

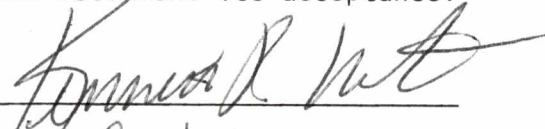
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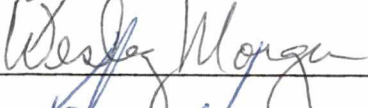
I am submitting herewith a dissertation written by Celestine Fields entitled "Black Patients' Expectations of Psychotherapy." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

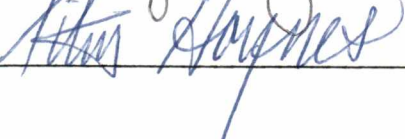


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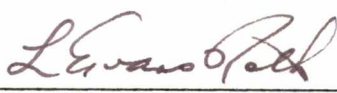
We have read this dissertation
and recommend its acceptance:







Accepted for the Council:



Vice Chancellor
Graduate Studies and Research

BLACK PATIENTS' EXPECTATIONS
OF PSYCHOTHERAPY

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Celestine Fields

March 1982

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ABSTRACT

The relationship between six demographic variables (sex, age, education, occupation, social class, and treatment) and five therapy expectations (active, medical, supportive, passive, and psychiatric) were examined for the purpose of finding out what Black patients expected from therapy, if their expectations actually differed from traditional treatment modalities, and if there were combinations of the above demographic variables that influenced or were most predictive of these expectations.

The sample consisted of 37 Black adults applying for treatment at a predominantly Black mental health center in Nashville, Tennessee. The instrument used to measure expectations was a 40-item questionnaire developed by Overall and Aronson (1963) and modified by Williams, et al. (1967). Social class was determined by Hollingshead's Two-Factor Index of Social Position (Myers and Bean, 1968).

It was hypothesized that:

1. The higher the educational level, the more the patient's expectations would be in congruence with traditional treatment modalities.
2. The expectations of younger patients would be more in congruence with traditional treatment modalities than would those of older patients.
3. The expectations of women would be more in congruence with traditional treatment modalities than men.

4. The expectations of patients who had been in therapy in the past would be more in congruence with that of traditional treatment modalities.

The data was analyzed using the stepwise multiple correlation/regression procedure. Results indicated that Black patients' expectations of therapy do not differ greatly from traditional treatment modalities. Although they expected the therapist to be active, medical, and supportive, to a much larger degree they expected the therapist to be passive and psychiatric. The best predictors of the expectations were: (1) Active--education, sex, and occupation; (2) Medical--education, age, social class; (3) Supportive--education; (4) Passive--age; and (5) Psychiatric--education and social class.

Although the study concluded with the purpose, for the most part, being achieved, it was felt that the results could not be generalized to all Black patients. The need for further research on a much larger scale was evident and suggestions were made for the implementation of such.

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CHAPTER I

INTRODUCTION

Some years ago Hollingshead and Redlich (1958) published results of a ten year study on social class and mental illness conducted in the New Haven, Connecticut area. Patients comprising five social classes were identified using the Hollingshead Index of Social Position, an instrument developed specifically for the New Haven Study (Hollingshead and Redlich, 1958; Myers and Bean, 1968). According to Hollingshead and Redlich (1958),

The Index utilizes ecological area of residence, occupation, and education to determine an individual's class status. To obtain a class status score on an individual, one must know his address, his occupation, and the number of years of school he has completed. Each of these factors is given a scale score, and the scale score is multiplied by a factor weight determined by a standard equation. The three products are summed, and the resultant score is taken as an index of this individual's position in the community's class system (p. 37).

It should be noted that Hollingshead discarded the residency variable in later works in order to increase the Index's generalizability across communities (Myers and Bean, 1968).

Major characteristics of each class were: Class I--upper class--wealthy, head of household was highly educated with a prestigious job; Class II--upper middle class--head of household was a college graduate with a professional job, although less prestigious than that of Class I; Class III--middle class--head of household was a high school graduate usually with some college and/or business or trade school education; Class IV--middle lower class or, more commonly, working class--head of

household, in most cases, finished high school and was employed in a semi-skilled capacity; and Class V--lower class--head of household usually had a grammar school education or less and was employed in an unskilled capacity.

The investigators found that therapists' diagnoses, treatment procedures, and personal opinions differed significantly according to the social class status of the patient with little regard for similarity of the patients' difficulties. Patients in the first three classes seeking treatment for any type of disorder were more likely to receive intensive, insight-oriented psychotherapy as compared to patients in the last two classes who were more likely to receive drug therapy, short-term, supportive therapy, and/or custodial care. In a ten year follow-up study Myers and Bean (1968), utilizing Hollingshead's Two-Factor Index (i.e., combined scores on education and occupation only), found essentially the same results.

Since Hollingshead and Redlich's (1958) classic study, many mental health professionals have used the Index to study various aspects of the relationship between social class and psychotherapy. For example, there have been studies on acceptance and duration of therapy (Brill and Storrow, 1960; Lorion, 1973), patient/therapist variables (Lorion, 1974a), attitudes toward treatment (Calhoun, Dawes, and Lewis, 1972; Fischer and Cohen, 1972; Fischer and Turner, 1970; Lorion, 1974b), and treatment expectations (Aronson and Overall, 1966; Levitt, 1966; Lorion, 1974b; Overall and Aronson, 1963; Williams, et al., 1967), to name a few. Many investigators have found basically the same results as Hollingshead and his colleagues (Hollingshead and Redlich, 1958;

Myers and Bean, 1968; Redlich, Hollingshead, and Bellis, 1955; Schaffer and Myers, 1954), though some have found somewhat contrary results (e.g., Fischer and Cohen, 1972; Lorion, 1974b).

The present investigator was interested in exploring patient expectations more. It was felt that social class may not have as great an influence on a patient's expectations and attitudes as was once thought to be the case, for patients in all classes (not just Classes IV and V) have been found to have attitudes and expectations contrary to traditional treatment modalities (Lorion, 1974a; 1974b). Where race is concerned, there has been only a few expectation studies where it was apparent that Blacks were a part of the sample population (see for example, Overall and Aronson, 1963; Warren, Jackson, Nugaris, and Farley, 1973; Williams, et al., 1967; Wolkon, Morivaki, and Williams, 1973), thus research is needed in this area. It is felt that since Blacks are seeking psychotherapy more, information is needed on what they expect from therapy. Thus the purpose of the present work was to study the relationship between six demographic variables (education, occupation, age, sex, social class, treatment) and five expectation variables (active, medical, supportive, passive, psychiatric) in an effort to determine what Black patients actually expect from therapy, if their expectations actually differ from traditional treatment modalities, and if the demographic variables affect their expectations in any way.

CHAPTER 11

SELECTED LITERATURE REVIEW

Since expectations and attitudes are somewhat related terms, this review will be divided into two sections--attitudes of psychotherapy, and expectations of psychotherapy--in an effort to cover all areas of importance. The review will begin with a discussion of the influence of demographic variables (i.e., social class, race, sex, age, education, occupation, and prior treatment) on patient's attitudes toward psychotherapy and therapists' attitudes toward patients. One should keep in mind throughout that a limitation present in the attitudinal, as well as expectation literature, is that the criterion for whether a patient's attitudes or expectations are acceptable or unacceptable is based primarily on insight-oriented psychotherapeutic techniques.

Attitudes and Psychotherapy

Attitudes have been defined as "predispositions to act, think, and feel in particular ways toward specific [people or] objects" (Understanding Psychology, CRM Books, 1974, p. 414). They are inevitable consequences of belonging to a group, be it familial, racial, cultural, or otherwise, and are continuously formed and applied every day.

In terms of social class, one finds that the lower class, more so than other classes, have been said to equate emotional problems with loss of reason, loss of control, and negative, violent behavior which result in involuntary hospitalization, and stigmatization and rejection

from society as well as their families. This group has also been said to have a defeatist attitude about possible recovery, for they feel, once "crazy" always "crazy" (Baum, Felzer, D'Zmura, and Shumaker, 1966; Riessman and Scribner, 1965). Unfortunately, therefore, persons in this group tend to delay seeking help until their condition approximates what they believe mental illness to be (Heitler, 1976; Hollingshead and Redlich, 1958; Myers and Roberts, 1959; Redlich, Hollingshead, and Bellis, 1955). Riessman and Scribner (1965) have asked if these lower class views of emotional problems and when to seek help are indeed myth or fact. They responded,

Attitudes and feelings of this kind are often viewed by the mental hygiene movement as proof of backwardness and ignorance. Yet all recent treatment censuses confirm the fact that the overwhelming bulk of blue-collar and low-income individuals are institutionalized when they exhibit mental and emotional disturbances, and are commonly relegated to custodial care rather than active treatment programs within the institutions (p. 799).

The authors continued,

In a very real sense it can be said that our social and professional institutions and practices have not only failed to re-educate them about illness but have helped to create and reinforce their negative attitudes (p. 799).

Since the influx of the community mental health movement, however, more Class IV and V individuals have been seeking help in the early stages of their difficulties. Some have reported the absence of social class differences in treatment attitudes of clinic applicants (see, for example, Calhoun, Dawes, and Lewis, 1972; Fischer and Cohen, 1972; Fischer and Turner, 1970; Kadushin, 1969; and Lorion, 1974a), while others have reported differences, the most prevalent tendency being to drop out of treatment early (Baekland and Lundwall,

1975; Storrow, 1962). At least one set of investigators (Fiester, Mahrer, Giambra, and Ormiston, 1977), however, have found no difference, in terms of demographic variables, between dropouts and non-dropouts, thus failing to confirm the notion that the lower classes represent the bulk of dropout patients.

