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# Expectations of patients assessed in clinical psychology in a mental health center

## Abstract

At present, an understanding of psychic suffering marked by the biomedical model predominates, which also permeates the approach from clinical psychology and determines the expectations of patients. Expectations are one of the least studied variables of therapeutic change, despite being included among the common factors and their importance being confirmed in different studies. This research seeks to describe the expectations of the population assessed in the clinical psychology service in a Mental Health Center. Expectations are assessed quantitatively using the MPEQ questionnaire and qualitatively using an ad hoc questionnaire. The results reflect that most patients have the expectation that therapists will help them through techniques to reduce their symptoms and have disproportionately high expectations regarding the results of psychotherapy, which in accordance with the biomedical and rational-scientific predominant conception in this area.

**Keywords:** expectations in psychotherapy, biomedical model, common factors, clinical psychology, descriptive-observational study

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## Introduction

There are different models that trying to explain how "*change*" happens in psychotherapy. Psychology, for more than half a century, has been adopting the biomedical model, and has approached the technological and rational-scientific paradigm.[1] The political and social influences, typical of postmodern society, and the need to be productive and efficient in order to fit into the neoliberal market model are evident.[2]

The predominant model of psychology today is the cognitive-behavioral model, the one that best suits the medical model, comparing the techniques that can be offered to the patient with prescriptions or drugs. A model that has promoted a liberal vision of psychology to be able to sell therapies "*supported by science*" as effective and fast products to eliminate symptoms, but that favors a passive and less empowered attitude in patients. Patients, within this conception of psychotherapy, have some symptoms to be eliminated by the therapist, while their intrapsychic conflicts, dilemmas or vital dissatisfactions and the influence of social determinants in their suffering lose importance. That is, their symptoms are decontextualized in order to receive a diagnostic label and be treated. A reductionist conception that defends itself as the only scientific one.[3]

However, this way of understanding psychotherapy, on one side, is not without risks[4] and, on the other, it underestimates the so-called common factors or non-specific factors of change,[5] which have been shown to have a greater weight in the explanation of the results of a therapy than specific techniques that cognitive behavioral therapy gives to patients.[6]

Among these factors are the expectations of the patients, which would the hope that the patient has of being able to obtain a certain result or that some change will occur during therapy. Lambert and Barley[7] estimate that patient expectations contribute up to 15% of the variance related to therapy outcome, while others hypothesize that the percentage may actually be higher.[8] Recently, the theory of the Contextual Model of Wampold and Imel[9] defends that the expectations of the patients are part of one of the three ways by which psychotherapy works, placing them at the same level as the "*genuine*" relationship between the therapist and client and release of health promotion actions.

Two types of expectations are usually differentiated:[10]

1. Outcome expectations: Defined as "*patients prognostic beliefs about the consequences of engaging on treatment*".[11] They are already existing before coming into contact with the therapist or the treatment and are malleable for the duration of the treatment. They depend on personal experience, interactions with other therapists, and constant evaluation of the course of treatment and its efficacy.[12]

2. Therapy expectations: These are defined as "*patients' beliefs about what will happen during therapy, including how the therapist and they will behave (role expectations), their subjective experience of therapy (process expectations), and how long will be the treatment (duration expectations)*".[11] Studies carried out in recent years have found that these types of expectations determine 3% of the outcome of psychotherapy[13] and that they are associated with essential components of the therapeutic process, such as therapeutic alliance and "*level of positivity*" of the session.[14]

In general, at least three ways in which client expectations can influence therapy have been identified:[15]

- Determine the decision to start therapy: Preconceptions about psychotherapy influence help-seeking behaviors.[16]

- Influencing the duration of therapy: If what the person expects is not fulfilled during therapy, it can lead to feeling dissatisfied and drop out.[17]

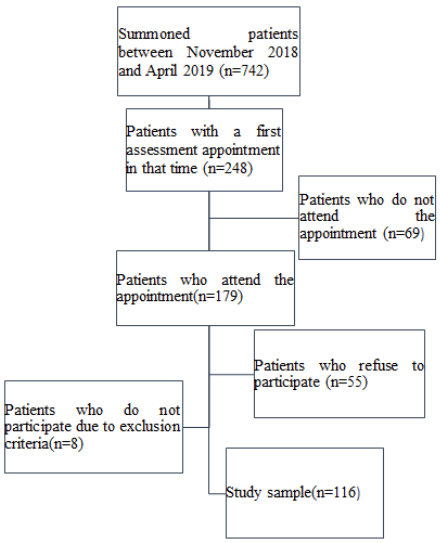
- Moderate the effectiveness of therapy. It has been hypothesized that this association would be mediated by the therapeutic alliance.[18–20] Thus, patients with more positive beliefs about the outcome of therapy will be more likely to engage in a collaborative relationship with their therapist, which, in turn, promotes improvement. In turn, having low result expectations is related to a worse therapeutic process and worse results, in addition to being a risk factor for breaking the therapeutic Alliance.[21]

