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DEVELOPMENT OF A PSYCHOLOGICAL ASSESSMENT BATTERY TO MEASURE
CLIENT BELIEFS ABOUT THE EFFECTIVENESS OF PSYCHOTHERAPY

A DOCTORAL PAPER
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IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE
DOCTOR OF PSYCHOLOGY

BY
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The purpose of this study is to develop a brief, structured self-report questionnaire to be given prior to the beginning of a psychotherapy relationship in order to gauge a client's beliefs about the overall effectiveness of psychotherapy, the Modified Treatment Optimism Scale (MTOS). Meyer et. al. (2001) found in a meta-analysis of over 125 studies that information collected through interviews alone is "prone to incomplete understandings" (p. 128). The meta-analysis indicated that correlations between self-report and clinician report were low, usually in the .20 to .30 range, suggesting that there is high potential to gain significant new client data through such a survey. There are no extant surveys designed for this purpose, and the hope is that this scale will fill this void in the existing literature.

Given this lack of an extant scale, the current study will be attempting to determine if the scale can predict therapy outcomes based on attitudes towards effectiveness of psychotherapy. The basic hypothesis is that, if the scale is accurately measuring beliefs about effectiveness of therapy, then that will be reflected in differences in therapy engagement. With the aid of this data, the scale could help demonstrate extant relationships between beliefs about effectiveness of therapy and actual therapy engagement. This information could then be utilized to engage with incoming clients about the therapy relationship to improve therapy outcomes.

Literature Review

Psychotherapy Effectiveness

At present, there are no specific measures designed to explicitly measure client beliefs about the effectiveness of psychotherapy before therapy begins. Constantino et. al. (2012) indicated that there is little available data on the interaction between therapy

expectations and outcomes, although the data that is available supports the notion that addressing expectations for therapy early in the relationship leads to better overall outcomes. However, they define therapy expectations in a way that is fundamentally different than how the author wishes to do so. Constantino et. al. break down therapy expectations into two broad categories, “outcome expectations” and “treatment expectations.” Outcome expectations can be defined as the individual client’s beliefs about the treatment’s efficacy for her on an individual level, or a general belief that change itself is possible. Treatment expectations are more based on specific expectations about the therapy process, such as how the therapist and client will behave, how they will experience therapy, or how long therapy will last. In both instances, the goal is not a global assessment of whether or not therapy is useful in a global sense.

Norcross (2011), in the results of an APA task force investigation into evidence based therapy relationships, indicated that the therapy relationship itself was the most important component of positive therapy outcomes. This was true across multiple therapeutic orientations. Teachman et. al. (2012) demonstrated the importance of information flowing in a bidirectional manner between psychotherapists and researchers in a literature review. They demonstrated that therapy outcomes improve if the clinician and client have a relationship wherein they are able to openly share information about the process. In both cases, studies have indicated the importance of openly collaborating and sharing information about the therapy process with clients to maximize outcomes.

Wampold (2006) similarly holds that clients need to be engaged in the therapeutic process in order to create better client determined therapy outcomes. He elaborates that it is important for us as therapists to stay sensitive to the clients’ expectations, and this

includes the expectations about how the therapy process itself will work for them. They also discuss specific scales that measure therapy expectations, primarily in an attempt to determine how the therapy process changes those beliefs, there are none designed to specifically determine the beliefs an individual has regarding psychotherapy on a global scale, distinct from specific therapy modalities or therapeutic relationships. Said scales, while probably measuring similar constructs, are inherently designed to focus on how an individual views psychotherapy following a therapy relationship or through the lens of a specific therapeutic dyad. They do not approach the question of how effective the client finds therapy divorced from a specific psychotherapy context.

