

PRACTICE REVIEW

Clinician Interventions and Participant Characteristics That Foster Adaptive Patient Expectations for Psychotherapy and Psychotherapeutic Change

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Patients' expectations about the efficacy and nature of psychotherapy have long been considered important common treatment factors, and the empirical literature has largely supported this perspective. In this practice-oriented review, we examine the research on the association between patients' psychotherapy expectations and both adaptive treatment processes and outcomes. We also examine the research on specific psychotherapist interventions and patient and psychotherapist characteristics that influence the development of positive expectations for psychotherapy and psychotherapeutic change. The primary function of this review is to derive applied clinical strategies from the extant empirical literature in order to help clinicians in their attempts to address and influence their patients' psychotherapy-related expectations. Although the literature is not yet conclusive in supporting such strategies, we place the results in theoretical, clinical, and empirical contexts to suggest the most likely best practices at this time, and to stimulate further research on the expectation construct.

Keywords: patient outcome expectations, patient treatment expectations, practice review, common factors

Substantial research suggests that different bona fide psychotherapies produce largely equivalent results, leading some to suggest that common (i.e., pantheoretical) treatment factors, such as patients' expectations, have a greater influence on psychotherapy outcomes than theory-specific treatment techniques (e.g., Duncan, Miller, Wampold, & Hubble, 2010). As the empirical literature on common factors grows, it becomes increasingly important to integrate such research findings into psychotherapy practice (Bjornson, 2011; DeFife & Hilsenroth, 2011). However, there are currently few recommendations to help clinicians with this empirically indicated task.

Regarding patients' psychotherapy-related expectations, there is evidence of their relevance for psychotherapy process and outcome, yet they remain one of the most neglected common factors (Constantino, 2012; Goldstein, 1962; Greenberg, Constantino, & Bruce, 2006; Kirsch, 1985, 1990; Weinberger & Eig, 1999). Thus, the aim of this practice-oriented review is to delineate current practice implications based on the extant research on (a) the relation between patients' psychotherapy expectations and adaptive treatment processes and outcomes, and (b) psychotherapist interventions and patient and therapist characteristics that foster adaptive expectations. Before fleshing out the research findings

and practice suggestions, we operationalize the primary expectancy types that have been articulated in the literature.

Expectancy Types and Definitions

The literature highlights two prototypical expectancy types. "Outcome expectations" represent a person's prognostic beliefs or feelings about a treatment's personal efficacy (Constantino, Glass, Arnkoff, Ametrano, & Smith, 2011). When low, such beliefs likely reflect "demoralization"; when higher, they likely reflect "remoralization," or a belief that change is possible and that therapy can help effect change (DeFife & Hilsenroth, 2011; Frank, 1961; Howard, Moras, Brill, Martinovich, & Lutz, 1996; Kuyken, 2004). "Treatment expectations" reflect patients' beliefs about what will transpire during therapy, including how they and their therapists will behave (role expectations), their subjective experience of therapy (process expectations), and how long treatment will last (duration expectation; Constantino et al., 2011). These two overarching expectancy types have been supported empirically (Norberg, Wetterneck, Sass, & Kanter, 2011).

Expectations can be differentiated from related, yet distinct constructs. For example, while hope reflects a general process of anticipating a personally meaningful outcome (Dew & Bickman, 2005), psychotherapy expectations are more specifically related to what a person believes about the process and outcome of a given treatment. Although such specific beliefs might contribute to one's overarching hope orientation, they are inherently more localized. Treatment expectations can also be differentiated from treatment preferences, which have been defined as those things that are valued or desired in the psychotherapy or the psychotherapist (Swift, Callahan, & Vollmer, 2011). Although patients will likely have various preferences when they enter therapy, such as a desire to have a female

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therapist or a brief treatment, they are not necessarily aligned with what patients expect to occur or to be beneficial.

Treatment motivation can also be viewed distinctly from expectations. Reflecting a readiness and orientation to engage purposefully in treatment (Norcross, Krebs, & Prochaska, 2011), motivation does not necessarily equate to expectations about how treatment will unfold or whether it will be effective. Although positive expectations may be a precondition for deriving intrinsic motivation, the terms are not synonymous. The same can be said for perceptions of treatment credibility, which reflect how logical a treatment seems for its stated purpose (Devilly & Borkovec, 2000). Although credibility beliefs might influence one's expectations, they are not the same types of beliefs. Furthermore, to make credibility judgments, one needs to be exposed to the treatment and provider, whereas expectations about how treatment will look and how effective it will be can exist before contact with a specific treatment rationale or a specific clinician (Schulte, 2008).

Outcome Expectations and Psychotherapy Process and Outcome

Box count and narrative reviews point to patients' psychotherapy outcome expectations being fairly consistently linked to treatment outcome across various psychotherapies, such as cognitive-behavioral, psychodynamic, and interpersonal (e.g., Arnkoff, Glass, & Shapiro, 2002; Greenberg et al., 2006; Noble, Douglas, & Newman, 2001). This association was supported in a comprehensive meta-analysis of studies published through 2009 that examined the correlation between patients' self-reported outcome expectations (assessed at baseline or Session 1) and posttreatment symptomatology (Constantino et al., 2011). Including 8,016 patients across 46 independent clinical samples, there was a small, but significant positive effect ($d = .24$), suggesting that higher expectations of a treatment's utility were associated with greater posttreatment symptom reduction. There was also no moderating effect of this association for treatment orientation (cognitive-behavioral or other), diagnosis (mood, anxiety, substance, or other), treatment modality (individual, group, or other), study design (comparative trial, open trial, or naturalistic), or publication date (before 2000 or 2000–2009). Reflective of the pantheoretical and pandiagnostic outcome expectancy-treatment outcome link, DeFife and Hilsenroth (2011) argued that positive expectancies represent one of the three most important factors that influence early psychotherapy process variables and are associated with treatment continuation and outcome. Furthermore, several studies published after those included in the Constantino et al. (2011) meta-analysis have provided additional support for the association between outcome expectations and adaptive treatment outcome (e.g., Newman & Fisher, 2010; Price & Anderson, 2012).

