Psychol. Belg.
1989, XXIX-1, 63-79.

THE INFLUENCE OF THE THERAPEUTIC FRAME OF REFERENCE ON THE EVALUATION OF THE FIRST SESSIONS OF PSYCHOTHERAPY: A PILOT STUDY

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The discrepancy between the therapist's and the client's frame of reference and the mutual acceptability of the frame of reference were manipulated to examine the respective effect of the two variables on the evaluation of the first sessions of treatment. According to Sherif and Hovland's assimilation-contrast theory it was predicted that subjects in a condition with an acceptable frame of reference would have a more favorable psychotherapy process than subjects in a condition with an unacceptable frame of reference. It was also hypothesized that in the acceptable condition the frame of reference discrepancy would be positively related to the client's and therapist's evaluation of treatment, whereas in the unacceptable condition the relation would be negative or non-existing. The hypotheses were tested in an analogue treatment situation on twenty-two undergraduate students, receiving two treatment sessions. Two treatment conditions were defined by the time-orientation of the therapist's frame of reference. Though our hypotheses are not confirmed, supporting elements in our results are discussed.

Although already in the sixties some authors have argued for an experimental social psychology approach in psychotherapy research (Frank, 1961/1973; Goldstein, Heller & Sechrest, 1966), it was not until the last decade before this approach was used indeed (Beutler, 1983; Dorn, 1984; Stricker & Keisner, 1985; Strong & Claiborn, 1982). From the social psychological perspective, psychotherapy can be conceived of as an interactional process with an effect on the cognitive, affective and behavioral level. The influence of a psychotherapist during treatment may be considered identical with the influence processes that are studied in the laboratory of the social psychologist. In both conditions, the same variables are believed to determine the outcome. One of the most important variables in both research areas, is the perceived "discrepancy" between the persuasive information (the interventions of the psychotherapist) on the one hand and the attitudes of the receiver (the ideas of the client) on the other. According to Festinger's (1957) theory of cognitive dissonance, the attitude change will be most pro-

The authors gratefully acknowledge the assistance of Elly Kog in conducting the treatment-sessions, of Rob Stroobants for the statistical analyses and of Majan Peeters in the administrative tasks.

nounced when the discrepancy is very large. Furthermore, the same theory predicts that the effect is enhanced when the communicator of the discrepant message is very trustworthy and attractive, and when the receiver is very involved in the subject under discussion.

With very great discrepancies, it was found however, that changes may occur in the opposite direction of what is expected. In order to account for this phenomenon and to predict its effect, Sherif and Hovland (1961) have developed the "assimilation-contrast theory". The main difference with Festinger's theory is that the discrepancy of the information that is communicated, is no longer defined as a discrepancy with the attitude or opinion of the receiver, but instead as a discrepancy with the "latitudes of acceptance and rejection" of the receiver. If the message lies within the range of the acceptable points of view, assimilation will occur (i.e., the attitude change in agreement with Festinger's theory). If, on the other hand, the message lies within the range of the rejected points of view, a contrasting position will be taken or no attitude change will occur.

A number of findings in psychotherapy research are in accordance with the above mentioned social psychological theories (Beutler, 1978, 1983; Beutler, Jobe & Elkins, 1974; Beutler, Johnson, Neville, Elkins & Jobe, 1975). Although initial discrepancy between the values of a psychotherapist and those of his/her client was related to attitude change of the client in the direction of the therapist's attitude, improvement during treatment was related to the degree of acceptability of the therapist's values for the client, and not to the similarity of their values.

Our research concerns the importance of the perceived discrepancy and acceptability of the therapeutic frame of reference, i.e., a conceptual framework in which the complaints and the problems of the client are situated and from which therapeutic methods and strategies are derived. It also includes the role patterns of the client and the psychotherapist in the psychotherapy process and the goals of the treatment. Research findings suggest that unrealistic (and hence, discrepant) expectancies of the client as to the course of the treatment and the role patterns which are established during the treatment, are related to an unfavourable outcome such as premature termination (Clemes & D'Andrea, 1965; Goin, Yamamoto & Silverman, 1965; Heine, 1962; Heine & Trosman, 1960; Overall & Aronson, 1963; Pope, Siegman, Blass & Cheek, 1972; Tollinton, 1973; Webb & Lamb, 1975). A certain amount of discrepancy between the expectancies of the client and the reality of treatment, however, may be necessary for a successful therapeutic

process (Begley & Lieberman, 1970; Horenstein, 1975; Horenstein & Houston, 1976). With regard to the importance of discrepancy for the process of change, Strong and Claiborn (1982) make a distinction between the beginning phase of treatment and the therapeutical process itself. The latter is facilitated by discrepancies between the client's and the therapist's frame of reference. During the beginning phase, however, the convergence of their frames of reference seems important in order to develop a "good faith" working relation. Again, not the similarity but the mutual acceptability of the beliefs is important.