For all these reasons, it is important to know the initial expectations of patients about what they expect from therapy in order to improve interventions by developing strategies that are adapted to the specific needs of patients and, therefore, improve results of treatment.[22]

The current study is based on the hypothesis that people who come to clinical psychology have too high expectations of psychotherapy and that most of the expectations of people referred to clinical psychology are based on a biomedical model, the most implanted in medicine and psychology. Therefore, the objectives are:[1] to describe and analyze outcome and therapy expectations before first session and[2] to know with which explanatory model the expectations are related.

## Material and methods

Descriptive observational design. The sample is made up of all people in legal age who were summoned for a first assessment appointment in the adult clinical psychology consultation of a Mental Health Center between the months of November 2018 and April 2019. This center is located in the C.I.D.T. Francisco Díaz, belonging to the Psychiatry and Mental Health Clinical Management Area of Príncipe de Asturias University Hospital, Alcalá de Henares (Madrid). The reference population of this Mental Health Center is 162,816 people and the total requests for referral during that period to the clinical psychology consultation for the adult population were 742. The only exclusion criterion was having difficulties in oral or written language.




An ad-hoc questionnaire (Annex 1) is created to collect sociodemographic, clinical and healthcare data. Likewise, the questionnaire includes open questions to qualitatively evaluate outcome and therapy expectations, which include: therapist role expectations, patients role expectations, process expectations and duration expectations. Finally, it qualitatively evaluates the patient's perceived self-efficacy and quantitatively the responsibility placed on oneself with respect to treatment using a 5-level Likert-type scale in which the patient is asked to indicate how much responsibility they believe they have to solve their problem or achieve the desired change.

A translation into Spanish of the *The Milwaukee Psychotherapy Expectations Questionnaire* (MPEQ)[15] is made (Annex 2), which quantitatively evaluates the two types of expectations, outcome and therapy expectations. It is a 13-item self-report questionnaire measured on a continuous 11-point scale ranging from 0 (not at all) to 10 (very much). Statements include expectations about what the patient is expected to do, therapist behavior, and predictions. Lower scores suggest negative expectations, while higher scores suggest positive expectations. It has been used in other studies that sought to find associations between patient expectations and symptom level or clinical improvement (20). One problem with this test is that its items are too specific in defining therapy outcome, as not all clients seek therapy to improve their self-esteem, to cope with distress, or to become a better/more optimistic person. Therefore, in order not to bias the responses to open questions, it was decided to place the MPEQ on the next page of the questionnaire.

Initially, the participants are informed by telephone about the research, as well as the voluntary nature of their participation, anonymity and confidentiality, asking them to come 30 minutes before their appointment with clinical psychology to fill out the questionnaires. Once there, one of the members of the research team will individually pick them up in the waiting room and take them to an office to guarantee anonymity and confidentiality. It is clarified that the collaboration in the research would not influence their therapeutic process because the members of the research team are independent from the clinical psychologist therapists of the Health Center to which the patients are assigned. They are given the study information sheet and given the questionnaires to complete before having the first contact with their corresponding therapist.

This research was approved by the Research Ethics Committee of the Príncipe de Asturias University Hospital at its meeting on October 30, 2018.

## Results

The statistical analysis is made with SPSS statistical package through a descriptive analysis of the sociodemographic (Table 1), clinical and care characteristics (Table 2). Quantitative variables are expressed as average, range and standard deviation; and the qualitative ones are categorized and expressed by means of percentages. For the categorization of the qualitative variables, an analysis of the discourse of the participants is carried out, grouping the responses into broader categories. For the construction of these categories, it were valued based on being clinically relevant and their level of adjustment or concordance with the different explanatory models in psychology. Likewise, inter-rater reliability was taken into account by two researchers and reviewed by an external expert. Table 3 shows the resulting categories for each open question of the questionnaire along with their values.

