleasant than expected when they received CBT and slightly less pleasant than expected when they received nondirective therapy. Those participants who were expecting nondirective therapy perceived the third session of treatment to be

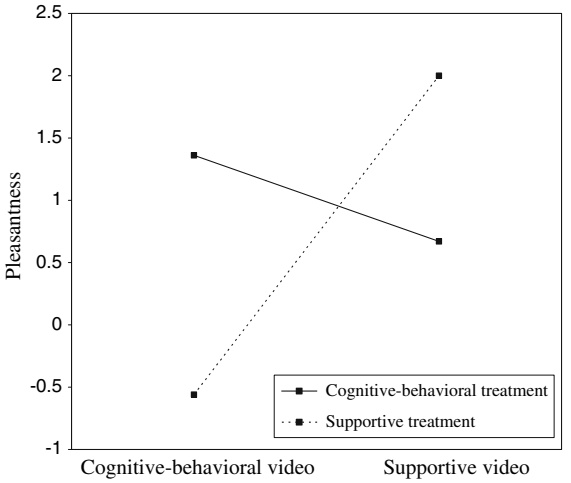

Fig. 5 Later perceptions of therapy pleasantness among matched and nonmatched participants

more pleasant than expected but this was particularly true when they received nondirective treatment.

Analysis of participants' perceptions of how enjoyable session three was revealed no significant main effects for treatment or expectation condition (F [1, 31] = 0.14, $P > .05$; F [1, 32] = 3.03, $P > .05$, respectively). Again, however, a significant Treatment Condition × Expectation Condition interaction was found (F [1, 31] = 7.55, $P < .01$), with participants expecting CBT viewing the third session as more enjoyable than expected if they received CBT treatment and less enjoyable than expected if they received nondirective therapy (see Fig. 6). Those participants who were expecting nondirective therapy saw both types of treatments as more enjoyable than expected but this difference was larger when they received nondirective therapy.

A total of 32 participants (51% of the sample) were contacted between 1 and 2 weeks after treatment sessions were completed. Many of the participants could not be located because treatment concluded around the same time the semester ended. Analyses of these participants' posttreatment affective responses revealed no main effects or interactions in terms of how helpful participants viewed the treatments; however, a significant Treatment Condition × Expectation Condition interaction was found for both pleasantness (F [1,28] = 6.56, $P < .05$) and enjoyableness (F [1,28] = 6.64, $P < .05$) of the treatments. Again, participants reacted more favorably to the treatment when they received a treatment that was consistent with their expectations (see Figs. 7 and 8).

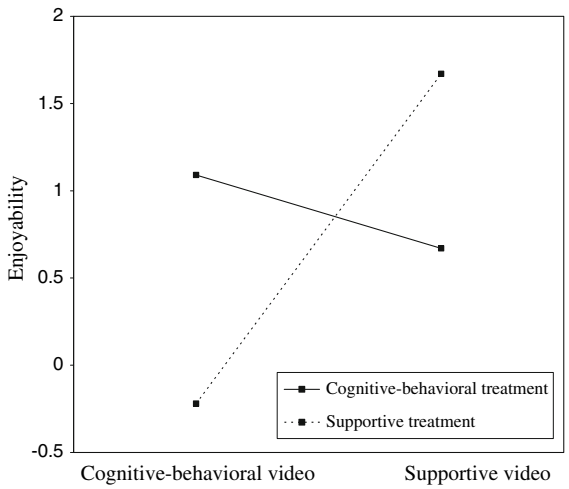

Fig. 6 Later perceptions of therapy enjoyability among matched and nonmatched participants