These findings as to the beginning phase of treatment have been applied in recently developed strategies for intake and indication. Herein, attention is paid to the client's perspective including the request for help. When clients are prepared for and informed about treatment, the therapy and the therapist are more acceptable for the client. Research findings suggest that there is a relation between these strategies and successful treatment (Lazare, Eisenthal & Frank, 1979; Stufkens, 1979; Van Audenhove & Vertommen, 1984; 1987).

The purpose of this study is to investigate, with an experimental methodology, the effect of the acceptability and the discrepancy of the therapist's frame of reference on the early stages of treatment. The hypotheses in this study are derived from the Sherif and Hovland assimilation-contrast theory: (1) Clients in the condition with an acceptable frame of reference will have a more favorable therapy process than clients in the condition with an unacceptable frame of reference. (2) In the acceptable condition the frame of reference discrepancy is positively related to the client's and therapist's evaluation of treatment whereas in the unacceptable condition the relation is either negative or non-existing. According to the social psychology literature the therapist's expertness, attractiveness and thrustworthiness and the client's involvement also determine the effect of the treatment. In our design these variables will be constant for the different conditions.

METHOD

Treatment conditions

The hypotheses were verified in an analogue treatment situation. The research of Strong and Claiborn and co-workers was inspiring for the development of our procedure (Claiborn, Ward & Strong, 1981; Strong, Wambach, Lopez & Cooper, 1979). Two treatment conditions

were defined by the time orientation of the therapist's frame of reference in her conceiving of the client's problem. The first session started for both conditions with a 30-minute segment consisting of problem exploration. In this segment the psychotherapist tried to get a clear insight in the problem, to gain information about the client and to build a working-relation with the client. In the next 20 minutes the content of the interview was different for the two conditions. In the past condition the therapist's interventions were oriented to experiences and relations in the childhood whereas in the present condition the experiences of the last months and actual relations were focused. The last minutes of the first interview were spent on homework assignment. In the past condition the homework instruction was: "Looking back to the distant past: what would you like to do over again in a different way than it actually happened?". In the present condition the same instruction was given concerning the last month. The client was asked to submit one written page concerning this instruction a few days before the second interview. The second 50-minute session started with a question about the client's thoughts and feelings concerning the first session. Afterwards the homework was discussed and the problem was further elaborated in the past or in the present (depending upon the condition). The psychotherapist raised her own impressions about the client's problem and its relation to the past respectively to the present situation. The client was then encouraged to explore further the past or present aspects (depending on the condition) of the problem.

Procedure

The clients were scheduled for the first session about four months after the assessment of their frame of reference (using the Frame of Reference Questionnaire). After a random assignment over the past and present treatment conditions, the distribution over both conditions was slightly modified. The treatment-condition of six subjects was altered in order to obtain a similar spreading of the discrepancy scores in the acceptable and unacceptable condition. The second session was scheduled 8 to 10 days later. After this session, the clients completed the Counselor Rating Form and the Manipulation Check Questionnaire. The second assessment of the frame of reference and the client's Evaluation Scale were provided as a homework for the next week. The psychotherapist completed the Evaluation Scale immediately after the second session of each client.

The clients were invited for an individual debriefing in order to answer questions concerning the investigation. Because of the possibility of a replication study in another group of psychology students, the hypotheses of the present study were not reported to the participants.

Independent variables

The *Frame of Reference Questionnaire* was developed for the assessment of the acceptability and discrepancy of the therapist's frame of reference. The outline of the assessment method used for this questionnaire was developed by Beutler (1983). The subjects received 14 scales, each consisting in an ordered series of (9) beliefs about treatment, about the cause of their problems, etc. These beliefs are arranged from one extreme position (position 1) to its opposite extreme (position 9). The subjects were asked to indicate their basic assumption or dominant belief about each dimension (their "own view point") and to indicate for each of the nine positions of each scale if it is acceptable or unacceptable. The range of beliefs encompassed by the acceptable statements represents the latitude of acceptance. The statements that are unacceptable represent the latitude of rejection.

