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ABSTRACT

Current theoretical approaches to understanding emotional difficulties are dominated by the medical model of mental illness, which assumes that emotional dysfunction can be viewed the same way as physical dysfunction. To examine the relationship between psychotherapy clients' beliefs about the medical model of psychotherapy and their behavior during treatment, 39 clients at a student mental health service were administered a measure of acceptance of the medical model at the outset of psychotherapy, and indicated their expectancies for therapeutic improvement. Eight weeks later or at termination, which ever came first, therapists rated their clients' behavior. Results showed that, as predicted, psychotherapy clients who were more accepting of the medical model reported higher initial expectancies for therapeutic gain, controlling for the value of making those gains, and terminated prematurely from treatment more often. Paradoxically, they were rated by their therapists as making more active attempts to address their problems both in and outside of treatment sessions. Clients who were more accepting of a responsibility/control orientation were judged as making less active attempts to address their emotional problems and as more dependent on their therapists; some discussion is given to this unexpected observation. The findings suggest that clinicians need to be sensitive to their patients' mental health ideology. (JAC)

Consequences of Psychotherapy Clients' Mental Health Ideology

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Abstract

Consequences of Psychotherapy Clients' Mental Health Ideology

Relationships between psychotherapy clients' acceptance of the medical model of psychopathology and their expectancies for improvement, activity in treatment, dependency upon the therapist to effect change and premature termination were examined. At the outset of psychotherapy, 39 clients were administered a measure of acceptance of the medical model and indicated their expectancies for therapeutic improvement. Eight weeks later or at termination, whichever came first, therapists rated their clients' behavior. Clients who were more accepting of the medical model demonstrated higher initial expectancies for improvement and greater frequencies of premature termination, but, paradoxically, were seen as more active and less dependent.

Introduction

Current theoretical approaches to understanding emotional difficulties are dominated by the medical model of mental illness. The central assumption of the medical model proposes that emotional or psychological dysfunction be viewed in the same way as physical dysfunction or illness. Accordingly, adjustment problems are understood from within a framework of biological or disease-like causes, illness classifications and disease-specific cures. Furthermore, this approach assumes individuals encountering adjustment problems are passive victims of psychological malady. Finally, the medical model argues for curative treatments administered in dyadic relationships between psychiatric authorities and sick individuals who seek out or are brought to mental health services. Empirically, a variety of important consequences have been shown to be associated with acceptance or rejection of the medical model (Milling & Kirsch, 1983). The current study examines relationships between psychotherapy clients' beliefs about the medical model of psychopathology and their behavior during treatment.

The implications of accepting the medical model have been suggested by a small, but growing number of empirical investigations. A review of this literature indicates that acceptance or rejection of the medical model is associated with three major sets of consequences. First, acceptance of the medical model seems to be related to devaluation of those experiencing emotional difficulties by the public (Rothaus, Cleveland, Hanson & Johnson, 1963; Ommundsen &

Ekeland, 1978; Golding, Becker, Sherman & Rappaport, 1975) and by mental health professionals (Langer & Abelson, 1974). Second, rejection of the medical model by lay people, psychiatric patients and psychotherapy clients appears to be associated with personal effort to overcome emotional problems (Farina, Fisher, Getter, & Fischer, 1978; Fisher & Farina, 1979; Morrison, Bushell, Hanson, Fentiman & Holdridge-Crane, 1977). Finally, acceptance of the medical model seems to be associated with initial expectancies for improvement in educational counseling and also premature termination from the counseling program (Coates, Renzaglia, & Embree, 1981). Conceivably, acceptance or rejection of the medical model may be related to a wide array of important consequences including in the counseling setting.