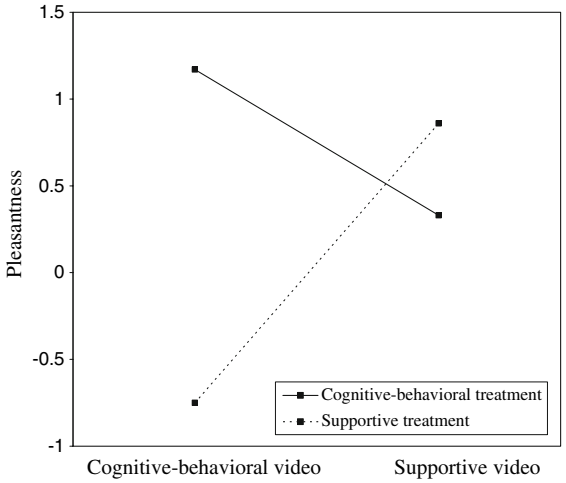

Fig. 7 Posttreatment perceptions of therapy pleasantness among matched and nonmatched participants

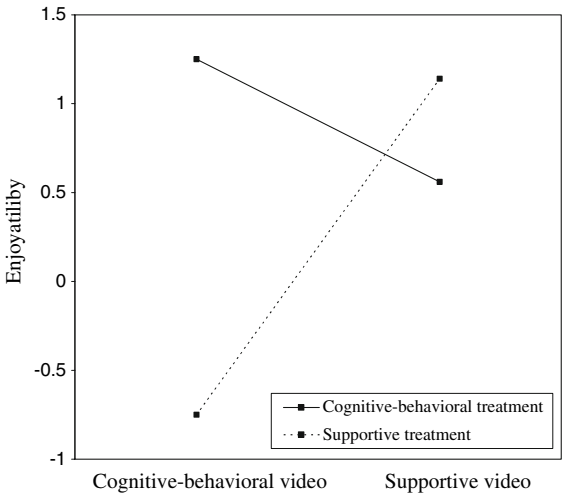

Fig. 8 Posttreatment perceptions of therapy enjoyability among matched and nonmatched participants

Therapy Behaviors

Attendance at sessions two and three[3] and interviewer rated progress (for the 32 participants contacted at posttreatment) were examined as dependent variables in separate 2 × 2 between participants, factorial ANOVAs (Expectation Condition: CBT/Nondirective; Treatment Condition: CBT/Nondirective). No significant effects (main effects or interactions) were found.

[3] Session one attendance was not included in these analyses because only participants who attended session one were exposed to the full manipulation (i.e., a match or mismatch between expectations and treatment).

Discussion

In general, results are consistent with Johnson's incongruency hypothesis and previous research (Deane et al. 1992; Johnson and Leventhal 1974; Johnson et al. 1973) suggesting that an individual's affective experience is in part determined by the expectations that the individual brings to the situation. That is, participants were generally more *pleased* with their experiences in therapy when their experience matched the expectation they had been given. The medical literature suggests that patients with accurate expectations for their treatment should also experience less *distress* than those with inaccurate expectations; however, in the current study we measured positive affect rather than negative affect. Replication of the current finding with measures of negative affect will be an important avenue for further inquiry as positive and negative affective reactions can be distinct.

It has been suggested that for ongoing experiences such as psychotherapy, effects due to accurate or inaccurate expectancies may dissipate over time (Tinsley et al. 1988), possibly because expectations become more accurate as a product of early experience. In fact, Day and Reznikoff (1980a) found that children and parents who viewed a videotape describing the treatment they were about to receive held more accurate expectations at the beginning of treatment when compared to unprepared families but that this difference was no longer apparent after six sessions. However, at least in this brief psychological treatment, affective experiences throughout the treatment appeared to be affected by participants' initial expectations. Given that the treatment used in the current study was only three sessions, this finding is tentative, suggesting the need for replication with a treatment of more realistic length (e.g., 12–20 sessions).