The Frame of Reference Questionnaire contained 11 scales (series of beliefs) concerning treatment, the role of the psychotherapist, psychological problems and symptoms and three scales concerning the internality, stability and globality of the cause of their problem. The latter scales were developed according to the Attributional Style Questionnaire (Peterson, Semmel, Von Baeyer, Abramson, Metalsky, Seligman, 1982). For this questionnaire dimensions were selected that were possible candidates to be manipulated in an experiment, they represent the broad range of existing psychotherapy approaches. A principal component factoranalysis with varimax rotation on the own viewpoints (of 84 subjects) resulted in a three factor solution. On the first factor series concerning the directivity of the psychotherapist, have a loading (e.g., "It is extremely indicated that the psychotherapist determines the therapy-goal versus that I define the therapy-goal myself"). The second factor contains series concerning the stability of the cause (e.g., "the cause of my problem will never be present again versus will allways be present"). The third factor gathers series concerning the problem-orientedness of the treatment (e.g., "Treatment should exclusively deal with the problem in it's broader context versus treatment should exclusively be focused on a particular symptom").

The frequency distribution of the responses (own point of view) on all the scales was asymmetrical, so that it was hard to find a scale on which opposite groups could be isolated in order to realise the planned conditions in the experiment. After all the dimensions of scale 2 ("My problems are exclusively determined by the past (position 1) vs. my problems are exclusively determined by my present situation (position 9)") was chosen. This series has its highest loading on the factor "problem-orientedness". The responses were reasonably distributed over the whole range of the scale and 37 of the 84 subjects indicated that this dimension would be an important one if they would start treatment. The answer on this scale defined the discrepancy and acceptability of the therapist's frame of reference in the intake sessions. The therapist's past/present approach was set to produce either position 3 of the scale for the "past" condition or position 7, for the "present" condition. The *discrepancy of the therapist's frame of reference* is the distance between the subject's "own point of view" and the therapist's position of this scale. The client is in the *acceptable or unacceptable condition* if the position of the therapist is situated in his latitude of acceptance or in his latitude of rejection, respectively. Discrepancy and acceptability can also be defined with respect to the client's perception of the therapist's viewpoint. We will indicate them respectively as the *perceived discrepancy* and the *perceived acceptability*. For the test of our hypotheses only the data of subjects who perceived the treatment as (un)acceptable were used for the (un)acceptable condition.

Dependent variables

The client's and therapist's evaluation of the treatment process was measured by five 7-point scales: (1) "To what extent are you satisfied with the interviews?" (2) "To what extent do you feel helped?" (for the client); "To what extent do you think you have something to offer to this client?" (for the psychotherapist). (3) "To what extent do you think that the process started during the interviews?" (4) "To what extent is this the kind of help you would want?" (for the client); "to what extent do you think you would continue this form of treatment with this client?" (for the psychotherapist). (5) "To what extent do you think you would continue or stop the interviews with this psychotherapist?" (for the therapist: with this client). The client's Evaluation Scale and the therapist's Evaluation Scale have alpha coefficients of .92 and .99, respectively.

Other variables

To assess the perceived *psychotherapist expertness, attractiveness and trustworthiness*, we used a translated and adapted version of the Counselor Rating Form (C.R.F.) developed by Barak and La Crosse (1975) (see also Barak & Dell, 1977; La Crosse, 1977, 1986; La Crosse & Barak, 1976). In a preliminary study vidiotapes of interviews by five therapists were watched by 124 students who rated each psychotherapist on 24 bipolar 7-point scales. The trustworthiness scale, the attractiveness scale and the expertness scale had 7, 8, 9 items, respectively. The alpha coefficients of the three scales are .82, .85 and .90, respectively.

The *Involvement Scale* consists of three items concerning the spontaneity and involvement in the interaction, as perceived by the client. The alpha coefficient was .93. To assess the client's perception of the treatment condition the *Manipulation Check Questionnaire* was developed. This questionnaire consists of 13 9-point scales. Scales 4 and 8 are especially meant to assess the client's perception of the present and past condition: (4) "To what extent did the psychotherapist consider your symptoms as determined by what you have been through in the past (position 1) or as determined by your present situation (position 9)?" (8) "To what extent was the psychotherapist particularly interested in your present functioning (position 1) or in your distant past (position 9)?"