Several reasons have been offered as to why many Class IV and V individuals do drop out soon after they enter treatment. One reason, which has been reported numerous times in the literature, is that of therapists' attitudes toward such patients. Many investigators have observed that therapists' attitudes tend to become more positive as the patient approximates his/her way of thinking, acting, and feeling. Thus, since all therapists are college educated and are members of the middle class, at least, lower class, less educated people more often come in contact with therapists who have negative attitudes toward them (Baekland and Lundwall, 1975; Baum and Felzer, 1964; Baum, Felzer, D'Zmura, and Shumaker, 1966; Brill and Storrow, 1960; Hollingshead and Redlich, 1958; Krebs, 1971; Lorion, 1978; and Schaffer and Myers, 1954). The patient perceives these attitudes in the therapist which influences his/her decision to continue or discontinue treatment (Heine and Trosman, 1960; Overall and Aronson, 1963).

According to Baekland and Lundwall (1975), the young, White, middle or upper class female patient is the ideal of experienced therapists because "such patients are viewed by their therapists as more communicative, more physically attractive, less aggressive, and more dependent" (p. 758). If this is true, then not only are lower class patients as a whole preferred less by therapists, but also Black people

of any class and sex, and White males of any class. This is perhaps one of the major reasons more White Class I, II, and III women are seen in therapy than other individuals.

Fischer and Turner (1970) cited Kandel (1966) as having shown that members of the lower class in treatment with therapists with lower class backgrounds tend to remain in treatment longer. Fischer and Turner (1970) speculated that,

Evidently, the rapport between therapist and client--and the effectiveness of the therapeutic relationship--can hinge on the client's attitude toward psychotherapy and on the therapist's appreciation for (or identity with) the client's values. Specifying the predilections of both therapist and client may refine the generalization regarding social class and aptness for therapy (p. 80).

Baekland and Lundwall (1975) and Cole, Hardin, and Allison (1962) suggested another reason preventing Classes IV and V individuals from remaining in treatment is pressure from their families. As stated earlier, many lower class individuals connote going to a mental health center as a sure sign of loss of control and reason. Thus as Cole, Hardin, and Allison (1962) have explained,

Contact with a psychiatric clinic can be identified as one more exposure to shame and one more evidence of personal inadequacy or failure Such pressure can be sufficient to force a patient from therapy (p. 1009).

What appears to be a most important reason as to why patients drop out of treatment after a short length of time, and this could probably be extended to other classes as well, is the fact that the patient may have gotten from therapy what he sought out to get and rightfully feels there is no need to continue in treatment. This is usually overlooked by therapists who believe they always know best. Baekland and Lundwall (1975) explained,

Such short-term dropouts may have a different idea of what their problems are and, therefore, leave at a different point in treatment than the therapist thinks is best. Having realized their goals, which are not the same as those of the therapist, they may nonetheless get considerable benefit from treatment (p. 744).

Hopefully as this is taken into consideration by more therapists when working with Class IV and V individuals, their attitudes toward such patients will be less negative and result in a more rewarding therapeutic relationship for both parties.

In contrast to lower class patients, middle class patients have been said to see psychotherapy in a more positive light. Myers and Roberts (1959), for an example, found that Class III patients felt that their difficulties were curable and, thus, were quite willing to seek treatment to help alleviate these difficulties. In a few studies this positive attitude has gone beyond racial differences. Wolkon, Morivaki, and Williams (1973), investigating the influence of race and social class on attitudes toward psychotherapy and self disclosure in women, found that the attitudes of middle class Black women were significantly more positive than those of lower class Black women. No significant differences were found between the Black middle class and the White middle class samples, although the Black group was slightly more negative in their attitudes toward help seeking than the White group and preferred Black therapists over White therapists. Unfortunately, the investigators were unable to obtain a lower class White sample and, thus, could not compare White women's attitudes in regards to class. The investigators concluded, however, that race was not related to help seeking attitudes in their sample. Warren, Jackson, Nugaris, and Farley (1973), investigating Black and White parents'

(social class membership was not indicated) attitudes toward psychiatric clinics and psychotherapy, were also unable to obtain a significant difference in overall attitudes. However, since significant differences were obtained on selected items in the interview, the investigators felt that this suggested differential attitudes between the two groups. This seems to be a somewhat exaggerated conclusion, however, judging from their overall results.

Therapists' attitudes regarding non-White patients have been found to be the same as their attitudes toward the lower class. Korchin (1980) stated that many therapists feel that working with non-White patients is a waste of time and effort

. . . either because they are considered to be so non-psychologically minded as to require more direct interventions, of a behavioral or counseling sort, or because they were viewed as pawns of overarching social forces who can gain only from profound social change (p. 266).

Thomas and Sillen (1972) have concurred with Korchin (1980) and have added that,

No matter what the good will of persons who take [the latter position of being victims of social forces], they are in effect shutting the door of treatment facilities on patients with emotional problems or mental illness. The attitude appears militant, but is actually a counsel of exclusion. The white psychiatrist would never think of adopting such a "revolutionary" doing nothing stand toward his white patients (p. 139).

The fact that most people automatically think "Black people" or "minorities" when the lower class is mentioned is most unfortunate. It is as if higher classes of Blacks do not exist. Even after a thorough search of the literature on attitudes and expectations of therapy, only one study was found to deal separately with class and race (Wolkon, Morivaki, and Williams, 1973), indicating a dire need for research in this area.

One has always been aware of differences in views on various issues between men and women; thus, one should not be surprised to also find differences in their attitudes toward help seeking and emotional difficulties. Gurin, Veroff, and Feld (1960), in a nationwide survey of views on mental health, found that women, more often than men, were willing to define a problem in mental health terms. The investigators cautioned the reader that the results could not be deduced to reflect a greater willingness to face strain and admittance to having difficulty in dealing with problems; however the results could suggest that ". . . there is a greater conscious experience of tension among women, that women dwell in their problems more, and more often view these problems in mental health terms" (p. 42). The investigators felt that such a difference should not be surprising in this society for

The male role is closely linked to an active, coping interaction with the world, and a man's masculine identity is closely linked to his success in coping with his environment, to his strength in the face of difficulties. It would not be surprising, then, if a man defended against feelings that attested to his failure in this respect, and not only experienced such feelings less often than women but also was less likely to report them if they were experienced. Women, on the other hand, commonly viewed as the "weaker" sex, would be less subject to identity problems linked to the experience and admissions of difficulties and suffering (p. 210).

In a study of college men and women Heilbrun (1961) gathered interesting findings concerning sex differences in personality characteristics of those who terminated and those who remained in therapy. It appeared that female remainers had masculine characteristics (i.e., greater achievement needs, less deference, more autonomy, more dominance, and less abasement) than female terminators. Male remainers

had more feminine characteristics (i.e., lower achievement needs, more deference, less autonomy, less dominance, and less abasement) than male terminators. However, on a whole, regardless of personality characteristics, women are more likely to seek treatment (Phillips and Segal, 1969), tend to disclose more freely (Jourard and Lasakow, 1958), have more positive attitudes (Calhoun, Dawes, and Lewis, 1972), and tend to remain in therapy longer (Yamamoto, Jones, and Palley, 1968) than men.

Although sexual differences in attitudes toward therapy between Black men and women have been found to be basically the same as those expressed above, the issue of race of therapist tends to affect their attitudes (especially the Black man's) as well. Vontress (1969), in discussing cultural barriers in the therapy relationship, explained that "To be a [Black] man means to renounce entirely the 'female' principle in society" (p. 14), which involved ". . . 'cooling it' which is another way of saying, 'keep it to yourself'" (p. 14). Warren, Jackson, Nugaris, and Farley (1973) found that there was a tendency for Black men to perceive psychotherapy and the therapist in a more negative light than Black women. The Black men felt that a White therapist could not like a Black person and a Black person could not like a White therapist. As stated earlier, the Wolkon, et al. (1973) study on women's orientation to therapy in regards to race and social class indicated that Black women of both the lower and middle classes preferred Black therapists for they felt more comfortable discussing their problems with someone of their own race. Bernard (1965) has pointed out, however, that Black patients' attitudes toward psychotherapy have been known to change when they are aware that there are Black therapists available, whether they

themselves are in treatment with them or not. This awareness is said to reassure them of the applicability and objectivity of psychiatry in general, and, thus, improve its effectiveness for them.

When attitudes toward help seeking and emotional difficulties are correlated with age and education, one finds that the older generation and less educated people tend not to view small tensions and problems in mental health terms. Gurin, Veroff, and Feld (1960) explained that,

. . . the younger and older age groups in our society may represent very different culture generations with respect to attitudes and values in the mental health area: Feelings of an impending "nervous breakdown," problems seen as reactions to "external" stress rather than as personality or interpersonal malfunctioning, are not experienced differentially by younger and older people; but the experience of problems requiring professional help, the more current "psychological" phrasing of such problems, is more often expressed among members of the younger generation (p. 46).

They found that the above also held true when education was controlled, the largest difference occurring among the more educated. They concluded that,

As the education level of the general population increases, and as the growing acceptance of psychiatry now evidenced in the younger generation becomes characteristic of the total culture, we should expect the demand for therapeutic facilities to increase . . . (p. 405).