Assessment Measures Regarding Client Beliefs About Psychotherapy

Although there are multiple variables that are related to a belief about effectiveness of therapy, none of them adequately measure that specific variable. Scales measuring similar constructs such as hope or optimism are too broad to specifically tie into the therapy relationship and process itself. Similarly, psychological mindedness focuses on tendency to approach problems in a way similar to a psychotherapist, but does not in and of itself address specific beliefs about therapy's effectiveness. In each case, the available instruments and studies measured constructs related to, but not directly analogous to, the actual topic of belief about effectiveness of psychotherapy. For example, Beitel et al. (2009) are specifically focused on the clients' expectations--that is, what the client expects to happen in treatment instead of whether or not they believe that the therapeutic process is in and of itself is useful. They further break this down into multiple domains, expectations about self as a client, expectations about the counsellor's in session behavior, expectations about the counselor's style, and expectations about the

processes and outcomes of counselling. In each case, the goal is not to determine how likely the client is to believe that psychotherapy is useful, but rather what they expect the therapy sessions to look like and what the outcomes might be. While similar to the beliefs that the scale being evaluated here will measure, they are sufficiently distinct on a conceptual level to warrant the development of the new instrument.

The Therapeutic Optimism Scale of Byrne, Sullivan, & Elsom (2006) includes 3 subscales developed through factor analysis: General Treatment Outcome Expectancy, Personal Treatment Outcome Expectancy, and Pessimism. The scale asks clinicians to rate their agreement with ten items on a Likert scale. While this scale is designed for use with clinicians, with some modification it would also be appropriate for potential psychotherapy clients. On a face validity level, items designed to measure the clinician's optimism regarding effectiveness of psychotherapy as a process should address general beliefs about psychotherapy when given to potential or new therapy clients. The authors admit that their instrument has not been widely used in clinical studies, but found that the overall instrument had good reliability on test retest, with a Cronbach alpha of .68. A t-test carried out on matched tests in the test retest also found no significant difference between the two test administrations. The individual subscales had lower reliability coefficients. The General Treatment Outcome Expectancy scale yielded an alpha of .65, the Personal Treatment Outcome Expectancy yielded a .58, and the Pessimism subscale obtained a .44. It should be noted, however, that the lower scores are attributable to the fewer numbers of items in each subscale; for example, the Pessimism subscale has only two items. The TOS also had significant correlation with the Clinician Optimism Scale

(COS), another instrument used to measure clinician optimism among caseworkers. The two instruments correlated positively at .54.

A scale designed to measure beliefs about effectiveness of therapy, divorced from any potential effects caused by entering into a psychotherapy relationship, could also provide data that could affect potential interventions as the therapy relationship goes on. While the therapist will address the client's views about psychotherapy in session, a dedicated instrument will allow for a different, and more well-rounded, overall assessment as well as more opportunities to specifically mention how this variable will affect the therapeutic relationship itself.

Similar Instruments and Concepts

The MMPI-2 Negative Treatment Indicators (TRT) is considered reliable and valid (Hathaway & McKinley, 1989) in measuring inability to disclose and lack of motivation. However, there is no clear indication of whether or not the TRT is actually a good indicator of treatment outcome. Clark (1996) found that TRT was a significant predictor of treatment success, correlating with improvements on "BDI scores, State Anxiety, (and) Trait Anxiety" among male chronic pain patients. However, Kurt et al. (2009) found that the TRT was significantly correlated with symptom distress at the beginning of the therapy relationship, but was not correlated with meaningful symptom change. Similarly, neither Minnix et al. (2005) nor Chisholm, Crowther, & Ben-Porath (1997) found any significant relationship between elevated TRT scores and premature termination from psychotherapy. In short, while the TRT measures some variables that could be related to overall beliefs about the effectiveness of therapy, it does not appear sufficient as an outcome predictor.

While no dedicated scale has been developed to address beliefs about effectiveness of therapy as a specific therapy variable, several studies have attempted to measure something similar. Allen et al. (1984) developed several scales designed to measure the therapeutic alliance to determine its usefulness as a treatment variable. The one most germane to the current study was Optimism about the Outcome of Therapy. The scale, which the authors used to rate transcripts of therapy interactions, is designed to measure whether or not the individual feels that therapy will end successfully. While similar to a concrete belief about the effectiveness of psychotherapy, this scale is less interested in a specific sense that the process of psychotherapy as a whole is viewed as worthwhile by the client, but instead in whether the specific therapy relationship will end positively.