Despite the relatively consistent association between treatment outcome expectancies (often measured before or early in treatment) and treatment outcome, little is known about the mechanisms through which outcome expectations operate. However, the relevant literature, although still in its infancy, has pointed to several promising mechanisms. One study found that homework compliance mediated the relation between baseline outcome expectancy and early symptom change in cognitive-behavioral therapy (CBT) for anxious patients; higher expectations were related to greater homework compliance, which in turn was related to

decreased anxiety (Westra, Dozois, & Marcus, 2007). Another promising mechanism is the therapeutic alliance—the quality of coordinated collaboration and affective bond between patient and therapist (Castonguay, Constantino, & Grosse Holtforth, 2006; Hatcher & Barends, 1996; Horvath, Del Re, Flückiger, & Symonds, 2011). In one study, early outcome expectations were associated with better patient-rated alliance quality, which in turn was related to better outcome in a sample of patients undergoing group psychotherapy for grief (Abouguendia, Joyce, Piper, & Ogrodniczuk, 2004). Several other studies have also found the alliance to be a mechanism of the outcome expectancy-treatment outcome link in samples of depressed patients receiving short-term psychotherapy or pharmacotherapy (Meyer et al., 2002) and those with mixed diagnoses in short-term psychotherapy (Joyce, Ogrodniczuk, Piper, & McCallum, 2003).

Other research draws additional connections between the therapeutic alliance and outcome expectations, but in a different temporal direction. In a study of CBT for generalized anxiety disorder (GAD), emergent alliance ruptures, or negative shifts in perceived relationship quality (Safran, Muran, & Eubanks-Carter, 2011), were associated with more negative postrupture outcome expectations (Westra, Constantino, & Aviram, 2011). This finding indicates the bidirectionality of the expectancy-alliance link. Not only do early positive outcome expectations appear important for developing a quality working relationship, but also the ongoing nature of that relationship may be instrumental for the subsequent maintenance of positive outcome expectations. Adding to this picture, Westra, Constantino, and Aviram also found that the negative rupture effect was much greater for those individuals with initially lower outcome expectations. Thus, early outcome expectations might be one indicator of how severely subsequent alliance ruptures will influence patients. Across studies examining the relation between outcome expectations and alliance in some manner, it is clear that these constructs are correlated; however, there is ample unshared variance, suggesting that they are distinct (e.g., Constantino, Arnow, Blasey, & Agras, 2005).

There is little work examining potential moderators of the outcome expectancy-outcome association. However, a few individual studies provide preliminary evidence for moderation. In an analogue study (Ahmed & Westra, 2008), anxious participants with high expectations for anxiety change had good outcomes only when hearing the treatment rationale from a warm, enthusiastic therapist. By contrast, patients with low expectations for anxiety change had good outcomes only when hearing the treatment rationale from a cold, less enthusiastic therapist. This finding suggests that therapists who match their patients' initial level of optimism may help to promote more positive treatment outcomes than those who do not. In a study of group CBT for insomnia (Constantino et al., 2007), patients with lower early treatment outcome expectations had better outcome expectations when perceiving their therapist as more affiliative during the first session. Perceived therapist affiliation did not matter for those patients with higher early outcome expectations. This finding suggests that early therapist support and affiliation may be especially important for patients who have difficulty believing that treatment will help them.

Outcome expectations can also be mechanisms (i.e., statistical mediators) of the association between other important psychotherapy variables. For example, in the CBT for GAD sample discussed earlier in the text, greater therapist competence in the delivery of

CBT was associated with higher subsequent patient outcome expectations, which were in turn associated with better overall treatment outcomes (Westra, Constantino, Arkowitz, & Dozois, 2011). In another study, early increases in expectancy/credibility ratings mediated the relation between baseline GAD symptom severity and decreases in GAD symptoms at posttreatment (Newman & Fisher, 2010).

Despite research demonstrating a relation between patients' outcome expectations and various psychotherapy course and outcome variables, few treatments or treatment components have been designed to address explicitly and systematically patients' outcome expectations (Constantino, 2012; Price & Anderson, 2011). Thus, data underscoring a causal link between outcome expectations and other treatment variables is scarce. For a long time, the most relevant experimental work in this area involved the use of pretreatment preparation strategies to influence patients' expectations and response to treatment. Some of these strategies centered on outcome expectations as one target.

For example, Hoehn-Saric and colleagues (1964) developed and tested a pretreatment role-induction interview (RII) (sometimes termed a socialization interview) to teach patients appropriate expectations about psychotherapy. Their RII included: (a) a general description of psychotherapy, (b) a description of the patient and therapist's expected behavior, (c) a preparation for some typical phenomena that were likely to occur during therapy (e.g., resistance), and (d) a specific suggestion that the treatment would be effectual within 4 months (i.e., an attempted outcome expectation manipulation). Compared with individuals who received no pretreatment intervention, those receiving the RII evidenced better attendance, more favorable in-therapy behaviors (objectively coded), and better patient- and therapist-rated outcome. However, although beneficial, the effects of the RII could not be isolated to the outcome expectancy persuasion tactic.

Several other researchers have also examined the efficacy of pretreatment motivation-enhancing interventions to influence patients' outcome expectations. McKee and colleagues (2007) found that cocaine users receiving motivational enhancement therapy (MET) before CBT attended more treatment sessions, had a greater desire for abstinence, and had higher outcome expectations than those individuals who received no pretreatment MET. In this study, MET involved one session in which therapists focused on increasing the patients' commitment to change while displaying empathy, avoiding argumentation, and supporting self-efficacy. However, because MET involved many motivational interviewing (MI) strategies (Miller & Rollnick, 2004), most of which are not explicitly centered on enhancing outcome expectations, it is unknown what strategies were responsible for the positive outcomes. Manipulation studies of interventions designed to heighten specifically patients' prognostic outcome expectations (thus isolating this variable) have been virtually nonexistent.

However, one recent, albeit very preliminary, line of work has focused on the development of an Expectancy Enhancement (EE) manual (Constantino, Klein, & Greenberg, 2006) designed initially as an augmentation to traditional cognitive therapy (CT) for depression. This manual, which remains in development, outlines standardized strategies for addressing and influencing both pre- and during-treatment outcome and process expectations. The manual's four components are: (a) an initial session EE interview that seeks to enhance patients' outcome expectations and to assess and

address their treatment process expectations, (b) standard and reactive strategies for checking in on and responding to (throughout the course of therapy) markers of decreased or unrealistic outcome and treatment expectations, (c) general relationship strategies that take into account patients' expected behaviors of self and other, and (d) a final session component intended to increase further patients' sense of self-efficacy (i.e., expectation of being able to address effectively future mood problems). Preliminary results of a pilot-randomized trial comparing seven patients receiving CT + EE versus seven patients receiving CT-only were promising (Constantino, Klein, Smith-Hansen, & Greenberg, 2009); CT + EE patients evidenced a comparatively greater reduction in early treatment hopelessness and early treatment depression level. Although these group differences did not hold at posttreatment, the findings are suggestive of an early benefit to the EE strategies, perhaps especially the first session EE interview. It is plausible that directly targeting expectations in the initial session of CT for depression (or perhaps any treatment or disorder given that expectations are pantheoretical and pandiagnostic) helps patients to develop more efficiently a realistic and optimistic outlook on treatment, which could have important implications for retention and treatment engagement. Of course, it will be important for future research to test further the EE manual or other EE-type strategies, and then to unpack the specific benefits and the pathways to achieving them.