Fischer and Cohen (1972) concurred with the above finding and cited Berelson and Steiner (1964) who noted that young people, as they become better educated than their parents, shift away from so-called class-anchored beliefs. Kadushin (1969), who studied 1,500 people in New York to determine the type of people that seek help and how they go about doing it, explained that higher educated people, through

normal social channels, are more likely to know others in treatment and thus are more aware of the ideology of psychotherapy and have more positive attitudes toward help-seeking. Kadushin (1969) added, however, that Blacks, regardless of level of education, appear to be less interested in psychotherapy. He felt this was the reason so few actually apply for treatment. Interestingly, Lorion (1974a) did not find a correlation between one's attitude towards therapy and one's age or education.

The literature on the relationship between one's occupation and one's attitudes toward psychotherapy is limited. Usually one's income is discussed rather than one's occupation, with the assumption being that the more a person makes, the higher his/her class membership and, thus, the more positive his/her attitudes will be toward therapy. However, this is not necessarily the case, for one's occupation has more to do with the types of people one associates with than one's income. For example, it is possible for a physician and some types of technicians to earn approximately the same amounts of income per year. The physician's associates, however, would probably be concentrated in the upper middle and upper classes (Classes I and II), while the technician's associates would probably be more concentrated in the lower classes (Classes III, IV, and V), for the physician's position is valued more by society than the technician's (Myers and Bean, 1968). Thus it is felt that regardless of a person's income level, more than likely his/her occupation would be of greater value when assessing his/her attitudes toward therapy.

In studying male heads of households, Gurin, Veroff, and Feld (1960) explained that a man's occupation is

. . . a potential factor in [his] general adjustment to life, and his own adjustment, in turn, affects the adjustment of his family. The job has consequences for a man's relationships with others and his acceptance of himself. His job has a certain status in the community, provides opportunities for the fulfillment of physical and ego needs, and has considerable influence on the establishment of living patterns outside of the job setting (p. 223).

The investigators found that more men in middle class occupational categories than blue collar categories admitted to experiencing problems; and that farmers and farmers' wives were the lowest in defining a problem in mental health terms and actually seeking help. The investigators felt the latter finding may either indicate the truth of the stereotype that farm people are "self-reliant individualists," or it may be a reflection of the differences in the availability of psychological resources as compared to other occupational categories. One should be cautioned, however, about the suggestive, rather than conclusive, nature of these findings. The investigators felt that ". . . the complex operation of this variable and the importance of the qualitative as well as quantitative status distinctions suggest the need for more intensive examination . . ." (p. 288). Also included in a more intensive examination of the occupational variable should be the questions of female heads of household and how this relates to their attitudes toward psychotherapy, for probably more women are heading households now than was the case when Gurin, Veroff, and Feld (1960) began their research.

In terms of whether one has been in therapy in the past and the influence of this variable on one's attitudes, Wolkon, Morivaki, and Williams (1973) found that although patients who had been in therapy before had more positive attitudes toward help seeking and disclosed more information than those who had not, no significant differences were

found between the two groups. On the other hand, Kadushin (1969) found that among the college educated people, previous contact was not important in whether they had positive attitudes toward psychotherapy; it had more to do with whether they knew someone in treatment. Among the less educated people Kadushin (1969) found that previous contact and knowledge of someone in treatment were important in determining their attitudes toward psychotherapy.

Other variables which have been said to affect patient's attitudes toward therapy and therapists' attitudes toward patients include religion (Aronson and Overall, 1966; Fischer and Cohen, 1972; Fischer and Turner, 1970), marital status (Lorion, 1974a), academic major (Fischer and Cohen, 1972; Fischer and Turner, 1970), and perceived severity (Calhoun, Dawes, and Lewis, 1972), to name a few. With regards to the variables mentioned in this review (i.e., sex, social class, race, occupation, education, age, and previous treatment), however, results have shown that they indeed affect patients' attitudes and decisions to seek or not seek psychological services for their difficulties, and that they also affect, in some instances, therapists' attitudes toward their patients. As the expectation literature is reviewed, one will likewise find relationships between the above variables and what patients expect of therapy and what therapists expect of patients

Expectations and Psychotherapy

Frank (1962) has stated that,

A person's expectations affect his perceptions of what goes on about him and thereby his behavior. His conduct in turn affects the way in which others perceive him and their behavior toward him. Thus one cannot understand a person's state of mind or his behavior without consideration of his expectations about himself and those with whom he interacts (p. ix).

Likewise, Aronson and Overall (1966) and Garfield and Wolpin (1963) have stated that the expectations and attitudes people bring with them to therapy is of great significance in determining the progress or lack of progress of therapy and the therapeutic behavior. In recent years, many investigators have studied patient expectancies of therapy and, to a much lesser degree, therapists' expectancies of patients in an effort to determine if these expectations were in congruence, and if not, what, if anything, could be done about the incongruence. Unfortunately, as stated at the beginning of this chapter, the basic criterion for determining whether the patient's expectations are acceptable or unacceptable has been the insight-oriented psychotherapeutic technique. Unlike the attitudinal studies, however, the expectation studies have practically exhausted the social class variable with seemingly little regard for other variables that may influence or have some bearing on one's expectations of therapy. This is not to say that attitudinal studies are not guilty of this, but that the investigators in this area have made more of an effort to study other variables. This section, then, will discuss basically what has been presented in the literature on social class influences on the patient's expectations of therapy and the therapist's expectations of the patient; although studies that have dealt with the influence of other variables on expectations will also be discussed.

The general consensus of expectation studies has been that persons who comprise the last two classes of social position may not be suitable for psychotherapy, at least not in its traditional form, because, as the results of the attitudinal studies have implied, their

expectations of what therapy involves differ significantly from that of the therapist's middle class expectations (see, for example, Hunt, 1960; Lorion, 1973; McMahon, 1964; Overall and Aronson, 1963; and Redlich, Hollingshead, and Bellis, 1955). Classes IV and V patients have been said to expect the treatment to be short (5-10 hours), relief to be quick, and the therapist to take on an active, medicinal role, offering advice, reassurance, direction, and support (Aronson and Overall, 1966; Bernard, 1965; Gould, 1967; Levitt, 1966; McMahon, 1964; Overall and Aronson, 1963; Williams, et al., 1967).

Yamamoto and Goin (1966) indicated that therapists, on the other hand, expect their patients

. . . to be reasonably intelligent, not too seriously disturbed, to have a relatively stable life situation, to be able to look at himself and his behavior, and to want to understand how his past experiences, feelings, fantasies, and dreams may lead to an understanding of his current behavior, problems, and symptoms (p. 337).

The authors continued,

It is apparent that in order to be able to do this, he [the patient] must be willing to wait for relief until some future time, must value an understanding of himself over present relief of anxiety, and be willing to anticipate that such an approach will offer hope of amelioration of whatever causes him to seek psychiatric treatment (p. 337).

Therapists, for the most part, feel that individuals of the lower classes are of lower intelligence and lesser education than their middle class counterparts, have difficulty thinking abstractly, have minimal fantasy capability and productivity, are unable to communicate adequately, have low levels of insight, and are negative and passive (Baum, et al., 1966; Bernstein, 1964; Brill and Storrow, 1960; Heitler, 1976; McMahon, 1964).

This incongruence of expectations between the therapist and the patient has been said to lead to frustration, irritation, and rejection (expressed overtly and covertly) on the part of the therapist, and to frustration, irritation, and either not improving or dropping out of treatment--many times before the second session--on the part of the patient (Baum, et al., 1966; Bernard, 1965; Heine and Trosman, 1960; Hollingshead and Redlich, 1958; Kupst and Schulman, 1979; McMahon, 1964; Overall and Aronson, 1963; and Sloane, et al., 1970).

Patients comprising Classes I, II, and III, on the other hand, are said to expect the treatment to focus on self-understanding and the development of insight, and the therapist to play a more passive role as they (the patients) talk about their feelings. These patients tend to be closer to the therapist's ideal because of congruence of expectations and of middle class backgrounds (Clemes and D'Andrea, 1965; Hunt, 1960; Strupp, 1963).

Interestingly, many studies have not supported the above findings entirely. Overall and Aronson (1963), for example, found that although the majority of a sample of 40 Black and White Class IV and V first time applicants expected things which were traditionally said to be of the lower class patient, a high percentage expected the therapist to focus on emotional or dynamic material. The investigators acknowledged that,

The particularly high percentage of affirmative response to questions in the psychiatric category strongly indicates that, contrary to the Hollingshead and Redlich conceptualization and to a much greater degree than we ourselves foresaw, these patients do generally anticipate that psychiatric issues will be raised (p. 424).

Garfield and Wolpin (1963) sampled 70 first time applicants to a Nebraska psychiatric clinic in an effort to ascertain attitudes and

expectations in various areas related to psychotherapy. They found that of the six demographic variables studied (age, sex, social class, educational level, marital status, and religious affiliation), only one (sex) appeared to be related to differences in response. Women expected the therapist to give more advice and direction, viewed therapy less seriously, emphasized more emotional problems, and admitted to less guilt about seeking treatment than men. These differences in the expectations of men and women are similar to those cited in the nationwide survey of attitudes toward help seeking by Gurin, Veroff, and Feld (1960).

In another study Goin, et al. (1965) devised a questionnaire to ascertain the expectations of 250 mostly Class IV and V outpatients at a Western psychiatric clinic. They found that over half of the patients (52%) checked the statement, "I want to solve my problems by talking about my feelings and past life"; and fewer than half (48%) checked, "I am here because I want to solve my problems by having the doctor do something to make me feel better." The investigators admitted their surprise that such a large number of Class IV and V patients expected from therapy that which is generally attributed to the higher classes. They speculated that the mass media has contributed to the knowledge of all classes regarding psychotherapy, resulting in similarity of expectations.

