Expectations in psychotherapy: A narrative review

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Abstract

Expectations can influence the outcome and the process of psychotherapy. Hence, this article aims to overview the types of expectations, i.e., outcome, treatment and change. Both patients' and therapists' expectations are considered. Furthermore, determinants of expectations and moderators/mediators of expectations-outcome relationship are described. We provided theories that try to explain the influence of expectations and their relationship with the psychotherapy process. Various instruments for measuring expectations and practical advice to manage expectations in psychotherapy will be discussed. Clinicians should become increasingly aware of their own and clients' expectations. Future studies should investigate the impact of every kind of expectation and its moderation/mediation role with other psychotherapy processes.

Keywords: outcome expectations, treatment expectations, change expectations, expectation measures, psychotherapy process outcome research

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Introduction

Expectations belong to the human being. For instance, expectations influence the perception of events and the evaluation of social objects (e.g., Asch, 1946; Farina & Ring, 1965). Regarding psychotherapy research, expectations were little considered, until the early 1980s (Weinberger & Eig, 1999). However, they have been studied more frequently in the following years. Hence, this article aims to overview the various expectations and how they are related to the psychotherapy outcome and process, regardless of any theoretical approach.

Since there is no single definition of expectations in psychotherapy, we define expectations as beliefs about something that will be. Based on this definition, there may be expectations about how the outcome and treatment will be and expectations about being able to change during psychotherapy. Nonetheless, the patient may have expectations about how the therapist will be, just as the therapist may share the same expectations about the patient. Some authors include expectations among the common factors, i.e., transversal factors to all psychotherapy approaches, regardless of the theoretical framework (Gelo et al., 2015). For instance, Lutz et al. (2021) conceptualize expectations as a dispositional factor like the motivation of change. Conversely, other authors consider expectations as a psychotherapy process, together with common factors, extra-therapeutic factors and specific techniques (e.g., Lambert, 2013)

Expectations affect the outcome (Arnkoff et al., 2002; Constantino et al., 2018; Snyder et al., 2000). For instance, patients reported less anxious and depressive symptoms when participating in a group where positive expectations were fostered than patients in a control group (i.e., no information was given; Thomas et al., 2021). Although Lambert (1992) affirmed that expectations would explain 15% of the psychotherapy outcome variance, some authors criticized this estimate. Specifically, it would not be based on statistical analyzes. In addition, expectations would have been defined as a single construct that overlapped with treatment credibility (e.g., Greenberg et al., 2006). Indeed, Ilardi and Craighead (1994) showed that common factors explained 40% of the outcome variance, while Wampold (2001) showed that specific factors explained only 8% of the outcome variance. However, the common factors do not coincide with the expectations. Therefore, it is impossible to establish whether this large percentage accounted by common factors reflects a more significant explained variance by expectations, compared to Lambert (1992)'s estimates.

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Outcome Expectations

Outcome Expectations (OEs) are beliefs about the consequences of participating in a treatment (Constantino et al., 2011). Since OEs are the most studied among the various types of expectations, there are more results to overview. OEs positively affect the intention to seek treatment (Constantino et al., 2016) and the psychotherapy outcome (*d* = .24; Constantino et al., 2011; *d* = .36; Constantino et al., 2018). From a statistical point of view, Arnkoff et al. (2002)'s review showed that studies conducted before 1980 identified a curvilinear relationship between OEs and psychotherapy outcome, i.e., the most favorable outcomes were associated with OEs that were neither too positive nor too negative (e.g., Noble et al., 2001). Instead, most studies from 1980-1999 reported that a positive linear association existed, although few studies showed a negative (Lax et al., 1992) or nonsignificant association (Başoğlu et al., 1994; Noble et al., 2001). Moreover, OEs predict the rate of change of symptoms, such as public-speaking anxiety (Price & Anderson, 2012). Nevertheless, OEs are not just about psychotherapy but also medical treatments in general. For example, after administering an "analgesic" placebo, subjects reported experiencing less pain and higher levels of endogenous opioids than those who did not receive it (Amanzio et al., 2011).

OEs can change across psychotherapy. Vîslă et al. (2021) showed that OEs increase linearly from pre to post-treatment. Regarding couple psychotherapy, although clients with avoidant attachment had more pessimistic OEs, these expectancies could change over the treatment (Muetzelfeld et al., 2020). Other studies identify differences in OEs at different stages of therapy. For instance, while positive OEs at the beginning and negative OEs in the middle of treatment predicted a better outcome (Thiruchselvam et al., 2019), Vîslă et al. (2019) found that OEs became more positive during psychotherapy, even though previous depressive episodes predicted more pessimistic OEs.