Patient and Therapist Characteristics That Relate to Positive Outcome Expectations

Although data are limited, a few studies have revealed participant characteristics that relate (positively or negatively) to outcome expectations. With respect to patient characteristics, more general hopelessness has been correlated with lower outcome expectations at pretreatment (Goldfarb, 2002). In another study, patients with more manic symptoms reported higher outcome expectations before treatment, whereas patients with symptoms related to substance abuse and personality disorders reported lower baseline outcome expectations (Constantino, Penek, Bernecker, & Overtree, 2012). Others identified substance use and somatic complaints (MacNair-Semands, 2002), diagnostic comorbidity and symptom severity (Connolly-Gibbons et al., 2003; Safren, Heimberg, & Juster, 1997), and low levels of psychological mindedness (Beitel et al., 2009) as being associated with negative patient outcome expectations. Thus, patients' psychological functioning holds promise as an important early forecaster of patients who have, or perhaps will develop, favorable versus unfavorable beliefs about a treatment's personal future efficacy.

Some limited research has also examined therapist characteristics as correlates of patient outcome expectations. More versus less effective CBT therapists had patients who reported higher outcome expectations across treatment (Westra, Constantino, Arkowitz, & Dozois, 2011). Furthermore, greater early therapist competence in CBT delivery mediated the relation between therapist effectiveness and midtreatment patient outcome expectations; that is, effective therapists appeared to be more competent in their CBT technique, which was related to higher midtreatment outcome expectations (which, as noted earlier in the text, were related to better posttreatment outcome). These findings support the idea that skill in CBT is important for patients to have faith in the treat-

ment's efficacy. Drawing on Frank's (1961) language, it is plausible that such skill is related to the clear correspondence between the treatment "rituals" and the treatment "myth," or rationale. Supporting this notion, Ahmed and Westra (2009) found that a therapist's ability to deliver a strong treatment rationale at the beginning of CBT for social anxiety had a positive influence on one's outcome expectations and treatment engagement (this finding actually seems to capture both a therapist characteristic and a therapist intervention—skillful rationale delivery—that positively relates to patients' outcome expectations). In another study focused on rationale delivery, the way in which treatments were presented to analog patients influenced the participants' treatment outcome expectancies; specifically, expectancies were higher after the following manipulations: (a) treatment was presented as based on scientific research, tested in clinical trials, and new in relation to other therapies; (b) the treatment presentation included examples of successful cases; (c) treatment was described as having a broad focus (on emotion, cognition, and behavior) versus a sole focus on behavior; and (d) treatment was presented in technical terms (i.e., theoretical jargon) versus lay terms (Kazdin & Krouse, 1983). Finally, in another study, psychotherapists who were rated as more understanding, affirming, and autonomy-granting, as opposed to more controlling during moments of resistance, had patients who reported higher outcome expectations following those moments (Ahmed, Westra, & Constantino, 2010).

Current Clinical Guidelines

Based on the best available evidence, we outline several practice suggestions to assist clinicians in fostering or responding to their patients' outcome expectations. First, given the reliable association between outcome expectations and adaptive treatment processes (e.g., homework compliance, alliance quality) and outcomes (e.g., treatment continuation, symptom reduction), we suggest that it is not only important, but also perhaps necessary to assess and address them explicitly. At a minimum, therapists should assess their patients' prognostic outcome beliefs informally through dialogue. However, formal measurement might be more reliable and likely more comprehensive. There are several measures from which psychotherapists can choose to help them systematically assess and monitor patients' outcome expectations (see Table 1). Below we provide several specific recommendations for clinicians based on the measure's psychometric properties and its feasibility for use in naturalistic clinical settings.¹

The Credibility/Expectancy Questionnaire (CEQ; Devilly & Borkovec, 2000) is the most widely used measure of outcome expectations. This brief, face valid measure includes three items that assess outcome expectations and three that assess treatment credibility beliefs. In light of its brief nature (it takes just minutes to complete), easy adaptability of wording for different conditions and treatments, psychometric strengths, and widespread use (thus allowing for benchmarking with published studies), the CEQ can be readily used in most clinical contexts.²

The Milwaukee Psychotherapy Expectations Questionnaire (MPEQ; Norberg et al., 2011) is a 13-item measure comprised of two empirically supported factors that assess outcome and treatment (or process) expectations, respectively. The outcome expectations subscale includes four items related to respondents' sense of how they might change as a result of therapy. Like the CEQ, the

MPEQ outcome expectancy scale should be readily adaptable for most clinical situations, and it is a brief, rationally developed, and psychometrically sound assessment tool. Armed with information related to patients' expectations, therapists can responsively work to foster, clarify, or shape these beliefs in the service of promoting more adaptive treatment process and outcome (suggestions for such expectancy "work" are elaborated later in the text).

Our second clinical suggestion related to outcome expectations builds on the first; that is, the assessment of patients' expectations should occur as early as possible. Not only do lower early outcome expectations generally relate to poorer treatment processes and outcomes, but they also appear to be a risk factor for decreased outcome expectations following an alliance rupture (Westra, Constantino, & Aviram, 2011). Thus, clinicians can use early expectancy assessment to help gauge those patients for whom they might need to attend even more closely to the climate of the therapeutic relationship. Although psychotherapists cannot always avoid alliance ruptures, it seems important that they at least stay closely attuned to the relationship with perhaps regular invitations to discuss its quality (Safran & Muran, 2000). For example, with patients who reveal early low-outcome expectations, a therapist might say, "I would expect that we will occasionally have different ideas about our work, and there might even be times when I disappoint or upset you. Not only do I invite you to share these experiences if they occur, but I believe that openly discussing them—in the service of collaborating toward your treatment goals—may be a useful therapy experience. Has anything like this happened yet, or is it happening now?"