Williams, et al. (1967) studied the influence of such variables as sex, age, education, social class, previous clinic treatment, race, and previous drug treatment on the treatment expectations of 587 Black and White predominantly Class IV and V first time applicants at 3 outpatient psychiatric clinics in Maryland and Pennsylvania. They found,

like Overall and Aronson (1963), that although some of the lower class patients expected the therapist to be supportive and to take on an active, medicinal role, the majority expected such topics as their thoughts and feelings and their childhood to be discussed. As did Goin, et al. (1965), the investigators attributed this increased awareness to the mass media. In terms of other variables, the investigators found that males, regardless of education, expected the therapist to diagnose what was wrong with them more so than females; furthermore, the higher the educational level of the females, the more the above expectation was reduced. Patients who had had little or no previous psychiatric treatment and no previous drug treatment also scored high on this expectation. Older patients tended to score high on the expectations that the therapist would be interested in their physical history and that he/she would take on an active role. Older Black male patients with little education and little or no previous psychiatric treatment, also tended to score high on the latter expectation.

Recent studies have continued to show that there are lower class patients who expect from therapy that which is generally attributed to middle and upper classes and that there are middle and upper class patients who expect from therapy that which is generally attributed to the lower classes.

In a study of Begley and Lieberman (1970) designed to ascertain patients' expectations of therapists' techniques, 65 consecutive patients applying for services at a Florida mental health center were given expectation questionnaires to complete prior to their intake interviews (the classes and races of these applicants were not indicated).

They found that patients varied as to their expectations of therapists' techniques. Some patients expected the therapist to be primarily analytic, but also expected him to be directive, personal, warm, and friendly. Other patients expected the therapist to be primarily directive, and also warm and friendly. The investigators also found that there was a high level of agreement on such items as, "The therapist will explain to the patient the ways in which the patient is avoiding the solution to his problems," "The therapist will want me to discuss events of my childhood," and "The therapist will ask me to tell him whatever comes to my mind," to name a few. The investigators felt this suggested that,

. . . patients recognize that they have been avoiding these solutions, showing a degree of insight which patients (or people in general) do not usually reveal. That patients expect their childhoods to be explored and that they expect to tell whatever comes into their minds indicates acceptance of some parts of psychoanalytic doctrine (p. 115).

Lorion (1974b) administered attitude and expectation of therapy questionnaires to 90 White Class III, IV, and V persons applying for outpatient treatment. He found that their attitudes and expectations were moderately positive and appropriate to traditional therapy modalities. In terms of expectations, specifically, all of the applicants expected questions to be asked and problems to be defined by the therapist, most expected to do most of the talking, fewer than half expected the therapist to offer solutions to their problems and to make them forget their problems, and even fewer expected the therapist to intervene with others or provide rules for cure. These expectations did not relate to age, education, occupation, or marital status. Lorion concurred with Williams, et al. (1967) and Goin, et al. (1965) that the growing

publicity about psychotherapy is probably responsible, at least in part, for more persons becoming aware of what traditionally goes on in therapy.

In another recent study, Terestman, Miller, and Weber (1974) compared the case records of 45 lower class patients who had been treated between 1945 and 1962 with the records of 1,303 middle and upper class patients. Results indicated that qualities traditionally said to be lacking in lower class patients were present in many of these patients; and those qualities traditionally said to be present in the middle class patients and viewed as indicators of progress in therapy were found to be quite unreliable predictors. However, with such a large difference in sample sizes, these results cannot be taken too literally.

Bent, et al. (1975) sampled 123 persons applying for services at a mental health facility with a median educational level of two years of college and found that the majority expected to receive advice and medicine which would lead to some improvement very soon. Although the investigators did not include occupational data on the applicants, which could have been used to determine social class by the Hollingshead system, judging from the applicants' median educational level, at least 50% could probably be placed in Classes III and above; yet they expected the same from therapy as that which has been attributed to Classes IV and V.

In a very recent study, Balch (1978), sampling 317 Caucasian patients from Classes I through V, found no difference in treatment expectations as a function of the patients' social class, sex, or marital status. The majority of the patients reported that they expected a "directive, advice-oriented interchange" (p. 111).

The results of the above studies appear to imply that therapy expectations are more than just a function of social class. It appears that some patients from all classes expect the same things from therapy, while others expect what is said to be traditionally of their classes. In a review of studies concerning low income patients in treatment, Lorion (1974a) concluded,

Despite extensive theorizing about the more inappropriate expectations held by low-income patients, few actual differences among social groups have been observed. All social classes share expectancies about the nature and duration of treatment (p. 344).

This was also implied in the attitudinal literature. Garfield (1978) and Garfield and Wolpin (1963) have concurred with Lorion.

The social class variable relates to cultural, economic, and psychological differences and, thus, can obscure important sources of individual variation (Fischer and Turner, 1970). Ignoring these variations by assuming that all persons of a particular class expect the same things from or have the same attitudes toward therapy can prevent a thorough understanding of therapy expectations. Characteristics of a person which are unique to him/herself are important to consider because these characteristics can give more information than if the therapist only made generalizations based on the patient's group membership. Tinsley and Harris (1976) observed that "The expectancies of a specific client may vary from . . . general expectancies . . . depending on the sex and year in college of the client" (p. 173). If sex and year in college can make a difference in one's expectations then it is quite probable that other variables or combinations of variables can cause one's expectancies to vary from generalizations attributed to his/her

social class. Lorion (1974a) cited Thomas and Sillen (1972) who stated that,

. . . ignoring individual differences by assuming that all low-income applicants respond similarly to a particular treatment modality supports, in a self-fulfilling manner, existing beliefs about such patients (p. 345).

The above can equally be said about individuals of other groups or classes.

In essence, the findings in both the attitudinal and expectation studies have implied that the way a person deals with psychological problems, his/her expectations of what therapy will be like, and his/her attitudes toward therapy is a function of other variables besides social class. Thus, before actually beginning therapy it would be wise for the therapist to become aware of the patient's expectations of therapy and the different variables and combinations of variables that may influence these expectations. Kupst and Schulman (1979) have cautioned therapists that the mere fact that Adams and Orgel (1975) saw reason to publish a consumer's guide to psychotherapy, ". . . underscores the need for delineation of client expectations as well as for their clarification" (p. 237). With this clearer understanding of patient expectations it is felt that psychotherapy would become more beneficial for all people.

Statement of the Problem

While many investigators have attempted to specify, compare, and generalize expectations of the lower, middle, and upper class patient, results of most expectation studies have been based on either an all White sample or a Black and White sample where most of the

Blacks in the sample were of the lower socioeconomic classes. What about the middle class Blacks, what are their expectations? Are they similar or different from Blacks of the lower classes? What variables most influence expectations of Blacks? Do Black patients' expectations really differ from traditional treatment modalities? With the increasing availability of services through mental health centers, more Blacks are seeking treatment for psychological problems. Thus, answers to the above questions will be of increasing importance to all mental health professionals who have contact with Black patients.

This study attempted to look at the relationship between Black patients' expectations and such demographic variables as social class, educational level, occupation, sex, age, and prior or no prior treatment in an effort to provide answers to the above questions.

It was hypothesized that:

1. The higher the educational level, the more the patient's expectations would be in congruence with traditional treatment modalities.
2. The expectations of younger patients would be more in congruence with traditional treatment modalities than would those of older patients.
3. The expectations of women would be more in congruence with traditional treatment modalities than men.
4. The expectations of patients who have had treatment in the past would be more in congruence with that of traditional treatment modalities.

CHAPTER III

METHODOLOGY

Sample

The sample consisted of 37 Black adult (17 males and 20 females) outpatient admissions and readmissions at Meharry Medical College Community Mental Health Center in Nashville, Tennessee. Although the original intention was to collect data on approximately 50 Black patients, several problems arose during the data collection phase of this research which prevented this from occurring. The major problems were the mental health center's staff being unfamiliar with the procedures of the study during the first few weeks of its implementation, patients failing to keep appointments, a decrease in the number of appointments and referrals being made during the summer months, and five of the six interviewers going on vacation the entire month of August, making it virtually impossible to collect data during this time. Six patients refused to participate in the study. The reasons given were that they had too many problems on their minds or that they did not have the time. Two other patients were experiencing visual hallucinations at the time of the intake and were judged too disturbed to participate in the study. Despite these problems, however, the sample size of 37 is 75% of the size originally intended and is quite representative of the mental health center's patient population.

All 37 patients who participated in the study did so voluntarily. The sample included both patients who had never been in psychotherapy, as well as those who had been in treatment in the past. Ages

ranged from 19 to 55 with an average age of 35.6. Education ranged from 2 to 16 years with an average of 11.7 years. Fifteen patients were of the middle classes (Classes II and III), and 22 were of the lower classes (Classes IV and V). There were no upper class (Class I) patients in the sample. Occupations of the patients included construction worker, housewives, students, fruit designer, nurse technician, welder, teachers, and printer. Several of the patients were unemployed. Most of the patients were self-referred. Seventeen had never been in treatment before and 20 had either been in treatment at a mental health center or with a private therapist. Some of the reasons stated by patients for seeking treatment included nerves, needing medication, loss of a loved one, family problems (marital, parental), headaches, quick temper, and various job related problems. At the time of intake, none of the patients were on any medications.