Subjects

The *clients* were recruited from a group of 84 students in their first year of clinical psychology (third year at the university), who also participated in the development of the Frame of Reference Questionnaire. At that time they were asked whether they would accept to participate in two treatment sessions during which they would talk about a personal problem of choice. The announcement of the investigation was made in a "Clinical Assessment" class, after they had seen videotapes of different intake models and before they would go to the clinic to observe intake interviews behind the one-way screen. In order to motivate the subjects, the participation in the study was presented as a possibly unique and instructive experience in their training program as clinical psychologists. The subjects were not informed about the type of treatment nor about the variables that were manipulated in the study.

The invitation to participate in the study was sent only to those 37 students who accepted to participate in the study and who did indicate the dimension of past-present as important for them if they would start treatment. From these 37 students 6 dropped out of the study; 2 students had moved, 2 students did not show up and 2 students were absent with notice. The final sample of 31 students consisted of 6 males and 25 females. The personal problem was for most students a relational problem; with their partner (10 cases) with their parents (3 cases) or with friends (3 case). Ten subjects had a social insecurity problem and the rest of the group talked about a religious problem (2 cases), a sexual problem (1), an eating disorder (1) and a sleeping disorder (1).

The *counselor* was a female clinical psychologist with a Ph. D. degree, trained in family-therapy. She was only informed about the fact that clients were receiving a treatment focusing either on the past or on the present. She did not have any knowledge about the hypotheses of the study (this was checked afterwards). In preparation of the experiment the psychotherapist had several hours of pre-experiment training in the two conditions with special emphasis on the condition-relevant interventions. After the first session, possible interventions for the second session were prepared by the psychotherapist and the authors. During the interviews the psychotherapist relied on a scheme that served as a reminder of the crucial interventions for both conditions and for the timing of these interventions in the interview. Except for this structuration, the psychotherapist conducted the sessions in her own personal style.

RESULTS

Effect of acceptability and discrepancy

The client's as well as the therapist's evaluation of the treatment was better in the acceptable condition than in the unacceptable condition, but the difference was not significant (see Table 1). No significant differences were found in a covariance-analysis, correcting the effect of acceptability for the covariance of discrepancy and present-past condition. However, inspection of the raw data revealed that 4 subjects (36.4%) in the unacceptable condition had obtained very low scores (a mean of 15 or less) on either the therapist's (3) or the client's Evaluation Scale (1). In the acceptable condition such low scores did not occur. The Fischer Exact probability test (Siegel, 1956) allows to reject

the null hypothesis that the acceptable and unacceptable group show equal proportions in the presence of a negative evaluation on either the therapist's or the client's evaluation scale or on both ($p < .05$).

Table 1. — *Mean Evaluation Scores on the Client's and Therapist's Evaluation Scale in the Acceptable and Unacceptable Condition*

Condition	Evaluation	
	Client	Therapist
Acceptable		
M	26.3	27.2
SD	3.9	6.0
Unacceptable		
M	24.8	23.3
SD	6.3	9.0

*n = 11 for each condition.

Table 2. — *Correlations Between Discrepancy Variables and Treatment Evaluation in Two Conditions*

Evaluation	Condition*		z
	Unacceptable	Acceptable	
	Discrepancy		
Client	−.27	.58	1.88**
Therapist	−.42	.66	2.48***
	Perceived discrepancy		
Client	−.29	−.01	0.58
Therapist	−.28	.38	1.38*

*n = 11 for each condition.
*$p < .10$. **$p < .05$. ***$p < .001$.

In Table 2 the correlation between the evaluation scales and the discrepancy variables are presented for the acceptable and unacceptable condition. In the unacceptable condition all correlations are negative. All of the corresponding correlations from the acceptable condition are

clearly more positive. One is a zero correlation (between the client's evaluation and his or her perceived discrepancy), but the other three are positive. The difference between those positive correlations and the corresponding negative correlations in the unacceptable condition were significant on at least a 10 percent level see Table 2).

Manipulation Check

To assure that the subjects perceived the past and present condition as such and that both conditions were distinguishable only on this dimension, the subjects answered the Manipulation Check Questionnaire. A survey of the differences between present and past condition is presented in Table 3. As intended both conditions differ on the scales that assess the perception of the therapist's orientation towards past or present. Furthermore differences were found only on three of the other scales of the Manipulation Check Questionnaire. The third and fourth scale in Table 3 reflect aspects of the problem-orientedness, like the present-past dimension. The difference on the last scale in Table 3 (perception of the therapist's opinion about the stability of the cause) is rather unexpected. No differences were found between the two conditions in the scales of the C.R.F., in the involvement scale nor in the client's or therapist's evaluation scales.