**Table 1** Sociodemographic characteristics

| Sociodemographic characteristics | Statistical value (n=116) |
|---|---|
| Age (years) | |
| Average (±SD) | 41.5 (13.8) |
| Minimum and Maximum | 18-75 |
| Gender (n, %) | |
| Women | 80 (69%) |
| Men | 36 (31%) |
| Civil status (n, %) | |
| Married | 54 (46.6%) |
| Single | 42 (36.2%) |
| Divorced | 17 (14.7%) |
| Widowed | 1 (0.9%) |
| "Do not know" or "refuse to answer" | 2 (1.7%) |
| Children (n, %) | |
| No | 49 (42.2%) |
| Yes | 64 (55.2%) |
| "Do not know" or "refuse to answer" | 3 (2.6%) |
| Studies (n, %) | |
| Without studies | 5 (4.3%) |

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Table Continued...

| Sociodemographic characteristics | Statistical value (n=116) |
|---|---|
| Secondary Education | 43 (37.1%) |
| Postsecundary education | 41 (35.3%) |
| University studies | 23 (19.8%) |
| "Do not know" or "refuse to answer" | 4 (3.5%) |
| Employment situation (n, %) | |
| Unemployed | 21 (18.1%) |
| Sick Leave Insurance | 19 (16.4%) |
| Working | 53 (45.7%) |
| Pensioner | 6 (5.2%) |
| Student | 10 (8.6%) |
| Housewife | 4 (3.5%) |
| "Do not know" or "refuse to answer" | 3 (2.6%) |

**Table 2** Clinical and care characteristics

| Clinical and healthcare variables | Values |
|---|---|
| Medication (n, %) | |
| Yes | 57 (49.1%) |
| No | 59 (50.9%) |
| Previous visits to a psychologist (n, %) | |
| No | 43 (37.1%) |
| Yes, in private health network | 25 (21.6%) |
| Yes, in public health network | 36 (31%) |
| Yes, in both | 11 (9.5%) |
| "Do not know" or "refuse to answer" | 1 (0.9%) |
| Previous visits to a psychiatrist (n, %) | |
| No | 67 (57.8%) |
| Yes | 49 (42.2%) |
| Initiative to make a medical appointment (n, %) | |
| Own | 54 (46.6) |
| Primary attention doctor | 32 (27.6) |
| Relatives | 8 (6.9) |
| Others | 1 (0.9) |
| Various | 17 (14.7) |
| "Do not know" or "refuse to answer" | 4 (3.5) |

**Table 3** Qualitative data on expectations

| Qualitative categories along with values | | | |
|---|---|---|---|
| Outcome expectations. "What do I hope to achieve by going to psychologist?" (n, %) | | Therapist´s role (n, %) | |
| Symptom reduction | | Do not know | 19 (16.4) |
| Problem solving | | Guidelines/Tips. | 44 (37.9) |
| Coping | 43 (41.0) | Active listening | 3 (2.6) |
| Guidelines/Tips | 15 (14.3) | Speak | 7 (6.0) |
| Emotional Management/Control | 16 (15.2) | Analyze/Understand problem | 20 (17.2) |
| Non-specific answers /Help | 12 (11.4) | Does not answer | 7 (6.0) |
| "Do not know" or "refuse to answer" | 9 (8.6) | Non-specific answers | 6 (5.2) |
| Missing | 3 (2.9) | Several previous: | 10 (8.6) |
| | 7 (6.7) | Guidelines – Listen | 9 (7.8) |
| | 11 | Guidelines – Talk | 1 (0.9) |
| Patients' role (n, %) | | Process expectations I (How the change will happen) (n, %) | |
| Follow guidelines/directions | 64 (55.2) | Do not know | |
| Active attitude | 29 (25.0) | Symptom reduction | 24 (20.7) |
| Do not know | 8 (6.9) | Follow directions | 31 (26.7) |
| Refuse to answer | 15 (12.9) | Coping ability | 10 (8.6) |
| Several previous: | | Process description | 11 (9.5) |
| Guidelines – active attitude | 3 (2.6) | Analyze/Insight | 15 (12.9) |
| | | Missing | 8 (6.9) |
| | | | 17 (14.7) |
| Process expectations II (What will help you) (n, %) | | | |
| Do not know | | | |
| Therapeutic alliance | 18 (15.5) | | |
| Guidelines | 19 (16.4) | | |
| Talk/vent | 18 (15.5) | | |
| Symptom reduction | 15 (12.9) | | |
| Coping ability | 15 (12.9) | | |
| Several previous | 12 (10.3) | | |
| Missing | 2 (1.7) | | |
| | 17 (14.7) | | |