They consequently found that this optimism was positively correlated with another of their scales, collaboration. Collaboration was considered the most reliable scale of the study, and the authors determined it was a good measure for determining the successful, collaborative interaction of therapist and client. In short, optimism was important in the formation of the therapeutic alliance. While the optimism scale is not designed to address the same specific variables as the MTOS, it measures a construct that appears to be similar to the construct measured by the MTOS. Optimism in therapy, at least on a face level, would seem to be very similar to a general sense of belief about psychotherapy as a whole. The optimism measured by the authors, however, was too focused on the specific therapy relationship to capture a global view about therapy as a process. Again, it is a similar construct but not exactly what the current study hopes to measure.

Johansson, Hoglend, & Hersoug (2011) carried out a study to determine if there were any specific relationship between optimism, therapeutic alliance, and treatment outcomes. They found that a global sense of optimism was significantly associated with positive outcomes on both General Assessment of Functioning (GAF) scores, as well as the Psychodynamic Functioning Scales. However, when the effects of therapeutic alliance as rated by outside clinicians were controlled for, optimism was no longer a significant predictor. Littman-Ovadia and Nir (2014) carried out a similar study where participants carried out a short, self-administered optimism intervention. They found that this intervention led to reduced “pessimism, negative affect, and emotional exhaustion” for a period of a month after the initial intervention. Furthermore, they found that individual who rated higher on optimism prior to intervention showed more pronounced effects during the trial. However, Littman-Ovadia and Nir acknowledge that their findings are not typical, as multiple other cited studies contradict their findings.

These findings indicate again that, while optimism is a potentially important variable for continued consideration, its relationship to the alliance is unclear and does not fully encompass beliefs about effectiveness of psychotherapy. It is also worth noting that “optimism” is defined separately by each author, and thus is too nebulous for the current study’s purposes. It may be an important therapeutic variable, and while it may be related to beliefs about effectiveness of therapy, it appears to be distinct enough that a more specific instrument is called for.

Similar to optimism is the concept of hope as a therapeutic variable. Obayuwana et al. (1982) developed a hope scale, a 50 item questionnaire. While their scale produced a significant inverse correlation with Beck’s Hopelessness Scale, and might be a good

overall scale for the assessment of hope, it is not a good measure of beliefs about effectiveness of psychotherapy specifically. They defined hope as “the state of mind which results from the positive outcome of ego strength, perceived human family support, religion, education, and economic assets.” While the author does not question the importance of these facets in the ongoing therapy relationship, they are much broader than the current study is interested in measuring. Overall, hope and optimism are important therapeutic variables, but they do not speak directly to attitudes towards psychotherapy as a process.

Similarly, psychological mindedness (PM) seems to be another related construct. Beitel et al. (2009) conducted a study to determine any relationship between PM and expectations about counseling. They found that high PM is correlated with several specific expectations about therapy, specifically within the realms of expectations about their own behavior in therapy, expecting openness and therefore sharing of personal information, and expecting to take responsibility for process in the therapy relationship. PM was not significantly related to any other expectations about the counselor’s behavior, indicating that even clients with high PM are not sure what exactly to expect from a psychotherapy relationship. Piper et. al. carried out a similar study, wherein they followed up treatment on a comparative clinical trial over the course of six and twelve months following treatment terminating. They found no lasting effect from high PM in outcomes over the long term; this is in contrast to significant effect immediately following treatment ending.

While individuals with high PM are inclined towards thinking about their issues and problems psychologically, they still have some uncertainty about therapy as a

process. PM does not adequately address belief about how effective the psychotherapy process is for the potential or new client. PM also does not appear to be a totally successful predictor of therapy outcomes, further differentiating it from what the current study hopes to identify and measure: beliefs about therapy's effectiveness and how they affect the therapy relationship.