The second manipulation check concerned the acceptability conditions. The acceptable and unacceptable condition were supposed to be perceived as such by the clients. In fact the condition was correctly perceived by 22 subjects (11 in both conditions) and uncorrectly by 9 subjects (4 subjects in the acceptable condition and 5 subjects in the unacceptable condition). For the testing of our hypotheses, only the data of the 22 subjects who perceived the condition correctly, are used. Except for the uncorrect perception of the treatment-condition, no other differences were found between the included and excluded subjects.

No differences between the acceptable and unacceptable condition were expected for other variables. Nevertheless a few differences were found. Concerning the initial frame of reference a difference was found between both conditions for scale 2: "My problems are exclusively determined by the past (position 1) versus by my present situation (position 9). The means for the acceptable resp. unacceptable condition were 3.9 and 5, respectively ($t_{(20)} = 2.44$, $p < .05$). This difference is also reflected in the unequal distribution of acceptabilities over the past

Table 3. — *Overview of Significant Differences Between Present and Past Condition on the 9-Point Scales of the Manipulation Check Questionnaire*

Rating scale	Mean score		t^a
	Present	Past	
1. To what extent was the psychotherapist particularly interested in your present functioning (1) or in your distant past (9)?	2.8	7.0	7.60***
2. To what extent did the psychotherapist consider your symptoms as determined by what you have been through in the past (1) or as determined by your present situation (9)?	5.3	2.6	−4.98***
3. To what extent were the interviews focused on the backgrounds and deeper causes (1) of the problem or on the symptoms (9)?	4.6	3.3	−3.23**
4. To what extent was the treatment focused on the problem in its broader context (1) or on a specific symptom (9)?	4.2	2.2	−3.48**
5. It is the therapist's opinion that the cause of my problem will never be present again in the future (1) versus will always be present (9)	4.9	6.0	2.06*

[a] $df = 29$ for Scales 2 to 5 and 25 for Scale 1, which was added after a preliminary study on 4 subjects.

*$p < .05$. **$p < .01$. ***$p < .001$.

and present condition: the 11 subjects in the unacceptable condition were equally distributed over present 1 (5) and past (6) condition, while in the acceptable condition only 2 subjects received a present and 9 a past frame of reference. The relation between time condition and acceptability is due to the asymmetry of the frequence distribution in the responses of the total group: there were more subjects with an "own viewpoint" in the past extreme of this dimension (14 subjects had score 1, 2 or 3) than in the present extreme (5 subjects had score 7, 8 or 9).

In the perception of the treatment and psychotherapist, differences were found for one scale: "To what extent does the psychotherapist consider your symptoms as determined by inner causes (pos. 1) or by your relations to other people (pos. 9)?" The means for the acceptable

and unacceptable condition are 5.8 and 4.4, respectively ($t_{(20)} = 2.6$, $p < .05$).

The third manipulation check concerned the discrepancy and its relation to the perceived discrepancy and to acceptability. The distribution of the discrepancy scores over the acceptable and unacceptable condition is presented in Table 4. Inspection of this reveals that the discrepancy scores are distributed differently for both conditions. In the acceptable condition it is possible for psychotherapist and client to have exactly the same position on item 2 of the frame of reference scale

Table 4. — *Distribution of Discrepancy Scores in Two Conditions*

Score	Condition	
	Unacceptable	Acceptable
	Discrepancy	
0	0	2
1	2	4
2	4	2
3	3	3
4	2	0
5	0	0
6	0	0
	Perceived discrepancy	
0	0	4
1	1	4
2	2	2
3	3	1
4	3	0
5	1	0
6	1	0

concerning past/present, i.e., a discrepancy score of 0. For the unacceptable condition this is not possible (empty cell for discrepancy score 0). The relation between discrepancy and acceptability becomes also obvious in the fact that larger discrepancies are less frequent in the acceptable condition and vice versa.