Interviewers

All interviewers (which also included this investigator) were Black and consisted of three males and three females with an average age of 35.

Design

1. Measures. The Patient Expectation Questionnaire (Williams, et al., 1967) was used to determine a patient's expectations of therapy. The instrument was chosen over other instruments because of its previous use in a study consisting of a large number of Blacks. The instrument is a modification of a questionnaire developed by Overall and Aronson (1963) which consisted of 35 items designed to explore

five expectations of a therapist's possible behaviors in an initial interview. These five expectations were:

1. Active--"The therapist actively instructs or directs the patient . . ." (p. 423).
2. Medical--"The therapist focuses on the organic or physical problems of the patient . . ." (p. 423).
3. Passive--"The therapist leaves the direction of the discussion to the patient, encouraging all patient communication . . ." (p. 423).
4. Supportive--"The therapist avoids charged material in an effort to bolster or comfort the patient . . ." (p. 243).
5. Psychiatric--"The therapist focuses on emotional or dynamic material . . ." (p. 423).

It should be emphasized here that while these expectations were used in this study, it was felt that they were not mutually exclusive and that they did not necessarily describe the different therapist's behaviors.

The 40-item Patient Expectation Questionnaire (Williams, et al., 1967) used in this study consisted of the Overall and Aronson (1963) items plus five additional items and explored the five expectations mentioned above. The active expectation consisted of 9 items, the medical of 12 items, the supportive of 5 items, the passive of 3 items, and the psychiatric of 11 items. Several minor changes were made by this investigator in the wording of the questionnaire. The introductory item, "Do you think your treating doctor will _____?" was reworded to read, "Do you think the therapist will _____?" in an effort to make a distinction between physicians who treat physical problems and psychologists,

psychiatrists, and psychiatric social workers who treat emotional problems. The word "other" in item 20 was dropped for the same reason. Instead of reading, "Do you think the treating doctor will want to know what other doctors you have seen lately?" it reads in this study, "Do you think the therapist will want to know what doctors you have seen lately?" Williams, et al. (1967) reworded Overall and Aronson's (1963) original items 16, 29, and 30 in a positive direction. For the purpose of easier scoring (i.e., all "yes" responses were scored 1 and all "no" responses were scored 0), these items were reworded in a negative direction. For example, item 30 in this study reads, "Do you think the therapist will not want your opinion?" instead of "Do you think the treating doctor will want your opinion?" Finally, the word "she" was added to items 8 and 31 to indicate that the therapist may also be female. For example, item 31 in this study reads, "Do you think the therapist will listen more than he/she talks?" instead of "Do you think the treating doctor will listen more than he talks?"

The questionnaire instructs the applicants to read each question and to indicate their responses by circling "Yes" or "No." To reduce the possibility of a positive response set, the position of "Yes" and "No" was interchanged randomly by this investigator. Randomization was achieved by putting all of the item numbers in a bag, shaking them, and then blindly choosing 20 numbers out of the bag. These numbers became the items where the "Yes" response was positioned first. The scoring of the questionnaire was keyed toward a "Yes" response, where "Yes" responses were scored 1 and "No" responses were scored 0.

The questionnaire, its instructions, a general information sheet, and the consent form are found in Appendix B; the questionnaire divided into its five expectations along with scoring is found in Appendix C.

The Hollingshead Two-Factor Index of Social Position (Myers and Bean, 1968) was used to determine the applicant's social class. The Index consists of two scales--occupation and education--divided into seven positions each. The occupational scale is based upon the assumption that different occupations are valued differently by society (Myers and Bean, 1968). The seven positions on the scale and their values are (1) executives and proprietors of large concerns and major professionals; (2) managers and proprietors of medium concerns and major professionals; (3) administrative personnel of large concerns, owners of small independent businesses, and semiprofessionals; (4) owners of little businesses, clerical and sales workers, and technicians; (5) skilled workers; (6) semiskilled workers; and (7) unskilled workers.

The educational scale is based upon the assumption that people of similar educational levels tend to have similar attitudes, behavior patterns, and tastes (Myers and Bean, 1968). The seven positions on the educational scale and their values are (1) graduate professional training; (2) standard college or university graduate; (3) partial college training; (4) high school graduate; (5) partial high school; (6) junior high school; and (7) less than seven years of schooling.

The Index score is calculated by multiplying the scale value for occupation and the scale value for education by their respective factor weights and then summing these scores. The factor weight for

occupation is seven and for education, four. The score obtained can range from a low of 11 to a high of 77. The range of computed scores and the social class positions are offered by Myers and Bean (1968) as follows: Class I, scores of 11-17; Class II, scores of 18-27; Class III, scores of 28-43; Class IV, scores of 44-60; and Class V, scores of 61-77.

2. Procedure. Permission was obtained to conduct this study from the mental health center's director of research and evaluation. An orientation session was held with all service units prior to approval to discuss procedures of the study and how these would fit into the mental health center's existing procedures. Permission was granted to begin collecting data in July 1981. Data was collected during the last two weeks of July 1981 and the month of September through the second week of October 1981, totaling eight weeks.

Before implementation of this study, the regular procedures of the mental health center were as follows. All patients who applied for treatment were first seen by the intake worker. The duties of the intake worker were to familiarize incoming patients with the center's policies, to inform them that fees were based on their income and the size of their family, to inquire as to whether they were employed, whether they had insurance, and whether they had ever been in treatment before, and to record pertinent family information. The patients were then requested to sign a treatment consent form and a payment agreement form. After the intake interview was completed, the patient was taken to his/her assigned therapist.

During the eight weeks of this study, an interviewer was notified while the patient was being seen by the intake worker. The intake worker's duties were the same as listed above. Immediately following the intake interview and prior to the patient's initial meeting with his/her therapist, the patient was seen privately by one of the interviewers and informed of this study. The patient was assured that if he/she decided to participate in the study his/her responses would remain confidential and would not affect his/her treatment in any way. The patient was requested to read the instructions to the questionnaire before deciding whether or not to participate (see Interviewer's Script in Appendix A). The instructions explained to the patient that the questionnaire was designed to get an understanding of his/her expectations of therapy, and also reiterated some of the information the interviewer had discussed with him/her (see Appendix B). Patients who agreed to participate in the study were asked to sign a consent form acknowledging that they understood the instructions, were participating voluntarily, and had been informed that their responses would remain confidential and not affect their treatment in any way (see Appendix B). Patients were then given the questionnaire to complete. If a patient requested that the interviewer read the questionnaire to him/her, this was done. The entire procedure, from the time the patient left the intake worker to the completion of the questionnaire, took approximately 20 minutes. After the questionnaire was completed, the patient was taken to his/her assigned therapist. All patients who decided not to participate were thanked for their time and taken immediately to their assigned therapist.

3. Data analysis. The data was analyzed using a stepwise multiple correlation/regression procedure (Nie, et al., 1975). Dummy variables were used for occupation, where 0 = skilled (professionals and technicians were also included in this category) and 1 = unskilled; social class, where 0 = lower class and 1 = middle class; sex, where 0 = female and 1 = male; and treatment, where 0 = no prior treatment and 1 = prior treatment. Scores on each of the five expectations (see Appendix C) for each patient were calculated by obtaining a percentage of the items answered "Yes" in each aspect.

CHAPTER IV

RESULTS

The main focus of this research was on examining the relationship between a set of demographic variables (sex, age, education, occupation, social class, and treatment) and a set of therapy expectation variables (active, medical, supportive, passive, and psychiatric) for the purpose of determining which of the selected demographic variables (referred to as predictor variables) most influence or predict Black patients' expectations (referred to as criterion variables). Another purpose was to determine if Black patients' expectations differed, to any great degree, from expectations said to be held primarily by the White middle and upper class patient.

Table 1 presents the percentage of "Yes" responses to each item on the Patient Expectation Questionnaire. As noted, 33 of the 40 questions were answered in the affirmative by 50% or more of the sample. This indicates that despite the attempt to reduce a response set, the sample still had the tendency to answer "Yes" to most of the questions.