## Quantitative analysis of expectations

Some of the variables measured about what the patients expected from the consultation are the expectation that the therapy could have some negative effect, the frequency of the sessions they expect to have, the amount of responsibility placed on themselves to achieve the goals of therapy and perceived self-efficacy. 89.7% of the patients do not imagine that the therapy could have negative effects, 1.7% do not know it and only 8.6% are aware of it. Regarding the frequency of consultations they expect to have, 34.9% fall into the category "others" that includes answers such as "what the therapist considers necessary", "it will vary depending on what is needed" or "depending on the psychologist's agenda." A large part, 20.7% expect a monthly frequency and the lowest percentage (7%) expect a weekly frequency. The majority of patients, 41.4% and 31%, place a high and absolute level of responsibility on themselves, respectively; while 15.5% responded attributing a medium level of responsibility and only 3.4% a low level. In relation to self-efficacy, 71.6% of the patients did consider themselves capable of achieving the desired results, 20.7% did not know or did not answer, and only 7.8% answered negatively.

On the other hand, the quantitative analysis of Outcome and Therapy expectations that corresponds to the MPEQ questionnaire, is carried out through a descriptive analysis of the scores. Regarding Outcome expectations, a mean of 7.7 (SD=1.6) is obtained, with the minimum score being 2.5 and the maximum 10; the mode in statistical terms is 10, the maximum value. In relation to Therapy expectations, the mean is 8.5 (SD=1.2) and the values are between 4.3 and 10. In neither of the two there are differences in terms of sex or age.

## Qualitative analysis of expectations

In relation to Outcome expectations, 41% expect that going to the psychologist will reduce their symptoms, which includes statements such as the following:

"*Improve or change my mood or what I feel*."

"*Recover from anxiety, be able to sleep without nightmares, feeling good in the day*"

"*I hope they will help me to cope with anxiety and distress. To teach me not to take responsibility for everything and to deal with the guilt*"

"*See mechanisms, therapies, that help me get out of this state of sadness, loneliness and anxiety*"

"*Remove my anxiety, especially when driving vehicles, my job is parcel delivery and since the accident I've been very stressed*"

"*Anxiety control, phobia control, stress reduction*"

"*Improve my quality of life, feel less anxious, remove obsessions, cure my panic attacks, agoraphobia, etc*."

The previous answers are adjusted to biomedical model, in which the psychologist is considered to be in charge of making the symptoms disappear. Likewise, this model is supported by the category obtain guidelines or advice (11.4%), which is reflected in the following statements:

*"Help to be able to cope with the situation I have at home and to give me some guidelines or something to be able to get my son out of where he is"*

*"Well, professional vision tells me to follow guidelines to learn to manage my anxiety and anguish"*

*"I have no clear idea, I guess I have to get tools to face things that I don't know by myself"*

*"Tips to improve my family life"*

*"Give me some guidelines for some occasions when I overflow and I don't know how to do it."*

Concerning Therapy expectations, broken down as follows:

- Therapist´s role expectations: There is a predominance of answers that represent the rational-technological paradigm since 37.9% consider that the therapist will help them by giving them guidelines, advice or tools, as shown in the following answers:

*"I guess he will give me some guidelines to avoid anxiety states"*

*"Guide me to get my life on track"*

*"They have studied and can guide me if I am wrong"*

*"Giving me tools that help me know how to manage my emotions"*

*"Well, giving me techniques to help control"*

The 17.2% of patients believe that the role of the therapist will be to help them analyze or understand their problem, showing a more collaborative attitude between patient and therapist, with answers such as: "*Jointly investigating the root of the problem*", "*Making me understand why*?", "*Inquiring inside myself and seeing what happens to me*". Only 3% are in the "*active listening*" category, which would correspond more to a model based on common factors: "*listening to me*", "*with understanding and trust*".