Another potentially related variable could be mindfulness. Shapiro et. al. (2010) define mindfulness as a state of mind "wherein attention, informed by a sensitive awareness of what is occurring in the present, simply observes what is taking place." While this is not directly comparable to belief about effectiveness of therapy, it follows that more mindful individuals might be more inclined towards viewing the actual process of therapy as useful; this is conjecture based on the focus in the therapy process on being present in the moment and discussing events within the therapy room itself. Shapiro et. al. did find that individuals who measured higher on trait mindfulness prior to intervention with a mindfulness based stress reduction technique experienced better outcomes. However, this is another instance of a variable that is similar to belief about effectiveness of therapy but does not truly measure the same variable.

Hypotheses

As this is a pilot study, the hypothesis is that those patients who are not active in therapy, as defined by session attendance, will score significantly lower on the scale than those who are active, as they are already disinclined to view therapy as effective. The hope of the current study is that the use of an assessment tool designed to measure client perceptions of psychotherapy effectiveness will allow for a fuller, more complete view of clients' views about the psychotherapy process.

Method

Participants

After approval from the Internal Review Board, clients were recruited from an in-house student training clinic in a large Clinical Psychology program in the Rocky Mountains. The sample consisted of 32 psychotherapy clients. The clinic works with traditional outpatients from the greater community, and offers services on a sliding scale basis. Adult clients present with a wide range of diagnoses, primarily mood, anxiety, and adjustment disorders and represent multiple age, ethnic, and socioeconomic groups. While more than a total of 32 clients were administered the survey, several were disregarded due to spoiled responses (such as not answering all questions or answering a question multiple times), or due to administration errors that made it impossible to follow up on the individual client.

With regards to additional variables, the only descriptive or demographic variables gathered were gender and previous engagement in therapy. While other demographic or descriptive variables would be beneficial for further psychometrics on the MTOS, further variables were not specifically gathered in order to safeguard the clients' confidentiality; it was assumed that holding more detailed information would make it more likely that respondents could be identified. The first was gathered to try and determine if there was a specific gender gap within the sample, in order to address that failing in the sample as a whole. As the two groups were approximately even between male and female in the final sample, gender was used here as another variable to compare the MTOS on. Similarly, previous involvement in therapy was gathered to

attempt to control for interaction with previous therapy relationships on the MTOS scale. See Table 1 for breakdown of individuals between these variables.

Measures

MTOS- For the purposes of this study, the author has altered the Treatment Optimism Scale, creating the Modified Treatment Optimism Scale (MTOS). To do this, the author sought permission from the original Therapeutic Optimism Scale and modified the wording to make it appropriate for therapy clients instead of clinicians. The actual order and scoring of the instrument was unchanged from the original instruments, and the items as presented in the MTOS are in the Appendix.

The MTOS was evaluated over the course of the current study in order to determine if it is a valid measure of beliefs about effectiveness of psychotherapy; given the lower reliability coefficients present in the subscales, the current study primarily used the total score for all ten items to determine an overall score for belief about effectiveness of psychotherapy. All incoming psychotherapy clients were asked to complete the MTOS at their first consultation with their new therapist, in order to best control for potential effects caused by the therapeutic relationship after it is established. It is the author's goal for the MTOS to allow for a conversation about the effectiveness of therapy to happen as part of the initial therapy relationship, regardless of the severity and nature of the specific complaint.

MTOS scores, either high or low, and therapy engagement as measured by early termination and frequent cancellations or "no shows." In order to determine if the MTOS has any utility with psychotherapy clients instead of clinicians, it was administered to a group of incoming psychotherapy clients, as part of a small battery of other self-report

instruments. Each client was then tracked to determine if he successfully attended a full six sessions.

Six sessions was set as the cutoff for engagement due to the nature of the clinic used for the study. Within the clinic's paradigm, each client is given three sessions of initial consultation while the therapist performs the initial intake report. At the end of this period, the therapist and client negotiate the final fee for ongoing therapy session, which is usually higher than the consultation fee. It was assumed that if the client had been active in all three consultation session, and then at least that same number of sessions at the full fee, that they could be considered active in therapy for the purposes of this study.