Also related to early expectancy assessment, there is limited research to suggest that psychotherapist affiliation and support might be especially important in the context of lower early patient outcome expectations (Constantino et al., 2007). Interpersonal affiliation is marked by behaviors that are friendly, nurturing, sometimes autonomy granting, and devoid of hostility (Henry & Strupp, 1994). For example, in light of low-outcome expectations at treatment's outset, a therapist might offer in a warm tone, "I can appreciate how difficult this must be for you, and how change might not seem possible at this time. As I certainly want to align with you to help, can you help me understand what that experience is like for you?" Embedded in this communication is both warm and friendly affirmation/understanding ("I can appreciate . . ."), as well as autonomy granting ("Can you help me understand . . ."). This affiliative, supportive, and autonomy granting stance might go a long way in helping low-outcome expectancy patients become more optimistic about therapy (contrasted, e.g., with more controlling and less validating therapist behaviors). This stance has also generally differentiated good outcome from poor outcome cases

¹ The present review focuses on adult psychotherapy, as this is the population on which the expectancy literature predominantly focuses. However, it is important to note that several measures for younger populations, and their caregivers, have been developed, including the Hopes and Expectations for Treatment Record Form (HETA; Urwin, 2007) and the Parent Expectations for Therapy Scale (PETS; Nock & Kazdin, 2001).

² As noted earlier in the text when differentiating the constructs, that the CEQ expectancy items can be administered at any time before, during, or after treatment, whereas the credibility items can only be administered after exposure to the treatment rationale and/or provider.

Table 1
Summary of Published Measures of Psychotherapy Outcome Expectations

Measure/primary reference	Description	Strengths	Possible limitations	Availability
Credibility/Expectancy Questionnaire (CEQ; Devilly & Borkovec, 2000)	Assesses treatment outcome expectations (three items) and perceptions of treatment credibility (three items)	Two factors substantiated by principal components and factor analysis Good psychometric properties Wide use readily allows for clinical benchmarking	Scales with very few items may have problems related to sensitivity, specificity, and reliability	In the public domain (i.e., Appendix A of primary reference)
Milwaukee Psychotherapy Expectations Questionnaire (MPEQ; Norberg et al., 2011)	Assesses psychotherapy outcome expectations (four items) and psychotherapy treatment (or process) expectations (see Table 3)	Two factors substantiated by exploratory and confirmatory factor analysis Good psychometric properties	Although promising, this newer measure requires additional research for replication and evidence of predictive validity	In the public domain (i.e., Appendix A of primary reference)
Expectations About Counseling Scale (EAC; Tinsley, Workman, & Kass, 1980) and EAC-Brief (EAC-B; Tinsley & Wescot, 1990)	Predominantly assesses treatment expectations (see Table 3); however, one scale (three items) also assesses outcome expectations	Comprehensive assessment of outcome and treatment expectations Adequate psychometric properties of the EAC	EAC (135 items) and EAC-B (66 items) likely prohibitive for routine clinical practice (though the outcome expectancy scale could conceivably be used alone)	Contact authors
Patient Prognostic Expectancy Inventory (PPEI; Martin & Sterne, 1975)	Assesses, on a four-point response scale, expected improvement from hospital-based treatment across 15 domains (e.g., depression-sadness, feeling afraid, keeping a job)	Direct, face valid assessment of outcome expectations across multiple relevant outcome domains	Infrequent use; predominantly limited to one research program Limited psychometric data Possible limited generalizability to inpatient treatment	In the public domain (i.e., Table 1 of primary reference)

Note. Some measures assess both outcome and treatment expectations and are cross-listed in Table 3.

(e.g., Henry, Schacht, & Strupp, 1986). Clinicians can also use early diagnostic assessment (e.g., of substance abuse; Constantino et al., 2012), as well as assessment of patients' hopelessness (Goldfarb, 2002) and psychological-mindedness (Beitel et al., 2009) to help them forecast efficiently those patients who might be entering treatment with low-treatment outcome expectations.

Because early outcome expectations are related to adaptive treatment processes and outcomes, including in a possible chain from higher outcome expectations to greater homework compliance and alliance quality to better treatment outcomes (e.g., Meyer et al., 2002; Westra et al., 2007), our third practice suggestion is that clinicians should pointedly attempt to foster positive outcome expectations in their patients. Although the data are clearly limited at this time, we present several techniques that might be useful in this regard.

First, in attempting to promote positive outcome expectations as early as possible, clinicians might want to use persuasion tactics regarding the potential (or even likely) utility of psychotherapy at pre- and early therapy moments, such as when advertizing their services, making referrals, screening potential patients, and presenting a treatment rationale. For example, drawing on Kazdin and Krouse's (1983) work, a therapist or clinic might explicitly advertize (if it is true) that they offer the latest evidence-based treatments that have been tested in gold standard, controlled clinical trials. Providers might also add a passage to their treatment consent forms that highlights the general effectiveness of psychotherapy and its broad focus on affect, cognition, and behavior. Such a strategy would be consistent with Hoehn-Saric et al.'s (1964) role induction (RI) component of suggesting to patients that the upcoming treatment would be effectual within 4 months. Finally, in

early sessions, clinicians should not shy away from using theory-based language regarding change processes; although this language should not be overly esoteric, it can include jargon. For example, an interpersonal therapist might explain to patients, "Treatment will examine how past important relationships have been internalized in a way that governs current relationships, albeit often in a maladaptive way. Although these relationship patterns may have been adaptive at one time, they may be outdated now. Our goal will be to explore the origin and utility of your patterns, so that you can decide whether to change toward new patterns." It is possible that directly discussing theory in this manner can enhance patients' beliefs in the prospective utility of treatment.

Second, although the evidence is preliminary, it appears useful to assess patients' readiness for change, which has been linked to outcome expectations (McKee et al., 2007). If patients display signs of ambivalence or resistance to change, implementing MET as a pretreatment might increase their outcome expectations, as well as their desire for change and commitment to the therapy goals (McKee et al., 2007). In the context of MET, patients' presenting discrepancies between valued directions and existing beliefs, behaviors, and expectancies can be explicitly cultivated to enhance change motivation (Miller & Rollnick, 2002). It is also plausible that fully integrating MET or other MI strategies throughout treatment would be beneficial for addressing ambivalence or resistance, responding to fluctuations in outcome expectancies, supporting self-efficacy, and so forth (Westra & Arkowitz, 2010). This notion squares with the microprocess finding that the MI-consistent qualities of therapist support, affiliation (vs. control), and respect for patient autonomy in the context of resistance

episodes were related to higher subsequent outcome expectations (Ahmed et al., 2010).