In the current study, psychotherapy clients' acceptance or rejection of the medical model was used to predict four theoretically and empirically related client behaviors: level of activity in treatment, dependency upon the therapist, expectancy for improvement and premature termination from therapy. First, previous research has demonstrated that analogue psychotherapy clients led to understand emotional difficulties as similar to physical disease made less active attempts to resolve their own adjustment problems by thinking about their problems less often following therapy (Farina et. al., 1978). The current study predicted that actual psychotherapy clients who were more accepting of the medical model would make less active attempts to address their emotional problems, as judged by their therapists. Second, Morrison et al. (1977) showed that psychotherapy outpatients endorsing the medical model also reported attitudes of greater dependency upon their psychotherapists. The present research

predicted that clients adhering to the medical model would be seen by their psychotherapists as more dependent upon their therapists to effect improvement in psychotherapy. Finally, it has been shown that educational counseling clients espousing the medical model reported higher initial expectancies for improvement as a result of participating in this program, but also greater rates of premature termination (Coates, et al., 1981). In the current study, psychotherapy clients more accepting of the medical model were hypothesized to demonstrate higher initial expectancies for therapeutic gain and more frequent premature termination from treatment.

Method

Subjects

This investigation was conducted at the Mental Health Service of the University of Connecticut Student Health Service. Six male students and 33 female students who came to the clinic seeking psychotherapy and 15 psychotherapists served as subjects in the study. Students who came to the clinic for other reasons, such as one or two consultation sessions, were excluded from the study.

Instruments

Psychotherapy clients were administered the Medical Model Ideology Scale (MMIS) and the Symptom Check List (SCL-90). The MMIS is a multidimensional questionaire measure of acceptance/rejection of the medical model (Milling & Kirsch, 1983). MMIS Dimension One assesses acceptance of a disease analogy conception of emotional problems and appropriate mental health interventions. MMIS Dimension Two measures acceptance of the belief that people are responsible for and able to control their abberant thoughts, feelings and behaviors.

Scale items are rated according to a five point, Likert, agree-disagree format and rekeyed so that a high score is equivalent to greater endorsement of the medical model.

The SCL-90 is a well-validated 90 item symptom discomfort rating scale (Derogatis, 1977). Prior to treatment, clients were asked to circle those problems that were of most concern in relation to seeking help at the mental health service. Clients rated each of the circled presenting problems on "expectancy regarding therapy" by choosing one of five responses ranging from "I expect therapy to be of great help in solving this problem" (1) to "I expect therapy to make this problem worse" (5). The average of these ratings served as the operational measure of expectancy for improvement. Since reinforcement value is a powerful covariate of expectancy (Rotter, Chance & Phares, 1972), clients also rated each of the circled problems on "importance" by choosing one of four responses ranging from "It is of great importance that I solve this problem" (1) to "It is of no importance that I solve this problem" (4). The average of these ratings served as the operational measure of reinforcement value for improvement.

Therapists completed a behaviorally-oriented rating scale describing their clients' behavior after eight weeks of therapy or at termination, whichever came first. The first three questions measured how frequently the client: 1) made active attempts to deal with his or her problems in therapy sessions; 2) made active attempts to deal with his or her problems outside of therapy sessions; and 3) depended upon the therapist to effect change in treatment. Each question ranged along a five point continuum from "very frequently" (1) to "never or almost never" (5) and provided examples associated

with the construct being assessed. The final question asked therapists to judge whether the client was a premature terminator, operationally defined as a client who failed to accomplish less than half of the treatment goals and who left therapy against the therapist's recommendation.

In addition to these ratings, clients' sex and total number of sessions attended were obtained from the clinic's records.

Procedure

The investigation was conducted at the Student Mental Health Service throughout the Spring semester, 1981. Following their initial intake interview, clients seeking psychotherapy at the clinic for the first time were given reseach packets to take home, complete and return at the time of their first treatment session. This packet contained the MMIS and the SCL-90. Clients' attendance at weekly, hour-long, individual psychotherapy sessions was monitored tnrough the clinic's appointment book. At termination or after eight sessions, whichever came first, therapists were asked to complete the behavioral rating scale assessing activity in treatment, activity outside of treatment, dependency upon the therapist, and premature termination.

Results

Correlations between the two MMIS dimensions and the six dependent variables produced a matrix of 12 coefficients, six of which were significant at or beyond the .05 level of probability.

Level of Activity

The first hypothesis stated that clients who were more accepting of the medical model would be judged by their therapists as demonstrating

less active attempts to address their problems in treatment and outside of treatment. Clients espousing a responsibility/control orientation on MMIS Dimension Two were rated by their therapists as less active in treatment ($r = -.40$, $p \leq .01$) and outside of treatment ($r = -.35$, $p \leq .04$). Nonsignificant correlations between MMIS Dimension One and the two activity variables were observed.