The mean percentage scores and standard deviations for each expectation are presented in Table 2. Although the sample as a whole expected the therapist to actively instruct and direct them (active expectation = 63%), to focus on their organic and physical problems (medical expectation = 62%), and to avoid upsetting subjects (supportive expectation = 63%), to a larger degree the sample expected the therapist to leave the direction of the discussion to them (passive expectation

TABLE 1
PERCENTAGE OF "YES" RESPONSES TO THE
QUESTIONNAIRE ITEMS

Questionnaire Items	%
Do you think the therapist will _____	
1) sympathize with your problems?	41
2) ask about how you get along with your family?	84
3) ask about how well you sleep?	95
4) tell you how to get along better with people?	62
5) ask about your sex life?	65
6) tell you what is wrong with what you do?	18
7) tell you what kinds of food you should eat?	43
8) have a list of things he/she would want to check over?	81
9) tell you ways to solve your problems?	65
10) give you definite rules to follow?	59
11) tell you what is causing your troubles?	62
12) tell you what is wrong with you?	70
13) give you medication?	62
14) take your pulse and blood pressure?	62
15) ask you to describe the physical illnesses you have had?	68
16) not give you a physical examination?	49
17) ask questions about any operations you have had?	68
18) be particularly interested in your aches and pains?	59
19) be interested in your digestion?	57
20) want to know what doctors you have seen lately?	57

TABLE 1 (Continued)

Questionnaire Items	%
Do you think the therapist will _____	
21) ask what physical illnesses have been in your family?	62
22) avoid subjects which might upset you?	35
23) want to know what your friends are like?	81
24) try to get your mind off your troubles?	89
25) want you to look at the bright side of things?	92
26) want to know what your childhood was like?	89
27) ask what medications you have been taking?	78
28) try to cheer you up?	73
29) not ask you questions about your personal life?	22
30) not want your opinion?	35
31) listen more than he/she talks?	65
32) want to know what kinds of things make you unhappy?	73
33) want to know about your thoughts and feelings?	89
34) ask you a lot of questions?	62
35) want to know how you get along with people?	92
36) want to know how happy you are?	81
37) expect you to do most of the talking?	76
38) be interested in hearing any personal problems you have?	81
39) listen to your troubles?	96
40) be interested in knowing if some things make you afraid or nervous?	84

TABLE 2
MEAN PERCENTAGE SCORES AND STANDARD DEVIATIONS FOR EACH
OF THE FIVE EXPECTATIONS FOR 37 BLACK PATIENTS

Expectation	Mean %	SD
Active	63	25
Medical	62	25
Supportive	63	25
Passive	83	20
Psychiatric	80	19

= 83%) and to focus on emotional and dynamic material (psychiatric expectation = 80%). As indicated in the literature review, the latter two expectations are usually not attributed to Blacks (see, for example, Korchin, 1980). Also both Williams, et al. (1967) and Overall and Aronson (1963) were surprised to find that the lower class patients in their samples expected the therapist to be both passive and psychiatric.

Table 3 presents the intercorrelations among the predictor variables. An examination of the table shows that the highest intercorrelations are between sex and age (.59), education and social class (.64), education and occupation (.55), and social class and occupation (.85). The latter three intercorrelations are to be expected since social class in this study was determined by Hollingshead's Two-Factor Index of Social Position (Myers and Bean, 1968) where scores and weights for one's educational and occupational levels are summed to produce a social class score. These latter intercorrelations merely indicate that the higher the educational level of the patients in the sample the higher were their class and occupational levels; and that the higher the social class of the patients, the higher were their occupational levels. The former intercorrelation merely acknowledges the fact that males in the sample tended to be older than females.

The correlations between the predictor variables and the criterion variables are presented in Table 4. It appears that there are moderately fair inverse relationships between education and the active (-.42), medical (-.44), and supportive (-.40) expectations. This finding indicates that the more educated the patients were in the sample,

TABLE 3
INTERCORRELATIONS AMONG DEMOGRAPHIC VARIABLES
FOR 37 BLACK PATIENTS

Variable	S	A	E	SC	O	T
Sex	1.00	.59	-.18	.12	.08	.09
Age		1.00	-.04	.36	.28	.10
Education			1.00	.64	.55	-.18
Social Class				1.00	.85	-.01
Occupation					1.00	.01
Treatment						1.00

TABLE 4
CORRELATIONS BETWEEN PREDICTOR VARIABLES AND
CRITERION VARIABLES FOR 37 BLACK PATIENTS

Variable	Act	Med	Sup	Pas	Psy
Sex	.22	.17	-.08	.07	.00
Age	.04	.24	-.13	.41	-.23
Education	-.42	-.44	-.40	-.11	.27
Social Class	-.29	-.34	-.25	.07	-.10
Occupation	-.11	-.22	-.09	.11	.00
Treatment	.02	.08	.08	.29	.01

the less they tended to expect the therapist to actively instruct or direct them, to focus on organic or physical problems, and to avoid upsetting subjects. This finding is supportive of the hypothesis that the higher the educational level, the less the patient's expectations will be in congruence with that of traditional treatment modalities. Although Lorion (1974b) did not find a relationship between education and expectations, the above finding is consistent with the results of most expectation studies. Table 4 also shows a moderately fair positive relationship between age and the passive expectation (.41), indicating that the older the patients were in this study, the more they tended to expect the therapist to leave the direction of the discussion to them. This is quite inconsistent with the results of most expectation studies which indicate an inverse relationship between age and the passive expectation (see, for example, Williams, et al., 1967). It sheds light, however, on the possibility expressed by Fischer and Cohen (1972), Kadushin (1969), and Gurin, Veroff, and Feld (1960) who, in speaking of attitudes toward therapy, suggested that as the growing acceptance of psychiatry becomes more characteristic of the entire population, not just the younger generations, the demand for therapeutic facilities will increase. This may also be the case with therapy expectations. That is, as more people, young and old, enter psychotherapy, expectations become more congruent with traditional treatment modalities.

It should be noted here that these correlations between predictor variables and criterion variables are by no means conclusive. That is, the correlations, for the most part, are global and are not final indicators of how a particular predictor variable will rate among several

predictor variables (Thorndike, 1978). This will become clearer as the summary statistics for each criterion variable are examined. Also, the fact that the majority of correlations among predictor variables and between predictor variables and criterion variables are low is not a misfortune, although it is surprising to this investigator. Thorndike (1978) and Willemssen (1974) have indicated that in multiple correlation/regression analysis the variables with the larger correlations tend to receive large beta weights at the expense of the other variables.

Willemssen (1974) explained that,

Prediction by means of multiple linear regression is most successful when (a) the intercorrelations among predictors is low and (b) the correlation between each predictor and the criterion is moderate. Under this circumstance, the independent contribution of each predictor is optimized. If the correlations among predictors is high . . . then each to some extent duplicates the effect of the other (p. 146).

Thorndike (1978) has stated, however, that even when the correlation between the predictors and the criterions are moderate, ". . . the correlations among the predictors prevent most of them from having much effect on the predictor composite" (p. 159).

Summary statistics for each criterion variable is presented below in separate tables. Each table shows the value of the multiple correlation coefficient (R) and the percentage of variance accounted for (R^2) at each step in the analysis. Tables also show the change in R^2 (R^2 Change) resulting at each successive step, the standard error of estimate, the standardized regression coefficient (Beta), and the F-ratio.

Table 5 presents summary statistics for the active expectation. Examination of the table indicates that education alone correlates .42 with the active expectation, accounts for 18% of the variance, and is

TABLE 5
SUMMARY STATISTICS FOR THE
ACTIVE EXPECTATION

Variable	R	R ²	R ² Change	Beta	F
Education	.42	.18	.18	-.36	2.60**
Sex	.45	.20	.02	.22	1.28
Occupation	.46	.21	.01	.49	2.83**
Social Class	.52	.27	.06	-.48	1.97
Treatment	.52	.27	.00	-.07	0.02
Age	.52	.27	.00	-.06	0.09

Standard Error of Estimate = .22

**p $\leq$.05

significant at the .05 level. The addition of sex increases R to .45 and increases the variance accounted for to 20%. However its addition to the equation is not significant. When occupation is added, R increases to .46 and increases the variance accounted for to 21%. The joint effect of the three variables on the active expectation is significant at the .05 level. The addition of the social class, treatment, and age variables is shown not to be significant. Thus the predictor variables education, sex, and occupation jointly correlate .46 with the active expectation and account for 21% of the total variance. The average error or standard error of estimate in predicting activity scores from these variables is approximately .22 units. That is, the prediction of activity scores from the above three variables would differ only .21 units (on the activity scale) from the actual activity score.

Observation of the Betas shows that occupation and social class make the largest independent contributions to the multiple correlation (absolute Beta = .49 and .48, respectively). However this is not necessarily true. As was stated earlier, variables with high correlations tend to receive large Beta weights at the expense of the other variables. In actuality, education makes the largest independent contribution to the multiple correlation. This is indicated by its R^2 change of 18% as compared to the R^2 change of 7% for occupation and social class combined. Willemssen (1974) has pointed out that R^2 change is sometimes a better assessor of a variable's independent contribution than the Beta weight, especially in cases like the above. McNemar (1969) does not say that R^2 change is a better assessor than Beta; however he does say that R^2 change can be used instead of Beta for this purpose. Thus this

investigator opted to use R^2 change to determine the independent contributions of the predictor variables, and to use Beta weights to determine the direction of the correlations.

The Beta weights in Table 5 indicate that for the present sample, those with more education expected the therapist to be less active than their counterparts; whereas males and the unskilled expected the therapist to be more active than their counterparts.

Table 6 lists the summary statistics for the medical expectation. Examination of the table shows that the education variable also correlates highest with the medical expectation (.44) and accounts for 19% of the variance. Although R^2 change indicates that education makes the most independent contribution to R, its contribution alone is not significant. The addition of age, however, increases R to .49 and increases the variance accounted for to 24%. The joint effect of education and age on the medical expectation is significant at the .01 level. When social class is added to the equation, R increases to .54 and accounts for an additional 5% of the variance. The joint effect of the first three variables on the medical expectation is significant at the .05 level. The additions of occupation and sex contribute very little to R and R^2 and are shown to be nonsignificant. Since treatment's contribution was even less than occupation and sex, its values were not computed. Thus the predictor variables education, age, and social class jointly correlate .54 with the medical expectation and account for 29% of the total variance. The standard error of .21 indicates little error in predicting medical scores from these variables.

TABLE 6
SUMMARY STATISTICS FOR THE
MEDICAL EXPECTATION

Variables	R	R ²	R ² Change	Beta	F
Education	.44	.19	.19	-.23	1.15
Age	.49	.24	.05	.38	3.51*
Social Class	.54	.29	.05	-.53	2.53**
Occupation	.55	.31	.02	.24	0.06
Sex	.55	.31	.00	-.04	0.01

Standard Error of Estimate = .21

*p ≤ .01

**p ≤ .05

Examining the Beta weights one finds that patients who had more education and the middle class tended to expect the therapist to be less medical than their counterparts; whereas the older a patient was the more the therapist was expected to have a medical approach. These findings and those of the activity expectation are consistent with that found in the literature.