Third, clinicians might use early therapy to establish a foundation that will both allow for optimism in the treatment's efficacy and create a precondition for the subsequent manipulation of patient's outcome expectations. Regarding the former, the research suggests that the therapist's provision of a strong therapeutic rationale can have a positive effect on patients' outcome expectations and their engagement in treatment, especially for those patients who are unsure about whether they can change (Ahmed & Westra, 2009; Kazdin & Krouse, 1983). Thus, it seems that clinicians should deliver the rationale of the treatment in which they intend to engage in a manner that is clear and convincing. They should also subsequently deliver treatment in a manner that is consistent with the rationale, as this is likely to promote competent treatment delivery—a factor that is related to higher outcome expectations, which in turn foster more adaptive treatment outcomes (Westra, Constantino, Arkowitz, & Dozois, 2011). Regarding the latter, based on the information gleaned from assessing patients' outcome expectations, it might be beneficial for clinicians to first verify and validate their patients' outcome expectations (even if they are low) and to consider behaving in a way that initially matches their patients' presenting level of optimism (Constantino et al., 2011). The benefit of such matching has been preliminarily supported (Ahmed & Westra, 2009).

In addition, once clinicians assess and potentially match patients' initial outcome expectations (thus setting a potentially safe, credible, and facilitative precondition for change), they might begin to tread lightly and empathically in using strategies that aim to manipulate patients' prognostic outcome expectations directly. Constantino et al. (2011) outlined several such strategies, drawing partly on the EE manual (Constantino et al., 2006) discussed earlier in the text. At the outset of treatment, clinicians might personalize expectancy-enhancing or hope-inspiring statements to match the patient's specific situation. For example, with a patient suffering from depression, a clinician might say, "It makes sense that you sought treatment for the problems you are experiencing. Psychotherapy targets and can be quite effective for mood problems like yours." Or they could say, "Patients suffering from depression do tend to respond to treatment and your prognosis is good." Such statements convey that patients are not alone in their experience of psychological problems and that their therapist has a professional confidence in his or her ability to deliver treatment effectively (confidence that demoralized patients can "borrow" for inspiration that they might not yet possess). However, clinicians should also be mindful of structuring their statements in a way that promotes positive, but also realistic expectations in their patients. This underscores the need to monitor patients' outcome expectations throughout treatment to assess whether they might shift to unrealistically high or low levels. Still, therapists can avoid cultivating inaccurate beliefs about treatment, while at the same time demonstrating their confidence in the therapy and their patients' ability to improve. Frank (1968) discussed this notion of simultaneously conveying understanding (that patients might not yet fully believe that they can change) and competence (in the treatment and the patient) as being central to remoralization.

Clinicians can also tie expectancy-enhancing statements to patients' personal strengths. For example, a psychotherapist might state, "you strike me as someone who can really accomplish things

you set your mind to, and being here suggests that you have put your mind to it," "you have already overcome the obstacle of seeking treatment, which is difficult to do, so I suspect that you will be motivated to work toward change," and/or "you appear to have many people around you for support, which bodes well when going through something like this." However, in using such strategies, it is important to avoid arousing client threat and defensiveness or invalidating their concerns regarding change. Thus, therapists should convey these statements with an explicit respect for patient autonomy and a willingness to hear and process patient perspectives that deviate from the therapist's own beliefs about change potential. For example, therapists can express hope-inspiring statements in an autonomy-preserving manner—for example, "This is just my opinion of course, and you might disagree, but from my perspective it seems that you have several qualities that make you a good candidate for this treatment." Further, making room to hear and empathically process client concerns about change may also be important for enhancing patients' early confidence in treatment efficacy.

Clinicians can also try to foster patients' sense that they are powerful agents in the change process, and that they have control over the process (i.e., increased self-efficacy). The therapist might say, "I believe that you have the power to produce change in your life, and during the course of therapy you will build skills to help facilitate this goal." Also to bolster outcome expectations, psychotherapists can provide a nontechnical review of the research on the intended treatment (e.g., CBT, interpersonal psychotherapy, behavioral activation, short-term psychodynamic psychotherapy). In general terms, a therapist might say one or more of the following statements: "People who undergo psychotherapy tend to improve more than those who try to overcome their difficulties on their own"; "Psychotherapy tends to perform as well as, or in some cases better than medication"; "Most people experience at least some benefit after completing a course of psychotherapy." Therapists might also socialize the patient to the therapy process and to foreshadow the often gradual and nonlinear nature of change. This way, when patients experience the likely ebb and flow of therapeutic progress, they will be less likely to lose motivation, become demoralized, and/or leave treatment. And during moments of "flow," clinicians should consider providing overt positive feedback. As Kirsch (1990) has argued, the provision of feedback to patients is an important part of any effective treatment, especially when it brings to light for the patient any positive change events or mastery experiences. For example, a therapist using behavioral activation might say, "I see that you incorporated more pleasurable experiences into your schedule this week. Great job. I anticipate you being able to continue this trend, which should have a positive influence on your mood."

The fourth overall clinical guideline is to address alliance ruptures prudently. Not only is there a negative association between the presence of alliance ruptures and both session quality and treatment outcome (Muran et al., 2009), but recall that Westra, Constantino, and Aviram (2011) found that the presence of alliance ruptures negatively influenced postrupture outcome expectations. Thus, clinicians would be wise to pay keen attention to potential markers of diminished alliance quality, such as patient avoidance maneuvers and patient/therapist confrontation (Safran & Muran, 2000; Samstag, Muran, &

Safran, 2004). The Westra, Constantino, and Aviram findings also suggest that patients' reduced outcome expectations can be a rupture signal (which is another reason to assess outcome expectations throughout treatment). In the face of such markers, clinicians can implement alliance rupture-repair techniques, many of which are based on the two-person interpersonal strategy of metacommunication (Safran & Muran, 2000). Such strategies, which might involve therapist validation, empathy, and responsibility taking, have been shown to be effective in relationally oriented approaches (Muran, Safran, Samstag, & Winson, 2005), as well as when integrated into CT (Constantino et al., 2008; Newman, Castonguay, Borkovec, Nordberg, & Fisher, 2008). For example, in the context of expressed ineffectiveness of a homework assignment, a therapist might say, "I can see that the homework upset you, and it must have been frustrating to engage in a task that did not seem relevant to your most immediate problems" (empathy and validation). "I think that the homework was poorly timed on my part, as I think that I misread your most pressing needs. I apologize for this. Can you help me understand how you are feeling right now" (accepting responsibility and exploring current experience)? In Table 2 we provide a summary of clinician interventions for fostering or responding to outcome expectations.