**Patient´s role expectations**: 55.2% consider that what they have to do during therapy is to follow the indications or guidelines that the psychologist tells them, something representative of a conception of the figure of the psychologist as an expert or a technician who knows solutions to the problem, being able to encourage a more passive attitude in patients: "*Follow the instructions of the psychologist*", "*Follow the advice and guidelines that they give me*", "*Listen to the therapist*", "*The instructions that the mark the therapist*", "*Follow the instructions of the specialist to the letter*". Only 25% gave answers consistent with having a more proactive attitude during therapy, for example, with phrases such as "*having to think about the problem*", "*making decisions in relation to my life*", "*making an effort to change things*", "*thinking which is the best for me*".

**Process expectations I:** 26.7% declare that the change during the time they are in therapy will occur by reducing their symptoms, with answers such as:

*"I hope that I will be feeling better and can face problems without anxiety"*

*"I hope to be able to return to a routine life. Without fear and anxiety or at least knowing how to control it and that it does not affect my day to day.*

*"Well, if everything goes well, that anxiety levels remain low as much as possible, also knowing how to face the worst moments."*

*"I guess I will start to feel more confident in myself, develop self-esteem, better understand the situations around me, control and manage my environment as well as my emotions"*

These responses reflect a discourse more focused on coping and a greater ability to take charge of their situation, it being important to note that only 8.6% considered that change would occur through guidelines/advice. Finally, note that 20.7% do not know or have no knowledge of how this change will occur.

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**Process expectations II:** Regarding what will help you most during therapy, there are hardly any differences between the different categories. The importance of the therapeutic alliance is highlighted (16.4%) with responses such as:

*"Get a team with the therapist"*

*"That someone listen to me without judgment and understand my situation."*

*"Speak without problems with someone who can help me without judging"*

*"Talk to someone totally alien to my personal bond"*

*"Communication with the therapist".*

In this sense, it would be the first category in which elements of the common factors model are made explicit. However, the biomedical model is also evident, since 15.5% consider that what will help them the most will be to obtain guidelines or indications: "First explain what is happening to me, tell me the guidelines", "Let them recommend techniques to manage anxiety", "Good advice". Lastly, the category of not knowing (15.5%) what is going to help them.

## Discussion

The profile of the people referred to the clinical psychology consultation of the sample (female, 41.5 years old, married and working) is consistent with previous studies.[23–25]

Regarding the clinical and care characteristics, two thirds of the patients evaluated in the clinical psychology consultation had previously received psychological treatment, most of them in the public health network. This could indicate that these are people who have had a good previous experience on the public circuit, something consistent with expectations of results as high as the results show.

Regarding expectations, in the quantitative analysis of the results in the MPEQ there is an especially high average score, and the most common score is also the maximum possible.

Patients expect great outcomes thanks to coming to psychologist and have high expectations about the therapeutic process itself. The therapy expectations are slightly higher than those of the result, which means that people expect the therapist to give them their support, reflecting a great importance of the variables related to the therapeutic alliance ("*the therapist will be honest with me*", "*I will feel comfortable with my therapist*", "*my therapist will be understanding*"), which is consistent with what was previously stated in the introduction to this article. Psychology is probably one of the causes of the high expectations placed on the psychotherapeutic encounter, by defending an excessively idealistic vision of the possibilities of change at the individual level[26] and ignoring its defects and dangers, such as worsening after treatment psychological.[27]

In the qualitative analysis, the mostly frequent expected of going to psychologist is that the reason that has led the person to the consultation be solved, highlighting the importance given to reducing symptoms or solving the problem. This idea entails the vision of the psychologist as a medical figure (influencing in turn that this study was carried out in a Health Center), capable of reducing or eliminating symptoms. A conception of psychology to which professionals have also contributed, who, for more than 50 years, have been trying to fit into the dominant biomedical model.[1] However, it entails a reductionist conception of psychic suffering around symptoms and signs, forgetting the relational, socioeconomic, political and cultural contexts that surround human nature and, in addition, allow experiencing, evaluating and giving meaning to that suffering.[28]

Before the first appointment, the patients have framed the encounter with the therapist within the rationalist problem-solution paradigm, where their suffering corresponds to a solution offered by the psychologist and supported by science. A conception that accounts for the dangerously presumptuous disclosure that has been made of the psychological and psychiatric through the media, which excludes the possibility of being harmed from these encounters with the therapist (only 8.6% reported that such result could occur), and the high scores on the MPEQ are also not surprising. The expectations are so high because the conception of their discomfort implies that for the problem for which they come there already exists a technical answer that an expert will provide. However, the psychic suffering that has caused going to the consultation comes from very different experiences, questions or dilemmas more typical of our nature as human beings which, obviously, cannot be resolved by an expert, since these are issues that are impossible to reduce to scientific-technical knowledge.[29]