As can be seen in Table 7, education also correlates highest with the supportive expectation (.40). It accounts for 16% of the variance and contributes the most to R. Its contribution is significant at the .01 level. Although the addition of the remaining four variables increase R to .50 and increase the variance accounted for to 25%, their joint contribution to the predictor equation is not significant. Since the treatment variable's contribution was less than the latter four variables, it was not computed. The average error of predicting supportive expectation scores from the education variable is .23 units.

The Beta weight for education indicates that the more educated the patient, the less he/she expected a supportive therapeutic encounter. This is in support of the literature and of the education hypothesis.

The summary statistics for the passive expectation are shown in Table 8. This is the first expectation, thus far, that the education variable has not been the highest correlate. Here age is shown to correlate .41 with the passive expectation and account for 16% of the variance. It contributes the most to R and is significant at the .01 level. Although when the next five variables are considered jointly R increases to .54 and R^2 increases to 30%, their contribution to the equation is not significant. The average error of predicting passive scores from the age variable is .19 units.

TABLE 7
SUMMARY STATISTICS FOR THE
SUPPORTIVE EXPECTATION

Variables	R	R ²	R ² Change	Beta	F
Education	.40	.16	.16	-.52	5.62 *
Occupation	.43	.19	.03	.42	2.09
Age	.49	.24	.05	-.13	0.41
Social Class	.49	.24	.01	-.21	0.37
Sex	.50	.25	.01	-.10	0.27

Standard Error of Estimate = .23

*p $\leq$.01

TABLE 8
SUMMARY STATISTICS FOR THE
PASSIVE EXPECTATION

Variables	R	R ²	R ² Change	Beta	F
Age	.41	.16	.16	.58	7.68*
Treatment	.48	.23	.06	.24	2.37
Sex	.53	.28	.05	-.29	2.21
Social Class	.53	.29	.01	-.24	0.50
Occupation	.54	.30	.01	.20	0.47
Education	.54	.30	.00	-.05	0.05

Standard Error of Estimate = .19

* $p \leq .01$

The Beta weight for age indicates that the older the patient, the more he/she expected the therapist to be passive. This finding is not consistent with what has been presented in the literature and does not support the age hypothesis.

Table 9 presents summary statistics for the psychiatric expectation. Education correlates highest with the expectation (.27), but accounts for only 7% of the variance. The addition of social class, however, increases R and R^2 tremendously (.45 and 20%, respectively). It also makes the most independent contribution to R . The effect of education alone and the effect of education and social class jointly are significant at the .01 level. With the addition of the remaining variables, R increases to .54 and the variance accounted for increases to 30%; however, their joint effect on the psychiatric expectation is not significant. The average error of predicting the psychiatric scores from the education and social class variables is .17 units.

The Beta weights for education and social class suggest that the more educated patients expected the therapist to be more psychiatric than their counterparts; whereas middle class patients expected a less psychiatric encounter than their counterparts. The finding of the education variable is consistent with what has been found in the literature and supports the hypothesis that the higher the educational level, the more the patient's expectations will be in congruence with traditional treatment modalities. The fact that the lower class patient expected the therapist to be more psychiatric than the middle class patient is quite interesting. This finding suggests that therapy expectations of those said to be unaware and uninterested in what therapy

TABLE 9
SUMMARY STATISTICS FOR THE
PSYCHIATRIC EXPECTATION

Variables	R	R ²	R ² Change	Beta	F
Education	.27	.07	.07	.62	7.80*
Social Class	.45	.20	.12	-.70	4.19*
Sex	.48	.23	.03	.29	2.22
Occupation	.50	.25	.03	.29	0.97
Age	.53	.28	.02	-.22	1.07
Treatment	.54	.30	.01	.11	0.44

Standard Error of Estimate = .17

* $p \leq .01$

involves may be gradually becoming more congruent with traditional treatment modalities.

CHAPTER V

DISCUSSION AND CONCLUSIONS

The present study examined the relationship between six demographic variables (sex, age, education, occupation, social class, and treatment) and Black patients' expectations of therapy. The investigator was interested in finding out what Black patients expected from therapy, if their expectations actually differed from traditional treatment modalities and if there were any combinations of the demographic variables that could best influence or predict these expectations.

The results of the present study suggest that Black patients' overall expectations in this sample do not differ from traditional treatment modalities. Like Overall and Aronson (1963) and Williams, et al. (1967) it was found that the patients expected things attributed to both the lower classes and Blacks, as well as those attributed to the upper and middle classes. However, unlike results of the above studies, the percentage of affirmative responses in the psychiatric and passive aspects for the present study were considerably higher than those for the active, medical, and supportive aspects.

Some investigators have speculated that the mass media is probably responsible for the lower class patients beginning to have expectations of therapy similar to those of their middle class counterparts (Goin, et al., 1965; Lorion, 1974b; Williams, et al., 1967). This reason could probably be extended to include race as well. However this

investigator offers two other reasons for the findings in the present study.

First, in most expectation studies in which Blacks have been a part of the sample the investigators did not see fit to delineate expectations by race. Class differences appeared to be the most important concern. Since there is a tendency to think of Blacks and the lower classes in the same light, then it follows that whatever expectations lower class patients had about therapy were also attributed to Blacks. If more investigators had ventured to separate race and class, perhaps results such as those found in this study (i.e., the high percentages for the passive and psychiatric expectations) would have been more noticeable. Thus it is possible that Blacks have always had expectations comparable to traditional treatment modalities, but their expectations have just never been researched.

A second reason offered by this investigator for why patients in this study had expectations comparable to traditional treatment modalities is the environment in which the questionnaire was given. It is possible that the patients expected to do most of the talking and for the discussion to center around emotionally charged material because they were in an environment where they felt comfortable enough to want to talk to the therapist, in detail, about their problems. Meharry Medical College is a predominantly Black college with a predominantly Black staff. Thus the odds are in favor of the patient getting a Black therapist and the patient knows this. As Wolkon, et al. (1973) have pointed out, Black patients feel more comfortable discussing their problems with someone of their own race. Similarly,

Bernard (1965) observed that Black patients' attitudes toward psychotherapy tend to change for the better (i.e., in line with the passive and psychiatric expectations) when they are aware that there are Black therapists available, regardless of whether they themselves are in treatment with them. Thus patients may have responded to questions on the questionnaire based on this awareness and the fact that they had a Black interviewer.

Turning to the correlations between demographic variables and therapy expectations, again it was a surprise that the majority of correlations were low. Only 4 of the 30 correlations were considered to be fairly moderate (.40 or above) by this investigator and none were over 50%. Despite the overall small correlations, however, a fairly moderate inverse relationship was found between education and the active, medical, and supportive expectations, indicating that the more educated the patient was in this study, the less he/she expected an active, medical, supportive type interaction with the therapist. This finding is in agreement with the findings of most of the studies reported in the literature. However the Bent, et al. (1975) study indicated that persons who had had some college still expected advice and medicine from the therapist. As mentioned earlier, Lorion (1974b) found no relationship between education and expectations. The present findings support the hypothesis that the higher the educational level, the more the patient's expectations of psychotherapy will be in congruence with traditional treatment modalities.

A moderate positive relationship was found to exist between age and the passive expectation. This finding comes as a surprise. Since

older patients were more likely to have grown up during the time when to seek therapy to help resolve emotional difficulties was considered negative, it was felt their knowledge of what to actually expect in therapy would be limited. A possible reason for this finding, which is inconsistent with what has been found in other studies (e.g., Fischer and Cohen, 1972; Gurin, Veroff, and Feld, 1960), could be that these patients truly feel comfortable with the knowledge of Black therapists working at the mental health center.

As expected and as others have found (e.g., Garfield and Wolpin, 1963; Lorion, 1974b), social class alone was not found to correlate even to a moderate degree with patients' expectations (see Table 4, p. 40); although it did contribute the most to R when used as one of the predictors for the psychiatric expectation. Thus social class may have some bearing on expectations of the patients in this study; however it is not nearly as much as the literature has indicated. An important reason for this may be the fact that Classes II and III patients were collapsed into one group (middle class) and Classes IV and V patients were collapsed into another group (lower class) because of the small numbers in Classes II and V. It is possible that the collapsing of the social class variable had some bearing on the small correlations between the variable and patient expectations. Thus the findings on social class presented in this study can only be looked upon as tentative. It is suggested that in future research the social class groups not be collapsed.

In terms of the combined influence of demographic variables on patients' expectations, the results indicate that education, sex, and

occupation are the best predictors associated with the active expectation; while education, age, and social class are the best predictors of the medical expectation. With regard to characteristics of patients who expect supportive or passive therapists, the education variable and the age variable, respectively, were found to be the best predictors. Finally, the variables education and social class were found to be the best predictors for the psychiatric expectation.

The hypotheses that the expectations of younger patients, of women, and of those who had been in treatment in the past would be more congruent with traditional treatment modalities than their counterparts were not supported by the results. Although no hypothesis was given for occupation, it was felt that the skilled patient would expect the therapist to be more passive and psychiatric; however, this characteristic was not supported by the results either. Thus only the hypothesis that the more educated the patients, the more they would have expectations in congruence with traditional treatment modalities was supported by the results.