Treatment Expectations and Psychotherapy Process and Outcome

The connection between treatment expectations and psychotherapy process and outcome is less clear than it is for outcome

expectations. Several reviews on the relation between treatment expectations (e.g., role expectations, role expectation disconfirmation) and psychotherapy outcome have demonstrated equivocal results (Arnkoff et al., 2002; Duckro, Beal, & George, 1979). However, some more recent work has demonstrated significant associations. For example, Schneider and Klauer (2001) found that patients with higher role expectations of being actively involved in treatment evidenced greater improvement in interpersonal functioning. In another study, Davis and Addis (2002) found that patients participating in behavioral medicine groups who had treatment expectations that were inconsistent with the treatment rationale were more likely to drop out of treatment than patients who accepted the rationale. Similarly, Aubuchon-Endsley and Callahan (2009) found that patients scoring outside the average range on a measure of pretreatment role expectations were seven times more likely to terminate therapy prematurely than patients with more typical role expectations.

Additional research has focused on how treatment expectations relate to treatment process variables. For example, multiple studies have demonstrated that the longer patients expect to stay in therapy, the longer they actually remain in treatment (e.g., Jenkins, Fuqua, & Blum, 1986; Mueller & Pekarik, 2000). In another line of research, Joyce and Piper (1998) found that less discrepancy between patients' expectations about typical sessions and their actual experience during sessions was associated with better alliance quality.

Like outcome expectations, there is limited research on mediators or moderators of any treatment expectancy effects. The Joyce

Table 2

Summary of Clinician Interventions for Addressing Psychotherapy Outcome Expectations

Clinical guideline	Level of empirical support
Assess outcome expectations (either verbally or with a psychometrically sound measure)	<i>Strong</i> —Numerous studies evidence a relation between outcome expectations and both adaptive treatment processes and outcome, thus suggesting the importance of regularly assessing such expectations in clinical practice
Assess outcome expectations, as well as patient diagnostic (e.g., substance abuse) and psychological (e.g., psychological mindedness) variables that correlate with outcome expectations, as early as possible	
Be responsive to this early assessment (e.g., invite discussion of alliance problems and convey affiliation in context of low outcome expectations)	<i>Preliminary</i> —One or a few studies suggest early treatment as a sensitive period for using outcome expectancy and patient psychological information in a clinically informative manner
Attempt to foster positive outcome expectations with one or more of the following strategies: Attempt to persuade at pre- and early treatment	<i>Preliminary</i> —Some efficacy for RII, but no isolation of efficacy persuasion effect; some evidence for value of direct outcome expectancy manipulation in context of rationale delivery
Use MET or MI (as a pretreatment or fully integrated treatment approach) to address change ambivalence or treatment resistance	<i>Preliminary</i> —One or a few studies support the value of MET or MI for fostering positive outcome expectations and treatment engagement in the context of ambivalence or resistance
Provide a strong treatment rationale	<i>Moderate</i> —Several studies support the beneficial effect of rationale presentation on outcome expectations
Initially validate outcome expectations and match on presenting optimism level	<i>Preliminary</i> —One or a few studies support the value of matching on optimism for fostering positive outcomes
Attempt to enhance directly outcome expectations (e.g., provide hope-inspiring statements, manage unrealistic expectations, promote self-efficacy, capitalize on patient's personal strengths, provide nontechnical review of efficacy research, foreshadow nature of change, provide positive feedback)	<i>Preliminary</i> —One or a few studies support the efficacy of expectancy enhancing strategies
Address alliance ruptures prudently	<i>Preliminary</i> —One or a few studies support the importance of addressing alliance ruptures in order to maintain or restore outcome expectations

Note. RII = role induction interview (Hoehn-Saric et al., 1964).

and Piper (1998) findings provide preliminary support that the alliance might be a mechanism through which a specific treatment expectation (i.e., of the typical session) operates on outcome. However, much more research is needed to confirm this mediator pathway or to suggest others. Regarding potential moderators of the treatment expectancy-treatment process link, another study demonstrated that specifically for patients with higher quality of object relations (QOR), higher expectations about contributing to the treatment process were associated with declining alliance quality (suggesting that QOR may reflect a specific condition under which treatment expectations relate to the alliance; Joyce, McCallum, Piper, & Ogrodniczuk, 2000).

Overall, process-outcome findings related to treatment expectations have revealed some promising associations; however, mixed or null findings, as well as methodological shortcomings of some studies, make it difficult to make more definitive claims (Constantino et al., 2011). However, one area where there has been substantial research is on the experimental manipulation of treatment expectancies. Most of this work has focused on testing the efficacy of RI, or anticipatory socialization strategies; that is, teaching patients, before beginning therapy, about the treatment rationale, the expected treatment process and duration, appropriate therapist and patient behaviors, and realistic expectations for change (Hoehn-Saric et al., 1964; Walitzer, Derman, & Connors, 1999). The primary goal of preparatory RI has been to foster patients' accurate and adaptive expectations in the service of reducing dropout and enhancing overall treatment outcome (Hoehn-Saric et al., 1964). In Tinsley, Bowman, and Ray's (1988) comprehensive review of treatment expectancy manipulation strategies, they found that both audio and video pretreatment preparation methods were generally effective in improving patients' treatment expectations.

More recently, Rumpold et al. (2005) tested the efficacy of what they called a diagnostic and motivation-enhancing (DM) phase for affecting patients' treatment expectations. In this study, DM, which occurred pretreatment, consisted of (a) diagnosing the patient, (b) determining the appropriate type of therapy, (c) establishing an initial therapeutic alliance, and (d) increasing motivation for therapy. The authors found that during the DM phase, patients' treatment expectations and overall openness to therapy improved significantly. Following the DM phase, patients' ratings of the negative consequences associated with their illness decreased, and their ratings of the therapeutic alliance were positive. In another study, baseline education about treatment duration, in the form of a short script about the typical number of sessions it takes for patients to recover, was an effective means for changing duration expectations (Swift & Callahan, 2011). Further, altering duration expectations was associated with more sessions attended and fewer treatment dropouts. It may be that early expectations for treatment duration at least partially drive patients' therapeutic engagement.

Related to manipulating expectations about the therapist, Greenberg (1969) showed that presenting pre-session information about the therapist's warmth (as described by others) had a profound effect on attraction to the therapist, openness to the therapist's influence, evaluation of the therapist's work, and willingness to have a future meeting with him. Similarly, Greenberg and Land (1971) showed that premeeting information given to subjects about a hypnotist affected both their susceptibility to hypnosis and their opinion about whether they had been hypnotized. Greenberg and colleagues concluded that structuring patients' expectations

through information relayed in referrals (or before an initial therapeutic encounter) could be of value in motivating patients and increasing positive outcomes by keeping patients in therapy and lowering resistance toward self-exploration.