It must be said that OEs are distinct from motivation, i.e., the willingness to change or participate in psychotherapy, and from preferences, which refers to the positive attitude that a patient has towards a treatment (Arnkoff et al., 2002). Finally, although OEs and credibility (i.e., the belief about how well a treatment works and it is suitable for the client) are kept separate in the literature, the two concepts may overlap (Greenberg et al., 2006). Credibility is a set of beliefs that develops after having an experience so that OEs would be antecedent to credibility (Constantino et al., 2011). However, there is still a debate regarding the purity of these two constructs.

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Since OEs affect the outcome, it is crucial to understand the determinants of these expectations, such as demographic characteristics, psychological status, prior experiences, and feedback. For example, being older and female predicts more positive OEs, while symptom severity, comorbidity and lower well-being are associated with more negative OEs (Connolly Gibbons et al., 2003; Constantino et al., 2014; Tsai et al., 2014). In fact, Vîslă et al. (2021) found that higher depression levels at the beginning of psychotherapy were associated with worse OEs. Positive prior experiences predict good OEs for psychotherapy and art therapies (Constantino et al., 2016; Millard et al., 2021). Similarly, feedbacks from media, friends and family members influence OEs, such as prior experiences, opinions or attitudes (Morrison et al., 2021). Moreover, traits like fear of receiving compassion and self-compassion are associated with negative OEs (Merritt & Purdon, 2021). Finally, avoidant attachment is associated with more pessimistic OEs (Muetzelfeld et al., 2020).

Nevertheless, it seems that there is a positive association between alliance quality and OEs (Connolly Gibbons et al., 2003; Constantino et al., 2005). For instance, the greater the patient's OEs are in previous sessions, the better the alliance perceived by the therapist is in subsequent sessions (Constantino et al., 2020). Moreover, Constantino et al. (2021) have done a meta-analysis showing how alliance levels mediated the OEs-outcome relationship. For instance, therapeutic alliance as a mediator of OEs - outcome relationship has been found for patients suffering from major depressive disorder (Meyer et al., 2002) or with mixed diagnoses (Constantino et al., 2021; Joyce et al., 2003). Furthermore, a better alliance can promote OEs about reducing depressive symptoms (Kahn, 2020).

The therapist also has their own OEs (Bartholomew et al., 2019): greater OEs for the therapist predict a better alliance with the patient (Meyer et al., 2002). Positive therapists' OEs are associated with better patients' outcomes, explaining 7.3% of the variance (Connor & Callahan, 2015). Nevertheless, Coyne et al. (2021) showed that therapists underestimated patients' momentary OEs throughout the therapy. However, therapists tracked shifts in OEs accurately, becoming more aligned over time.

Treatment Expectations

There are many expectations about the treatment, i.e., what will happen in psychotherapy, such as therapist's behavior, therapeutic activities and so on. Patients may expect that therapists will give them advice on what to do to solve their harmful problems or that they will lie down in a

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bed as Freud usually did with his clients. For example, Weitkamp et al. (2017) found through a qualitative analysis of recurrent treatment expectations that adolescents suffering from mood disorders considered psychotherapy as a difficult process to know themselves better. However, Seligman et al. (2008) showed that 50% of patients had inaccurate treatment expectations that were not typical for a specific psychotherapy approach. Expectations regarded more atheoretical psychotherapies, such as giving advice or helping to talk of the problems.

Treatment expectations are related to the psychotherapy outcome. Regarding the review by Arnkoff et al. (2002), most studies show how good treatment expectations are positively associated with therapy outcome, while a minority identify mixed or non-significant effects. Clients who expected to work intensively (Patterson et al., 2008) or play an active role (Schneider & Klauer, 2001) in therapy showed a better outcome than those who did not have these expectations. Negative treatment expectations reduce also treatment-seeking behaviors (Gonzalez et al., 2005). Moreover, the confirmation and disconfirmation of expectations are not uniquely linked to the outcome. For instance, patients had better outcomes when negative expectations about being manipulated were disconfirmed (Westra et al., 2010).

If therapists give information about treatment, they contribute to forming patients' treatment expectations. Also, Deane et al. (1992) have shown that expectations were more accurate if patients saw a ten-minute video about psychotherapy before the intervention. However, drop-outs are more frequent if therapists disattend treatment expectations given at the beginning of therapy (Davis & Addis, 2002).