Procedure

Participants were given the MTOS prior to attending their first consultation session with a new student therapist. Clients were given a welcome packet of documentation at their first visit, and the MTOS was included within that packet, along with informed consent. Demographic information was gathered as part of the initial therapy intake process. To ensure confidentiality, each client's scores on the battery instruments were identified only by Client Identification (ID) number assigned to him/her by the clinic. Clients were not assigned unique ID numbers outside of the training clinic's charting system in order to gather necessary outcome data. As the clinic's ID numbers are also confidential and documentation is compliant with HIPAA, data security was maintained.

As part of the standard procedure at the clinic, each client was seen weekly by a therapist. Each individual client was tracked to determine if they successfully completed

six individual therapy sessions. Clients were classified as active for the purposes of the current study at the end of the sixth session. Any client who had not completed six sessions prior to being officially terminated by their therapist during the data collection period was considered part of the inactive group. Similarly, any client who had actually terminated therapy was only considered part of the inactive group. At the termination of therapy, each therapist filled out a short form outlining why therapy was ended. The terminated clients were further broken down into subgroups based on the reason for termination (i.e. loss of contact, referred out, lack of funds, etc.). While initially it was intended to break down terminated clients into these subgroups for further analysis, only one client was officially terminated at the end of the six week period and consequently no analyses could be performed.

Each client's individual therapist was given a brief questionnaire either upon the client being officially terminated or upon reaching their sixth session in order to determine the therapist's opinions regarding their therapy relationship. The questionnaire was delivered to each therapist through the clinic's internal mail system, along with informed consent, in a sealed packet. The questionnaire did not identify the specific client by name, but did have the client's ID# so that the therapist knew which specific client is being discussed. The questionnaire is based on the questions of the MTOS, in order to simplify comparison between the therapist and client groups. While the questionnaire was given to all therapists working with clients used in the current study, there were only two who completed the questionnaire and returned it. Because of this, no data regarding the questionnaire will be included in the study.

Data Analysis

Due to the sample size, statistical analysis consisted of several independent samples, two-tailed *t*-tests comparing scores on the MTOS. The independent variables in these tests were whether or not the client was active in therapy, gender, and whether or not the client reported being involved in psychotherapy before. While the original Treatment Optimism Scale utilized subscales, the MTOS was only evaluated on the total score, as the sample size was insufficient for a factor analysis to determine if those subscales were still valid for the MTOS.

Results

An independent samples *t*-test was conducted to compare those who were considered active in therapy, defined here as individuals who had completed at least six sessions, and those were not active, as defined by completing fewer than six sessions or having terminated outright. There was not a significant difference in the scores for the active group ($M=30.7059$, $SD=2.82322$) and not active group ($M=32.6667$, $SD=3.39467$); $t(30)=-1.96078$, $p=.085$ if significance is held at a .05 level. However, at the $p>.1$ level, the results could be considered significant. Based on the small sample size, for this study it is appropriate to use this less onerous level of determining significance. If this significance level is used, then the sample has statistical power of .685 (Decisions Support Systems, 2015). While this is not particularly high power, under the circumstances (small sample size, new instrument, and limited data collection time) it indicates that there is in fact some kind of definitive difference in scores on the MTOS based on being active in therapy.

To further demonstrate this possibility, independent samples *t*-tests were carried out to determine if there are any differences between MTOS scores based on two other

independent variables. The goal of these additional analyses is to ascertain if there are significant or nearly significant differences on MTOS scores based on variables other than being active or not active in psychotherapy. The first test was whether or not the client had been active in therapy prior to the therapy contact where he participated in the survey. There was not a significant difference in the scores for the group that had been in therapy before ($M=31.6154$, $SD=3.53358$) and those had not been in therapy before ($M=32.0000$, $SD=1.00000$); $t(29)=-.239$, $p=.813$. This result should be interpreted with caution, however, as the size of the group of people who had been in therapy before ($N=26$) and the group of those who had not ($N=5$) are extremely different.