Finally, other studies have demonstrated that pretreatment therapeutic assessment (e.g., Finn & Tonsager, 1997) and prereferral consultation meetings (e.g., Huber, Henrich, & Brandl, 2005) can have a positive impact on treatment engagement and subsequent patient-therapist alliance quality. Although these pretreatment strategies were not designed to manipulate treatment expectancies, and the researchers did not measure expectancies as dependent variables, it is possible that such strategies have a beneficial effect on one's beliefs about treatment and the therapeutic relationship in which one will engage. Future research will need to assess whether these models have a direct impact on treatment expectancies.

Patient and Therapist Characteristics That Relate to Treatment Expectations

Like with outcome expectations, data on participant characteristic that correlate with treatment expectations are limited and focused mostly on patient variables. In one study, previous therapy experience was associated with more positive treatment expectations (MacNair-Semands, 2002). In another, adaptive perfectionism (i.e., healthy, positive striving) was associated with positive expectations toward counseling process and outcome (Oliver, Hart, Ross, & Katz, 2001). Finally, more general hopelessness has been correlated with expectations of lower personal commitment to treatment (Goldfarb, 2002).

Several cultural and religious variables have also been linked to patients' treatment expectations. For example, Icelandic students expected their therapists to have more expertise than did American students (Ægisdóttir & Gerstein, 2000). Relative to Asian American, White American, and biracial college students, African American and Latino/a students had higher expectations for their therapist's multicultural competence (Constantine & Arorash, 2001). Finally, highly religious married Christian couples, compared with low-to-moderately religious couples, were more likely to believe that a Christian marital therapist would be more effective than a non-Christian therapist (Ripley, Worthington, & Berry, 2001).

Current Clinical Guidelines

Based on the best available evidence, we outline several specific practice suggestions to assist clinicians in fostering or adaptively responding to their patients' treatment expectations. As the literature is more diverse (in terms of types of treatment expectations) and less clear (in terms of findings), the guidelines are necessarily less elaborated than they are for outcome expectations.

First, given that various treatment expectations are at least sometimes related to adaptive treatment processes and outcomes, we again suggest that clinicians assess them. Like with outcome expectations, there are several measures from which therapists can choose to help them systematically assess and track their patients' treatment expectations (see Table 3). Below we provide several specific recommendations for clinicians based on the measure's psychometric properties and its feasibility for use in naturalistic clinical settings.

Table 3
Summary of Published Measures of Treatment Expectations

Measure/primary reference	Description	Strengths	Possible limitations	Availability
Psychotherapy Expectancy Inventory-Revised (PEI-R; Bleyen et al., 2001)	Assesses role behavior expectations across five factors: approval-seeking, impression, advice-seeking, audience-seeking, relationship-seeking (24 critical items)	Five factors substantiated by exploratory and confirmatory factor analysis Good psychometric properties	Restricted to assessment of role expectations	In the public domain (i.e., Appendix of primary reference)
Milwaukee Psychotherapy Expectations Questionnaire (MPEQ; Norberg et al., 2011)	Assesses psychotherapy treatment (or process) expectations (nine items), with items targeting aspects of the therapist, patient, therapeutic relationship, and change processes Also assesses psychotherapy outcome expectations (see Table 1)	Two factors substantiated by exploratory and confirmatory factor analysis Broad assessment of treatment expectancy aspects Good psychometric properties	Although promising, this newer measure requires additional research for replication and evidence of predictive validity	In the public domain (i.e., Appendix A of primary reference)
Expectations About Counseling Scale (EAC; Tinsley, Workman, & Kass, 1980) and EAC-Brief (EAC-B; Tinsley & Wescot, 1990)	Predominantly assesses treatment expectations across four domains: personal commitment, facilitative conditions, counselor expertise, and nurturance Also includes one scale that assesses outcome expectations (see Table 1)	Comprehensive assessment of treatment and outcome expectations Adequate psychometric properties of the EAC	EAC (135 items) and EAC-B (66 items) likely prohibitive for routine clinical practice Questionable factor solutions of the EAC-B (Ægisdóttir, Gerstein, & Gridley, 2000)	Contact authors

Note. Some measures assess both outcome and treatment expectations and are cross-listed in Table 1.

The Psychotherapy Expectancy Inventory—Revised (PEI-R; Bleyen, Vertommen, Vander Steene, & Van Audenhove, 2001) is a commonly used measure of treatment expectations. This measure includes 24 critical items (as well as six filler items), and focuses specifically on patients' expectations for their own during-treatment role behaviors and those of their psychotherapist. The PEI-R has five factors that are analytically derived subscales: approval seeking, impression, advice seeking, audience seeking, and relationship seeking, although some analyses have suggested a better fit for four factors (i.e., no impression factor; Bleyen et al., 2001). It has also demonstrated high internal consistency and good test–retest reliability. Thus, for clinicians aiming to assess role expectancies, the PEI-R may be a good measurement option.

For clinicians wanting a broader assessment of treatment expectations (i.e., beyond role behavior expectations), or a measure of both treatment and outcome expectations, the previously discussed MPEQ (Norberg et al., 2011) might be a good option. The empirically supported treatment expectancy factor, which includes only nine items (and thus can be administered with little patient burden), assesses various expectancies related to the therapist, patient, therapeutic relationship, and change processes.

Our second practice suggestion with regard to treatment expectations is to attempt to address them explicitly in some way before commencing treatment. Although an older literature, anticipatory socialization techniques have more often than not demonstrated a positive influence on the general quality of psychotherapy (e.g., Yalom, Houts, Newell, & Rand, 1967), the patient–therapist relationship (e.g., Greenberg, 1969), and treatment outcome (e.g.,

Acosta, Yamamoto, Evans, & Skilbeck, 1983). Thus, clinicians should heed the potential value of such preparatory work (likely aided by didactic written and/or video materials), perhaps especially for patients who have little knowledge of or experience with psychotherapy (Constantino et al., 2011). The research suggests that not only should such socialization focus on what to expect, but it should also outline a strong treatment rationale (Hoehn-Saric et al., 1964) and emphasize the importance of the patient being actively involved (Schneider & Klauer, 2001).

For example, regarding what to expect in terms of response patterns, a therapist working with a depressed patient might foreshadow and normalize small setbacks and mood fluctuations, thus highlighting that change is expected to be gradual and nonlinear. Then, in response to an inevitable setback (e.g., experiencing less change than expected after several weeks of therapy), a therapist might say, “Depression is a powerful emotion that you have been experiencing for awhile now. Although we know it can be treated effectively, we also know that change can be gradual and that your mood can wax and wane during the process of recovery. Your depression did not develop in just a few days and, thus, we would not expect it to disappear completely in just a few weeks.” Related to treatment process, a therapist might say, “It might be hard to attend session at times,” or “You might experience increased stress in your important relationships.” Regarding expected roles and patient active involvement, a therapist might highlight the collaborative nature of treatment. Such collaboration could even be framed as one between two experts—for example, “You are certainly the expert in knowing yourself, and we will need to draw on

that expertise as we progress. And, as an expert in this treatment approach, I can help to guide you through the process of therapy. The important thing is that we collaborate throughout the experience. Does this make sense?" By acknowledging the patient's self-expertise while simultaneously portraying confidence in his or her own treatment expertise, the therapist encourages a relationship of mutual respect and coparticipation. The therapist also sets an expectation that the patient will play an active role in the egalitarian, two-person approach to psychotherapy.