It is apparent that further research using a larger sized sample gathered from a variety of settings (e.g., Black patients at predominantly Black mental health centers, those at predominantly White centers, and those from centers that have mixed populations) is needed in order to really draw conclusive evidence on what Black people expect from therapy. The findings could also be further substantiated if possibly more demographic variables were employed in the study along with the addition of personality variables. A response set could possibly be avoided in future research if the sample had more alternatives to

choose from when answering the questions or if open-ended questions were used. The latter suggestion would probably also yield more information. A final suggestion for future research is a comparative study between Blacks who have sought or are in therapy and Blacks who have never been in therapy. It is felt that a study of this nature could begin to answer questions as to why small numbers of Blacks consider therapy when they are experiencing emotional difficulties as compared to their White counterparts.

Although all of the hypotheses were not supported by the results of this study, the purpose, for the most part, was achieved. The results are surely limited to the population studied and thus cannot be considered generalizable to Black patients as a whole. Nonetheless, the results strongly imply that Black people may not be as un-psychologically minded as most therapists believe. It is probable that within the right environment (merely a mental health center where Black therapists are visible) therapy could prosper and become more rewarding for both the therapist and the patient.

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APPENDICES

APPENDIX A

SCRIPT FOR THE INTERVIEWER

We're conducting a research project here designed to get an understanding of what patients expect when they enter therapy. You are not obligated to participate in the research, but if you do, you can be assured that neither your participation nor your responses to questions will affect your treatment in any way, and your responses will remain confidential. The only place you would have to sign your name is at the bottom here (indicate) giving your consent to participate. The consent form will be placed in a container separate from the questionnaire. We do not want you to sign your name on any other page of the questionnaire. Also, Mr., Mrs., Ms., etc. _____, you can stop completing the questionnaire and withdraw your consent at any time without consequence. Here (giving questionnaire to patient), read the instructions and if you decide to participate, just do as the instructions ask. If you decide not to participate, just return the questionnaire to me.

APPENDIX B

PATIENT EXPECTATION QUESTIONNAIRE

Instructions

The attached questionnaire is part of a research project designed to get an understanding of what patients expect when they begin psychotherapy. Your participation in this project is voluntary and will not affect your treatment in any way. If you have any questions regarding the questionnaire, please ask the interviewer. If you have questions regarding the research itself, please feel free to contact the primary investigator, Celestine Fields, at 327-6599. If you agree to participate in this study, please read and sign the statement below and give it to the interviewer before beginning the questionnaire; then read each item carefully and indicate whether you agree or disagree with it by circling Yes or No after the item. Please notice that the position of Yes and No is not always the same. There are no wrong answers, and the only "right" answers are those which you honestly believe.

I have read and understand the instructions. My consent to participate in this research is given voluntarily without coercion or force from anyone. I have been informed and fully understand that neither my participation nor my responses to questions will affect my treatment in any way and that my responses will remain confidential. I also have been informed and fully understand that I may withdraw my consent and discontinue participation in this research at any time without consequences.

Signature: _____

General Information

Before beginning the questionnaire, it would be appreciated if you would take time to provide the information requested below. Please do not write your name on this sheet or any page of the questionnaire.

Age _____

Sex _____

Highest grade completed in school _____

Occupation _____

If married, spouse's occupation _____

To your knowledge, were you claimed as a dependent on your parent's, guardian's, or other relative's 1980 income tax return? _____

Referred by (check one) relative _____ friend _____ physician _____ minister _____ self _____ other (specify) _____

Have you ever been in therapy at this or another mental health agency or with a private psychotherapist? _____

Briefly describe the problem(s) you are experiencing at present.

Do you think the therapist will _____

- | | | |
|--|-----|-----|
| 1) sympathize with your problems? | Yes | No |
| 2) ask about how you get along with your family? | Yes | No |
| 3) ask about how well you sleep? | Yes | No |
| 4) tell you how to get along better with people? | No | Yes |
| 5) ask about your sex life? | No | Yes |
| 6) tell you what is wrong with what you do? | Yes | No |
| 7) tell you what kinds of food you should eat? | Yes | No |
| 8) have a list of things he/she would want to check over? | Yes | No |
| 9) tell you ways to solve your problems? | Yes | No |
| 10) give you definite rules to follow? | No | Yes |
| 11) tell you what is causing your troubles? | Yes | No |
| 12) tell you what is wrong with you? | Yes | No |
| 13) give you medication? | No | Yes |
| 14) take your pulse and blood pressure? | No | Yes |
| 15) ask you to describe the physical illnesses you have had? | No | Yes |
| 16) not give you a physical examination? | No | Yes |
| 17) ask questions about any operations you have had? | No | Yes |
| 18) be particularly interested in your aches and pains? | No | Yes |
| 19) be interested in your digestion? | Yes | No |
| 20) want to know what doctors you have seen lately? | No | Yes |
| 21) ask what physical illnesses have been in your family? | Yes | No |
| 22) avoid subjects which might upset you? | Yes | No |
| 23) want to know what your friends are like? | Yes | No |

24)	try to get your mind off your troubles?	No	Yes
25)	want you to look at the bright side of things?	No	Yes
26)	want to know what your childhood was like?	No	Yes
27)	ask what medications you have been taking?	No	Yes
28)	try to cheer you up?	Yes	No
29)	not ask you questions about your personal life?	Yes	No
30)	not want your opinion?	No	Yes
31)	listen more than he/she talks?	No	Yes
32)	want to know what kinds of things make you unhappy?	Yes	No
33)	want to know about your thoughts and feelings?	No	Yes
34)	ask you a lot of questions?	Yes	No
35)	want to know how you get along with people?	Yes	No
36)	want to know how happy you are?	Yes	No
37)	expect you to do most of the talking?	Yes	No
38)	be interested in hearing any personal problems you have?	No	Yes
39)	listen to your troubles?	No	Yes
40)	be interested in knowing if some things make you afraid or nervous?	No	Yes

Thank you for taking the time to complete this questionnaire. If you have any comments about any of the issues presented, please write them on the back of this page.

APPENDIX C

TABLE C-1

THE QUESTIONNAIRE DIVIDED INTO ITS
FIVE EXPECTATIONS AND SCORING

Item No.	Expectation	Yes	No
Active: N = 9			
4	Tell you how to get along better with people?	1	0
6	Tell you what is wrong with what you do?	1	0
8	Have a list of questions he/she would want to check over?	1	0
9	Tell you ways to solve your problems?	1	0
10	Give you definite rules to follow?	1	0
11	Tell you what is causing your troubles?	1	0
12	Tell you what is wrong with you?	1	0
30	Not want your opinion?	1	0
34	Ask you a lot of questions?	1	0
Medical: N = 12			
3	Ask about how well you sleep?	1	0
7	Tell you what kinds of food you should eat?	1	0
13	Give you medication?	1	0
14	Take your pulse and blood pressure?	1	0
15	Ask you to describe the physical illnesses you have had?	1	0
17	Ask questions about any operations you have had?	1	0

TABLE C-1 (Continued)

Item No.	Expectation	Yes	No
Medical (continued)			
18	Be particularly interested in your aches and pains?	1	0
19	Be interested in your digestion?	1	0
20	Want to know what doctors you have seen lately?	1	0
21	Ask what physical illnesses have been in your family?	1	0
27	Ask what medicines you have been taking?	1	0
29	Not ask you questions about your personal life?	1	0
Supportive: N = 5			
1	Sympathize with your problems?	1	0
22	Avoid subjects which might upset you?	1	0
24	Try to get your mind off your troubles?	1	0
25	Want you to look at the bright side of things?	1	0
28	Try to cheer you up?	1	0
Passive: N = 3			
31	Listen more than he/she talks?	1	0
37	Expect you to do most of the talking?	1	0
39	Listen to your troubles?	1	0

TABLE C-1 (Continued)

Item No.	Expectation	Yes	No
Psychiatric: N = 11			
2	Ask about how you get along with your family?	1	0
5	Ask about your sex life?	1	0
16	Not give you a physical examination?	1	0
23	Want to know what your friends are like?	1	0
26	Want to know what your childhood was like?	1	0
32	Want to know what kinds of things make you unhappy?	1	0
33	Want to know about your thoughts and feelings?	1	0
35	Want to know how you get along with people?	1	0
36	Want to know how happy you are?	1	0
38	Be interested in hearing any personal problems you have?	1	0
40	Be interested in knowing if some things make you afraid or nervous?	1	0

VITA

Celestine Fields was born in Jacksonville, Florida and attended public schools in that city. After receiving her Bachelor of Science degree in Psychology from Howard University in Washington, D.C., she worked as an Educational Therapist at D.C. Children's Center in Laurel Maryland before entering graduate school. Ms. Fields received her Master of Arts degree in Psychology with a specialty in Minority Mental Health May 1975 from Washington University in St. Louis, Missouri.

During the summer of 1975 Ms. Fields worked as a Psychological Trainee at St. Elizabeths Psychiatric Hospital in Washington, D.C. In September she entered the graduate school at The University of Tennessee, Knoxville. During her training at the university Ms. Fields has worked at Birth Defects Evaluation Center, The University of Tennessee Psychological Clinic, and Overlook Mental Health Center. She completed her internship in Child-Clinical Psychology at Children's Memorial Hospital, Chicago, Illinois in August 1980. She received the Doctor of Philosophy Degree March 1982.

Ms. Fields is presently employed at Cherokee Mental Health Center in Morristown, Tennessee.