A more useful comparison would be the independent samples t-test comparing participants based on gender, as the sizes of the groups were much closer to equal. There was not a significant difference in the scores for the males ($M=30.8125$, $SD=2.88025$) and females ($M=32.1333$, $SD=3.28213$); $t(29)=-1.191$, $p=.243$. While this indicates that there are differences between the male and female groups, it does not even approach statistical significance, whereas the active vs. not active in therapy groups were much closer.

TABLE 1

Descriptive Statistics of Independent Variable Groups

	N	Mean	Standard Deviation
Active in Therapy	17	30.7059	2.82322
Inactive in Therapy	15	32.6667	3.39467
Previously in Therapy	26	31.6154	3.53358
Never in Therapy	5	32.0000	1.00000
Male	16	30.8125	2.88025
Female	15	32.1333	3.29213

Discussion

The most salient result found in this study is the difference between those who were active in therapy versus those who were not. The fact that those who were not active in therapy scored higher than those who were requires some further thought, as it directly contradicts the initial hypothesis for the study. The inverse, wherein those who did not hold high belief in the effectiveness of therapy terminated early, would seem to be more logical on a face valid level. The fact that those who were not as engaged with therapy scored higher on the MTOS leads to several questions.

The first, and most important for these purposes, is whether or not the MTOS itself is actually measuring anything at all. While further study and more robust psychometrics are necessary before considering the MTOS to be a success, it seems premature to declare the instrument to be inherently flawed based on the current data. Based on the fact that the scores on the MTOS were different based on engagement with

therapy, but not when comparing other variables, the MTOS does appear to be measuring some variable tied into how people look at and consequently engage with therapy. With a larger sample and more time spent with data collection, this relationship can be clarified and a more accurate statement on what the MTOS is measuring can be made.

It is possible that the difference in scores can be attributed to higher expectations of therapy as a process, and consequently less willingness to remain active in therapy if those expectations are not met. It is also difficult to determine what interactions there might be between the individual therapy relationships and the clients' engagement in therapy. While the original intent was to try and control for this through the use of a therapist questionnaire, the low return rate made this aspect of the study untenable.

Therapist effects had the potential to be particularly confounding in this study, as the difference between a first year training therapist and a third year training therapist can be incredibly wide. This is in addition to the expected differences in skills and approaches that can be expected between a large group of psychotherapists. This, in addition to the small sample size, seem to be the biggest shortcomings of the study as a whole.

It is thus difficult to make a case that the MTOS, as it currently exists, is ready to be used as a more widespread assessment tool in therapy. However, based on the available data it does appear feasible that there might be future directions for study that might make the MTOS more valuable. This pilot study was not able to definitively state anything regarding the instrument, but it seems that there would be more possibilities that call for further evaluation.

Recommendations for Future Study

The first thing that will be required in order to better ascertain the MTOS's overall utility is a larger study with a bigger sample. It would also be beneficial for there to be a more limited number of therapists involved, perhaps no more than five or six, in order to better control for therapist effects. In an ideal situation, a small group of therapists employed at one clinical setting, such as a large private practice or community mental health center, who all had similar levels of experience would be asked to give the MTOS to clients as part of their initial therapy intake paperwork. The follow up after administration could be carried out similarly to the current study, in that after a set period of time clients could be evaluated to determine if they had attended a set number of sessions. Each therapist could then fill out the therapist questionnaire to qualify differences in individual therapy relationships in order to control for them. Data collection could continue until a larger N is found, as there would not be the same sorts of time constraints inherent in a doctoral project such as this study.

Again, this would be an ideal situation, but given sufficient institutional buy in it does not appear to be one that is infeasible. It is the author's hope that such a study could be carried out during a post doctoral fellowship, as that kind of research project is often encouraged during a dedicated fellowship. This seems particularly important given that the results of the study were the opposite of the research hypothesis. A larger study could help determine if the MTOS is measuring what it is intended to measure, and consequently if it would be useful in predicting therapy outcomes. A larger, more dedicated study would also be helpful in evaluating if clients are actively ending therapy after a few sessions due to feeling satisfied, or if they are terminating due to dissatisfaction with the process or therapist. Having a smaller number of clinicians

would make it feasible to separate clients who terminated in fewer sessions with a positive outcome from those who simply did not return for sessions.