In addition, treatment expectations about therapy length influence the attendance level. For instance, patients' pretreatment expectations about duration were positively associated with the number of sessions that clients attended (Callahan et al., 2014). Similarly, patients who expected a shorter duration of therapy were less satisfied (Mueller & Pekarik, 2000) and dropped-out more likely (Schneider & Klauer, 2001) if the psychotherapy lasted longer. Generally, severity symptoms predict expectations about length. Constance et al. (2008) found that patients with less severe disorders expected a shorter duration than those with moderate or severe symptoms.

Patient characteristics can be determinants of treatment expectation. For example, patients with good interpersonal functioning have low expectations about contributing to psychotherapy, which predicts a better outcome (Joyce et al., 2000). However, other studies (e.g., Kaplan, 2000) have shown that high expectations of contributing to the intervention were positively associated with the outcome. Regarding attachment sty-

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le, Zilcha-Mano et al. (2021) showed that if expectations were measured explicitly (e.g., using self-reports), patients with anxious attachment did not have lower positive treatment expectations. However, positive expectations were less accessible if measured implicitly (e.g., lexical decision task). Nevertheless, treatment expectations are different between races. For instance, African Americans expected more frequently than Whites a male heterosexual therapist of the same religion with an assertive style (Charles et al., 2021). Instead, Asian patients expected higher directiveness, confrontation, self-disclosure, empathy, expertise, and tolerance levels by the therapist (Fowler et al., 2011). White clients usually expect a therapist of the same race with good interpersonal skills that motivates them (Charles et al., 2021; Fowler et al., 2011; Weitkamp et al., 2017).

Treatment expectations are also positively associated with the therapeutic alliance (Joyce & Piper, 1998). Specifically, patients' expectations about therapists' commitment, responsibility, genuineness and expertise are associated with the alliance level (Patterson et al., 2014). Moreover, alliance levels are lower when patients' treatment expectations are disregarded (Frankl et al., 2014). In addition, patients may have treatment expectations about the alliance that predict alliance levels and symptoms change during psychotherapy (Barber et al., 2014). Symptom severity seems to moderate treatment expectations-alliance relationship. In fact, more pessimistic expectations about alliance formation were more likely in patients with higher depressive symptoms (Lebowitz et al., 2021).

Finally, patients and therapists can have different or similar treatment expectations. The congruence between patient and therapist expectations predicts a better outcome (Joyce et al., 2000) and a better alliance (Al-Darmaki & Kivlighan, 1993). Nevertheless, patients and therapists may have different expectations regarding the mechanisms of change. For example, patients consider changing their emotions and cognitions more important than therapists usually do (Tzur Bitan & Abayed, 2019). Similarly, the opportunity to speak of the problems is one of the most important mechanisms of change for patients (Tzur Bitan & Lazar, 2019). This incongruence between expectations can last over time. For instance, Tzur Bitan et al. (2021) showed that before the first session, therapists thought that the therapeutic relationship was the principal component of the psychotherapy process, while patients expected to be the techniques for cognitive control. Moreover, patients maintained these expectations about cognitive control after three months of therapy.

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Expectations of Change

The expectation of change in psychotherapy is considered a crucial factor. Indeed, Grencavage and Norcross (1990) classified the expectation of being able to change as a change mechanism of psychotherapy. Specifically, having positive expectations of changing predicts a better outcome (Snyder et al., 2000) and a greater adherence to therapeutic techniques, such as exposure (Bootzin & Lick, 1979; Chambless et al., 1997; Newman & Fisher, 2010). Similarly, expecting helpful changes is associated with positive outcomes in art therapies (Millard et al., 2021). Moreover, symptom improvements are more significant if patients believe they are responsible for the change than patients who think it depends on a placebo drug (Liberman, 1978).

Furthermore, homework compliance seems to mediate change expectancy and outcome. Specifically, greater change expectancy is associated with greater homework compliance, which is related to symptomatologic improvement (Westra et al., 2007). Finally, expect to change is associated with help-seeking, i.e., contacting a psychotherapist to begin psychotherapy (Elliot et al., 2014). Unfortunately, literature about expectations of change is scant. Table 1 shows the association between expectations, outcome, determinants, and psychotherapy processes.