Regarding our third clinical guideline, the patient might already be knowledgeable about therapy in general, yet have treatment role or process expectations that are incompatible with the therapist's treatment modality. In this situation, the theoretical literature has evolved. Early approaches suggested that patients would need to fit the theory/approach, whereas subsequent conceptualizations focused on the need to meet patients' expectations and perhaps preferences (e.g., Glass & Arnkoff, 1982). Others (e.g., Strupp, 1978) have advanced that expectations are markers for patients' underlying dynamics, suggesting that the therapist's task is to address the potential etiology of patients' expectations about what will and will not occur in the therapy process. Perhaps the most dominant contemporary approach to patients' treatment expectations is one of negotiation, with the therapist investigating the patient's perspective, informing the patient of the therapist's own perspective, entering a process negotiation, and letting the patient choose if the treatment seems appropriate (Van Audenhove & Vertommen, 2000). For example, a cognitive therapist who would not typically focus on a patient's childhood, might suggest the following to a patient who expects that a historical approach is necessary for change: "Actually, in discussing your thoughts, we will often find the root of these in your early childhood. So, although we will spend much time discussing issues here and now, we will gain insight into and be informed by your childhood experiences. Does this work for you, or should we consider alternatives?" There might also be a phase process whereby therapists might initially need to meet patients where they are (e.g., matching

on optimism; Ahmed & Westra, 2009), or first engage in strategies that align with their clients' typical expected coping styles (even if they believe them to be restrictive) (Glass & Arnkoff, 1982). Such initial expectancy confirmation could go a long way toward building credibility as a therapist, managing patients' anxiety, and optimizing engagement. With such engagement, later phases of treatment could focus on change-oriented strategies aimed at heightening optimism and revising patients' expectations about potentially helpful treatment behaviors (Constantino & Westra, 2012).

The fourth clinical guideline is to monitor regularly any distance between patients' treatment expectations and their actual experiences in therapy. Recall that Joyce and Piper (1998) found that the larger the discrepancy between the two, the poorer the alliance quality. Assessment can be done verbally or through brief measures, such as those discussed previously. In keeping with the most recent aforementioned clinical example, it is possible that the patient would express during treatment wanting to talk more about when he was a child interacting with his parents. Instead of rigidly maintaining a secondary focus on history, the therapist may need to reenter a negotiation phase. The therapist might say something like, "I can appreciate your desire to stay with your past. Can we think about that in terms of our treatment plan and goals? I am open to revising our focus if it makes sense to us in terms of what we are trying to accomplish—and it very well may."

A fifth clinical guideline is to provide patients up front with an approximate length of treatment, as Swift and Callahan (2011) found that pretreatment duration education was an effective means for changing duration expectations, which in turn were related to more sessions attended and fewer treatment dropouts. Swift and Callahan suggested that this education could be very brief (in their study it included only a few sentences on the recommended number of sessions needed to recover). As one example related to dosing in many empirically supported interventions for mood or anxiety syndromes, a therapist might say, "Based on an abundance of research in this area, 16 to 20 sessions is a minimum recom-

Table 4
Summary of Clinician Interventions for Addressing Treatment Expectations

Clinical guideline	Level of empirical support
Assess treatment expectations (either verbally or with a psychometrically sound measure)	<i>Moderate</i> —Although the findings are equivocal overall, multiple studies evidence a relation between treatment expectations and both adaptive treatment processes and outcome, thus suggesting the importance of regularly assessing such expectations in clinical practice
Address treatment expectations explicitly with pretreatment socialization strategies (e.g., a RII) that emphasize expected role behaviors and process elements, outline a strong treatment rationale, and highlight the importance of patients' active involvement	<i>Moderate</i> —More than half of the numerous studies support the efficacy of pretreatment socialization techniques on adaptive psychotherapy process and outcome
Negotiate treatment expectations in the service of fostering engagement (e.g., initially meet patients' treatment expectations) and change (e.g., ultimately helping patients revise their treatment expectations in the service of improvement)	<i>Preliminary</i> —One or a few studies support the value of negotiating treatment expectations and/or addressing them differently based on the phase of treatment
Monitor regularly any distance between patients' treatment expectations and their actual experiences in therapy	<i>Preliminary</i> —One or a few studies support the value of monitoring discrepancies between patients' expected and actual experiences in treatment
Educate patients before treatment on the expected length of treatment needed for recovery	<i>Preliminary</i> —One or a few studies support the value of pretreatment duration education on treatment engagement

Note. RII = role induction interview (Hoehn-Saric et al., 1964).

mended treatment dose. Can you commit to that?" In Table 4 we provide a summary of clinician interventions for fostering or responding to treatment expectations.

Conclusions

Although translating research on patients' psychotherapy-related expectations into specific psychotherapeutic practices remains at a preliminary stage, we extracted nine overarching practice suggestions based on the existing literature. These recommendations for assessing, addressing, and influencing patients' psychotherapy-related expectations provide a starting point from which clinicians can work; however, there remains much more progress to be made. For example, future research should continue to develop and refine clinically sensitive and feasible measures of the various expectancy types and subtypes. Future work should also focus on continuing to develop and test expectancy-fostering strategies in rigorous clinical trials (in both laboratory-based and effectiveness contexts). Furthermore, to close the gap between science and practice, and to promote specificity of the so-called "nonspecific" variables like expectations, these methods need to be disseminated effectively (e.g., compiled into manuals, taught via workshops or in training programs, etc.).

It will also be valuable to develop a better understanding of what factors influence patients' expectations, as research in this area remains in its infancy. Such work could be done in a controlled laboratory-based setting, or clinicians can do this via case studies (e.g., by qualitatively assessing determinants of their own patients' expectations). Moreover, because it seems clear that expectations are malleable, it is also important that future research treat expectations as dynamic variables (e.g., by measuring the sequential course of expectations throughout treatment). Through such continued investigations on the construct of expectations and how best to assess and address them, the field can continue to learn how to capitalize clinically on what appears to be a potent, and largely nondiagnostic, psychological variable.

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