Discussion

The hypothesis that clients with a psychotherapist whose frame of reference they accept, show a more favorable judgment about treatment

than clients that are confronted with an unacceptable frame of reference, is not confirmed in this study. The mean evaluation scores in both conditions are not significantly different. However an inspection of the data reveals a remarkable difference between both conditions. Whereas in the acceptable condition overall negative evaluation did not occur, 4 (36.4%) clients in the unacceptable condition showed unfavorable judgments of the treatment. A negative evaluation in an early stage of treatment can be considered as a precursor of negative phenomena in the treatment process such as dropping out. The exclusive presence of negative evaluations in the unacceptable condition suggests that the "acceptability of the therapeutical frame of reference" may be a useful decision criterion for the choice of a therapy. The results, however, are not as persuasive as expected: 7 (63.6%) clients in the unacceptable condition judged the treatment sessions positively. Reasons for this will be discussed later in this section.

The hypothesis that the relation between discrepancy and treatment-evaluation is negative in the unacceptable condition and positive in the acceptable condition received partial support: For 3 out of 4 corresponding correlations, a significant difference between a negative and a positive correlation is found. These data are consistent with the above mentioned theory of Sherif and Hovland (1961). However the hypothesis seems to hold better for the therapist's evaluation of treatment than for the client's evaluation of treatment. This is a surprising result. Post-hoc explanations for it may be found in the analogue character of the treatment-situation. Maybe the psychotherapist was more really involved in his role than the clients were, although such a difference is unplausible from observations of the treatment-sessions (by the first author). A replication of the study is needed to increase the reliability of this result and to allow firm conclusions. The use of a single psychotherapist administering both experimental conditions in this pilot study, was intended to control the characteristics of the psychotherapist for the different treatment-conditions. However this method raises serious doubts about the generalizability of the findings. In further and larger studies we intend to use at least two therapists for all the conditions.

The manipulation of acceptability shows several inadequacies, as may be concluded from the unintended covariates (the difference in the initial frame of reference and in the perception of the psychotherapist). The asymmetrical frequence distribution of the answers on the present-past dimension leaded to an unequal distribution of the present-past

treatment condition over the acceptable and unacceptable condition. It is plausible that this phenomenon is inherent in the population (clinical psychology students) used in this study. In a following study this unequal distribution will be avoided by the use of a larger recruitment group.

Another finding was that the conditions differ with respect to the perception clients have of the therapist's attribution of the problem. In the unacceptable condition, more attribution to internal causes was perceived than in the acceptable condition. A possible explanation for this might be the more threatening character of the treatment in the unacceptable condition.

The relation between "acceptability" and "discrepancy" might suggest that discrepancy suffices to account for the results. Both variables are highly related. In that case a curvilinear relation between discrepancy and treatment-evaluation would be supposed that is: very small and very large discrepancies would have a lower treatment evaluation than intermediate levels of discrepancy. In our data evidence for this was not found. Our results speak in favor of preserving the distinction between acceptability and discrepancy. The concept of "acceptability" seems especially useful for the indication stage, while "discrepancy" has its role in the change processes in the course of treatment.

Furthermore our results lead to considerations concerning the manipulation of the frame of reference. The time scale we used to define the acceptability conditions concerns the opinion of the subject about the origin of the problems in the past or in the present. A scale concerning the client's opinion about the therapist's interventions as directed towards the past or the present, would be more direct and precise. The present-past dimension might be also less important or intrusive for the clients than other dimensions as, e.g., "focusing on the broader background versus on the specific symptoms" or "the neutrality of the psychotherapist". Acceptability on the latter dimensions might have a stronger impact than acceptability on the time dimension. In a next study we will work on a stronger manipulation of the frame of reference.

Concerning the selection of subjects, only those who indicated the present-past dimension as "important" were invited. The "importance" of the dimension was conceived as an index of "ego-involvement". Other variables might be good indices for ego-involvement as well, e.g., "the extremity of the own viewpoint" and "the latitude of acceptance". For subjects with an extreme viewpoint, an unacceptable frame of

reference may be more intrusive than for subjects with a moderate opinion. And for subjects with small latitudes of acceptance an unacceptable condition may be more interfering than for clients with large latitudes of acceptance. Arguments for this assumption may be found in recent social psychological publications (Judd & Johnson, 1984; Petty & Cacioppo, 1981).

In an earlier study the effect of a negotiation approach to indication on the treatment-process was investigated (Van Audenhove, 1986; Van Audenhove & Vertommen, 1987). In this approach the client's request was elicited with special attention to what would be an acceptable therapeutical frame of reference. In our clinical experience, very often the dimensions that are considered as important by the client, are at the same time dimensions on which the client shows a more extreme point of view and a rather narrow latitude of acceptance. Our future research is aimed at improving our understanding of the role of those variables in the beginning phase of treatment.

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Received July 1988