Tab. 1 – *Associations Between Types of Expectations, Outcome, Determinants, and Psychotherapy Processes*

Type	Outcome	Determinants	Processes
Outcome Expectations (OEs)	Positive association Influence on the rate of change	Age, sex, symptom severity, comorbidity, well-being level, prior experiences, feedbacks, personality traits, attachment style	Positive association with alliance; alliance mediates OEs-outcome relationship
Treatment Expectations	Positive association Influence on the drop-out rate	Race, interpersonal functioning, attachment style, symptom severity	Positive association with alliance; symptom severity moderates treatment expectations-alliance relationship
Expectations of Change	Positive association Influence on the adherence level	No study available	Homework compliance mediates change expectations-outcome relationship

Note. Based on the literature, this table shows the associations between types of expectations, outcome, determinants, and psychotherapy processes.

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Theories of Influence

Some theories try to explain why expectations are influential. Frank (1961) believed that a *demoralized* client has negative expectations about the outcome and/or therapeutic activities, which negatively affects the outcome. In fact, a demoralized patient will be less involved in therapy. Conversely, involvement will be greater when a patient is *remolarized.*

According to the Goal Theory (Austin, 1996), a goal is a desired state or outcome. Specifically, commitment will be more significant if a goal is important or evaluated as feasible. Hence, when patients believe that therapy is a feasible and effective strategy to achieve a goal (e.g., reduce symptomatology), their commitment and involvement might be greater. These would explain the better outcome and why there is an association between OEs and therapeutic alliance (Constantino et al., 2005; Joyce et al., 2003).

Furthermore, Regulatory Focus Theory (Higgins, 1997) states that individuals adopt different strategies to achieve a positive goal (i.e., promotion focus) or to avoid a negative outcome (i.e., prevention focus). In the first case, a patient suffering from depression would say, "I want to stay better," while in the second case, a client might affirm, "I don't want to be sad." Park et al. (2019) found that promotion focus predicted more positive OEs than preventive focus. Since promotion focus is associated with positive mental health variables (i.e., self-esteem, optimism, lower neuroticism; Gorman et al., 2012) and treatment engagement (Katz et al., 2016), there might be a link between the desire to achieve a positive outcome and the expectation that psychotherapy is effective (Park et al., 2019). Hence, promotion focus regulation could be associated with commitment, mental health status and OEs. However, though Dakof et al. (2001) found an association between expectations and engagement for clients suffering from substance disorders, Ransley et al. (2019) did not find it for mothers in parent-infant psychotherapy.

Moreover, the Patient-Treatment Fit (i.e., how much a client thinks that treatment is suitable for his needs and characteristics) could also explain the influence of expectations. For instance, patients with a reasonable degree of Treatment Fit were more likely to continue treatment (Elkin et al., 1999). On the other hand, when the patient's expectations for treatment were disconfirmed, the patient was more likely to drop-out (Clinton, 1996). Hence, Goal Theory and Patient-Treatment Fit could explain how expectations about efficacy and suitableness of therapy influence the patient's behavior, which is linked to the outcome.

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Measures

This section describes the main instruments that measure general expectations or the specific ones described above. Regarding the expectations in general, the *Milwaukee Psychotherapy Expectations Questionnaire* (MPEQ; Norberg et al., 2011) measures clients' expectations about therapy's components and effects. Finally, although the *Expectation for Treatment Scale* (ETS; Barth et al., 2019) has been validated with patients under acupuncture, future studies could adapt it for psychotherapy. ETS measures expectations about coping ability, vitality, physical health and reduction of patient complaints.

About specific expectations, the *Credibility / Expectancy Questionnaire* (CEQ; Devilly & Borkovec, 2000) is an updated version of Borkovec and Nau (1972)'s self-report and it measures OEs and credibility. Besides the fact that CEQ is one of the most utilized in psychotherapy research, it is also one of the few self-reports that can also be used to assess therapists' expectations. Furthermore, the *Patient Prognostic Expectancy Inventory* (PPEI; Martin & Sterne, 1975) measures OEs, even if the questions refer to hospital treatment, whereas the *Expectations About Counseling* (EAC; Tinsley et al., 1980), and its short form (Tinsley & Westcot, 1990) measure both treatment expectations and OEs. Instead, the *Psychotherapy Expectancy Inventory-Revised (PEI-R*; Bleyen et al., 2001) measures clients' treatment expectations about their behaviors and the therapists' behaviors. Regarding couple psychotherapy, the *Expectation and Preference Scales for Couple Therapy* (EPSCT) assesses clients' OEs and role expectations for the Self and the Partner (Friedlander et al., 2019). Finally, *Patients' Therapy Expectation and Evaluation* (PATHEV; Schulte, 2008) measures the hope of being able to change (or the expectation that the treatment is effective), treatment suitability and fear of change.