On the other hand, these findings did not generalize to behaviors such as treatment dropout or to treatment outcome. Although it may be true that the effects of expectations on psychotherapy experience are limited to affective reactions, several studies have found a link between accuracy of treatment expectations and variables such as premature termination, number of cancelled appointments, and no-shows for appointments (Borghi 1968; Day and Reznikoff 1980a; Holmes and Urie 1975; Overall and Aronson 1963; Zwick and Attkisson 1985); moreover, affective reactions have been linked to treatment adherence (Annesi 2005). Therefore, it may also that the use of a student, non-helpseeking sample complicates the interpretation of these findings. For example, participants received course credit for their participation and were not actively seeking treatment. Therefore, it is possible that some in the sample viewed their participation in the treatment sessions more as an academic obligation than as a treatment in which they had a right to expect results, as such, attendance may have been in part a function of participants' conscientiousness and not their satisfaction with or desire to complete the treatment. Similarly, given that these students were not seeking help for their academic problems, the severity of the problems they identified, as well as their motivation for addressing these problems varied. While these factors and the limited duration of the treatment program may have produced effects on treatment outcome and attendance that overwhelmed any produced by expectations, our study design did not allow for an examination of this possibility.

The literature on medical interventions suggests that expectations can and do affect both affective experiences and behavior. This is supported by correlational studies of expectations in psychotherapy and studies comparing prepared and nonprepared psychotherapy clients. The fact that we found the hypothesized effects on affective expectations suggests that pursuing this line of research with clinical samples may prove fruitful.

General Discussion

Results of the current investigation suggest that people presenting for psychotherapy will, at best, present with expectations that are not specific to CBT and, at worst, present with expectations that are not consistent with CBT. Expectations tended to be more consistent with atheoretical psychotherapies (e.g., the therapist gives advice, helps the patient to talk everything out, and stays positive) or with uncovering/psychodynamic therapies (e.g., the therapist sits behind the patient and asks questions about his/her childhood). This may be particularly problematic in that at least some studies have shown atheoretical treatment to have little to no effect for clinical problems (e.g., Cohen et al. 2005; Kolko et al. 2000; Rowa and Antony 2005; Weiss et al. 1999) while psychodynamic treatments, to date, have been shown to work for only a very limited number of problems (Chambless et al. 1998; Chambless and Ollendick 2001). Very few people reported expectations specific to CBT such as having to complete tasks outside of treatment or changing environmental contingencies. The inconsistencies of people's expectations with some of the tasks in CBT may be one of the reasons that clients are often unsuccessful at completing tasks, such as homework assignments (Malouff and Schutte 2004), that are part of CBT but not part of nondirective treatments. Research into medical treatments suggests that these inconsistencies may also affect the success of CBT. In the current study, however, treatment outcome did not vary as a function of expectations; therefore, additional research with psychological treatments is needed to clarify this

point. Results do suggest that expectations upon entering psychotherapy do affect affective reactions. This in turn may affect motivation for engaging in treatment tasks (Annesi 2005).

These findings, coupled with the fact that the majority of current ESTs are cognitive behavioral therapies, suggest that those seeking treatment should be educated about CBT prior to beginning therapy. This can be done effectively in a relatively brief time period preferably using either audiotaped or videotaped information as written pamphlets do not appear to be as effective (Tinsley et al. 1988). Past research suggests that this information may be most effective when it is based on experienced patients' perceptions of the therapy (Johnson 1999) and when it includes information on the objective events that could be expected (i.e., what the patient or client will actually do or experience).

However, it should be noted these interventions, like the one used in the current investigation, help to develop a new expectation that is likely to compete with a preexisting expectation based on our cultural conception of psychotherapy. This may be different than the case in which a patient has no preconceived notion of what to expect from a treatment, as is likely the case with some medical treatments, and is given an accurate expectation. It is likely that when two competing expectations are present they are both likely to be accessible for comparison with the actual event (Bouton 2002); therefore, expectations for psychotherapy and the actual events occurring in treatment may or may not be consistent depending on which expectation is accessed. Consequently, public education campaigns that include specific information on the goals and tasks of CBTs may be more effective than individual preparation upon entering therapy in that, over time, this could create a shift in initial expectations for psychotherapy that is consistent with many current ESTs.

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