This conception on the psychologist as a doctor has drawbacks, such as decontextualizing the suffering of people[2] In this way, the responses to patient's role are mostly consistent with coping with problems based on following guidelines and instructions, with the inconvenience of promoting a passive role and highlighting that only 25% give responses of a more active nature. However, when the participants are asked about their level of responsibility, the majority affirm that it is very high or absolute, a response that could be due to a factor of social desirability, since it is important to appear to "take charge" of what it happens because it is what is expected of me. If these answers are related to those given to the question about the therapists role, a narrative of the patient as a sick person in need of treatment that generates a dangerous self-concept is glimpsed, since he considers himself dependent and in need of the hands of an invested specialist. of psychological authority.[30] The responses of the patients regarding their role reflect one of the risks of any therapeutic process, that the patient believes that he should adopt a submissive role, limiting his role to following the instructions. This can invalidate his ability to cope or make him disresponsible for his behaviors, which he believes should depend on "what the expert tells him". All this fosters such an unequal relationship that it can damage its interpersonal character,[31] weakening the patient's therapeutic alliance, self-esteem and internal locus of control, to the detriment of a context that promotes the empowerment of the person who suffers.[32]

In relation to how the change will occur, it is important to point out the high percentage of patients who say they do not know how it will occur. A result consistent with other studies that found that patients arrive without having a clear realistic idea of how therapy works, which is the therapist's role is, and what is required of them as clients.[33] Likewise, in relation to what they consider will help them, although there are hardly any differences between the categories, it is important to highlight the weight given to the therapeutic alliance, since what was found in this study contrasts with others such as the one carried out by Bitan and Abayed S,[34] who state that it has been proven that therapists and patients have different points of view about what works in psychotherapy. Therapists tend to place more importance on establishing positive relationships between patient and therapist, while patients place more importance on the provision of tools for cognitive control.

Previously, has been discussed the way in which expectations determine the therapist's performance and the evolution of the therapy

process. Therapists can use knowledge of the patient's expectations to help them establish a more accommodating therapeutic mood, staying in tune with the patient's opinion and openly discussing each other's role in therapy or what to expect from it. It has been proven that most patients have exaggeratedly high expectations regarding the reality of psychotherapeutic treatment, based on the biomedical and rational-scientific conception of clinical psychology, which, however, are related to acquiring a passive role during treatment or abandoning it early.[35] Therefore, it is important that therapists do not forget the relevance of evaluating, discussing these expectations (malleable) and offering a more realistic conception of therapy, as well as moving away from the omnipotent vision that the patient can bring in order not to damage the therapeutic relationship and of the technical-medical vision, including other points of view regarding psychic suffering beyond its conception as an illness. There are models based on non-diagnostic or non-blaming narratives, which demystify the figure of the therapist and understand human beings within their social and relational contexts.[36]

## Conclusion

The results show the narratives that patients bring when they arrive at the psychologist's office, these being a reflection of the dominant social and cultural discourses, norms and expectations. These expectations are part of a biomedical model, in which the symptoms correspond to a nosological entity that has a specific approach, either in the form of medicine or a psychological tool. These narratives include a conception of the clinical psychologist as an expert possessor of solutions to vital problems; a technician who knows certain techniques or exercises that one must acquire and practice to solve their mental health problem. This discourse is properly characteristic of the current postmodern times in which the myth of specialized competence prevails[37] where the supposed experts offer a technical solution for any problem that arises and an asymmetric and paternalistic relationship is favored. Contrary to this model, others approach the psychic suffering that has promoted going to the consultation as coming from very different experiences, life conditions, questions or dilemmas more typical of our nature as human beings, thus facilitating a contextualized vision and a collaborative therapist-patient relationship.

### Study limitations

Regarding the limitations of the study, it must be taken into account that the sample size is not too large. This study does not include the expectations of people who did not attend the first appointment for various reasons, including the long waiting list for the first appointment; variables that may affect initial expectations, so the results of this study may not represent all the people referred. It would be advisable to replicate this study to assess the expectations of people at the first moment of referral to the clinical psychology service. Likewise, it would be interesting to extend it to other areas/centers.

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## Conflict of interest

None.

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