Discussion

This manuscript aimed to give a general overview of expectations, creating links between other psychotherapy processes. Expectations affect the outcome (Thomas et al., 2021). Specifically, clients' outcome, treatment and change expectations explain a part of the variance of the psychotherapy outcome (Arnkoff et al., 2002; Constantino et al., 2018; Snyder et al., 2000). Also, therapists' expectations are associated with patients' outcomes (Connor & Callahan, 2015). Moreover, the outcome is also affected by the congruence between therapist-patient expectations (Bartholomew et al., 2019; Joyce et al., 2000). Specifically, disconfirmation of expectations can be either positive or negative (Davis & Addis,

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2002; Westra et al., 2010). For instance, there is a therapeutic gain if the belief to be manipulated is disconfirmed. In addition, expectations change during the treatment and the therapist can trigger this modification (Vîslă et al., 2021).

There are determinants of expectations such as demographic characteristics (e.g., age, gender, race), symptom level, attachment style, interpersonal functioning, personality traits (e.g., fear of compassion), past experiences and feedbacks (Charles et al., 2021; Merritt & Purdon, 2021; Millard et al., 2021; Morrison et al., 2021; Muetzelfeld et al., 2020; Vîslă et al., 2021). Therapists should consider these elements when assessing expectations. Nevertheless, there are moderators or mediators between expectations-outcomes relationships, such as alliance level, symptom level, or compliance (Constantino et al., 2020; Vîslă et al., 2021; Westra et al., 2007). For instance, the alliance level mediates the expectation-outcome relationship (Constantino et al., 2021). There are also expectations about the alliance that predict alliance levels during psychotherapy (Barber et al., 2014). Hence, we could hypothesize that alliance and expectations influence each other and their relationship is moderated by other variables, such as patients' characteristics or therapists' expectations.

Why expectations affect commitment might be explained by Goal Theory, Regulatory Focus Theory and Patient-Treatment Fit (Austin, 1996; Elkin et al., 1999; Higgins, 1997). The engagement level will be greater when a goal is important and expected to be feasible. Furthermore, patients should be more engaged in therapy if the goal is a desirable state of greater well-being (Park et al., 2019). When patients seek help and begin a treatment that is judged as fitted with symptoms or problems, their outcome, treatment and change expectations might be better, fostering commitment and alliance levels.

Hence, clinicians should become increasingly aware of their own and clients' expectations. Questionnaires might be helpful for the assessment of expectations, such as MPEQ, CEQ, EAC, EPSCT, PATHEV (Bleyen et al., 2001; Devilly & Borkovec, 2000; Friedlander et al., 2019; Norberg et al., 2011; Schulte, 2008). The clinical interview is an alternative way to assess expectations. Possible questions could be "*what results do you expect?*", "*What do you expect or think psychotherapy is?*", "*What do you think about the activities that we will do?*" or "*Do you think that you can change*?". The psychotherapist should also understand what patients seek from psychotherapy and which interventions they consider suitable.

After the evaluation phase, Swift and Derthick (2013) suggest different ways to address clients' expectations. First, a convincing rationale should be presented, explaining the causes of problems and how psychotherapy techniques help. Therapists should foster positive expectations

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toward treatment and outcome, favoring a sense of hope to succeed. Moreover, therapists have to show that they are experienced and trustworthy (i.e., genuine, warm, empathetic). Finally, therapists should evaluate expectations at the beginning and during psychotherapy to assess discrepancies that might predict drop-out.

If distorted expectations that could hinder psychotherapy (e.g., the therapist is omnipotent, psychotherapy can be effective in 3-4 sessions, the therapist manipulates people's lives) emerge, the therapist should try to change them. It is not necessary to change the expectations from the first session. However, the modification should be a gradual process where the therapist demonstrates step-by-step that the distorted expectations are not consistent with the "*reality of psychotherapy*" (i.e., the characteristic of the psychotherapeutic approach).

In conclusion, this article overviewed the types and effects of expectations in psychotherapy. However, little is known about therapists' expectations. Hence, future studies should investigate the effect of various types of therapists' expectations. Furthermore, researchers should conduct mediation/moderation studies to understand the relationship between expectations and elements of the psychotherapy process, regardless of the theoretical approach. Specifically, patients' and therapists' characteristics should be further investigated. Finally, new studies should test the theories that explain why expectations influence the outcome and psychotherapy process, creating a meta-theory of change.

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