Similarly, it could be beneficial to utilize the MTOS as part of a larger study, looking into other variables such as hope or optimism and how they affect therapy engagement and outcomes. This could then help establish how much of the actual variance in therapy outcomes can be attributed to beliefs about effectiveness of therapy as opposed to other factors. Doing so will be necessary to not only judge the effectiveness of the MTOS, but also in judging the importance of belief in effectiveness of therapy, as a global concept, in predicting therapy outcomes. While it is possible that the MTOS itself would not be found to be a useful instrument, the underlying concept of belief in effectiveness of psychotherapy as a process can still be evaluated to determine how it affects therapy outcomes.

Finn and Tonsager (1997) suggest the importance of using assessment in a specifically therapeutic manner. They suggest thinking of assessment in a different paradigm, where instead of simply using it as an information gathering tool it can be used to discuss specific issues as a therapeutic intervention. The assessment may prove useful as an intervention on its own, when used regularly during initial therapeutic contacts, to help specifically address the client's incoming beliefs about therapy and allow him to address any concerns he may have come into therapy with.

This is the goal of the MTOS; to be able to evaluate a client's attitude towards the therapy process with an eye towards a psychoeducation intervention. For example, if a client is pessimistic regarding the actual process of psychotherapy, the therapist can focus on psychoeducation over the course of the first few sessions to inform the client about

how psychotherapy can be effective for clients with his specific problem, as well as increasing overall functioning. Similarly, if the client scores extremely highly on the MTOS, psychoeducation can focus on setting realistic expectations and encouraging him to discuss any shortcomings that he is experiencing in the therapy relationship. By using this instrument as a therapeutic assessment, a conversation can begin regarding how exactly the client looks at psychotherapy and what the therapist can do with that information to provide the best possible outcomes.

If the MTOS does prove to be a useful instrument, further study can be pursued to determine if it is useful at predicting therapy outcomes, with a goal of designing potential interventions based on the client's attitudes towards therapy. The MTOS appears to have some potential at differentiating people's engagement with psychotherapy, and consequently being able to gauge this at the beginning of the therapy relationship would be beneficial. Being able to do so with a numerical value that can then help determine what form a psychoeducation intervention should take seems to likewise be a useful tool for therapists to have. The author maintains that this kind of information will be helpful for a therapist starting a new therapy relationship, and further study of the MTOS could demonstrate that it is an instrument that can garner this kind of data.

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Appendix A

MODIFIED TREATMENT OPTIMISM SCALE

Have you ever been in therapy before?

Y N

1. Mental health clinicians have the capacity to positively influence outcomes for people with mental disorders.

2. There is little that can be done to help many people with mental disorders.*

3. Psychotherapy's contribution to positive outcomes is insignificant in comparison to other treatments such as medication.*

4. A therapist can make a positive difference for most people with mental disorders.

5. Positive outcomes are directly related to the quality of mental health clinician skills and knowledge.

6. There are always new skills and knowledge a therapist can acquire to improve his/her work.

7. The outcome of mental disorders is not significantly affected by clinician interventions.*

8. With my therapist's help I will be able to recover.

9. I believe there is little my clinician can do to help me with my mental illness.*

10. Even my most challenging problems can benefit from my therapist's intervention.

**Indicates item is reverse scored*

Appendix B

THERAPIST QUESTIONNAIRE

1. I believe that I was able to positively influence the outcome for my client.
2. There is little that can be done to help my client.*
3. My contribution to the client's outcome would not be different from a medication intervention.*
4. I have been able to make a positive difference in my client's life.
5. The client's outcome is directly related to my skills as a clinician.
6. There are always new skills and knowledge a therapist can acquire to improve his/her work.
7. The client's outcome was not significantly affected by my interventions.*
8. The client is able to recover with my help.
9. I believe there is little I can do to help the client with his/her mental illness.*
10. My client's most challenging problems were not affected by my interventions.

**Indicates item is reverse scored*