Dependency Upon the Therapist

The second hypothesis stated that clients who were more accepting of the medical model would be judged by their therapists as more dependent upon their therapists to effect therapeutic change. Clients rated as more dependent upon their therapists advocated a responsibility/control orientation on MMIS Dimension Two ($r = .36$, $p \leq .03$). A nonsignificant correlation between MMIS Dimension One and dependency was obtained.

Expectancy for Improvement

The third hypothesis stated that clients who were more accepting of the medical model would report lower expectancies for improvement in psychotherapy. Nonsignificant correlations between the MMIS dimensions and expectancy for improvement were observed. To assess the mediating effects of reinforcement value on these relationships, a hierarchical multiple regression was performed with simple expectancy and reinforcement value entered first into the regression equation and the interaction between the two variables entered as the last predictor in the equation. MMIS Dimension Two regressed on these variables yielded a marginally significant multiple correlation of $R = .40$ (F (3,35) = 2.21, $p \leq .15$), with the interaction term contributing a significant increment to the regression equation (Beta = -2.14, $F = 3.29$, $p \leq .05$). MMIS Dimension One regressed

on these variables failed to produce a significant multiple correlation.

Premature Termination

The fourth hypothesis predicted clients who were more accepting of the medical model would terminate prematurely more often from treatment. Clients judged by their therapists to be premature terminators advocated a disease orientation on MMIS Dimension One ($r = -.35$, $p \leq .03$). A nonsignificant correlation between MMIS Dimension Two and premature termination was obtained.

Other Correlational Analyses

Clients' sex was significantly correlated with MMIS Dimension One ($r = -.37$, $p \leq .02$), but not with MMIS Dimension Two. More specifically, female clients were more rejecting of a disease orientation than male clients. Also attendance at psychotherapy sessions was significantly correlated with acceptance of a responsibility/control orientation on Dimension Two ($r = -.52$, $p < .001$), but not with Dimension One.

Discussion

In general, the findings of the investigation provided mixed support for the study's hypotheses. As predicted, psychotherapy clients who were more accepting of the medical model reported higher initial expectancies for therapeutic gain, controlling for the value of making those gains, and terminated prematurely from treatment more often. On the other hand, psychotherapy clients who were more accepting of the medical model, paradoxically, were rated by their therapists as making more active attempts to address their problems in and outside of treatment sessions and as being more dependent upon their

therapists for making improvement. In addition to these hypothesized relationships, two other interesting findings were observed. Men were more accepting of the medical model, as were clients who attended less treatment sessions.

Clients who were more accepting of the medical model were found to report higher initial expectancies for improvement and terminated prematurely more often. More specifically, clients who were more rejecting of a responsibility/control orientation initially expected to make greater improvement, controlling for the importance of making those gains. Additionally, clients who were more accepting of a disease analogy conception of emotional difficulties terminated prematurely from therapy more frequently. Apparently, clients who attributed relatively greater responsibility for causing therapeutic change to psychotherapists seen as possessing considerable expert knowledge consequently were more hopeful of achieving gains. However, when these clients later discovered that psychotherapeutic expertise is not nearly as well-developed as the technology of physical medicine, they became disenchanted and left treatment prematurely. These findings replicate the results of a similar study conducted by Coates et al. (1981) in an educational counseling program.

That psychotherapy clients who were more accepting of a responsibility/control orientation were judged by their therapists as making less active attempts to address their emotional problems and as more dependent upon their therapists to accomplish therapeutic change presents a greater conceptual puzzle. At least three explanations for these findings can be proposed. First, therapists' ratings may have been invalid and subject to systematic bias common to MMIS Dimension Two as well. Second, clients who actually accept little

responsibility for their psychopathology may have responded defensively by portraying themselves as in control of their problems as measured by the MMIS. According to the third and most benign explanation, clients who accepted high levels of responsibility for their behavior acted relatively independently of their therapists' interventions. These clients may have been seen by their therapists as being resistant and consequently rated as making less active attempts to address their difficulties and in turn as more in need of a therapist's expertise to accomplish gains. Clients who were less accepting of a responsibility/control orientation may have related to their therapists in a compliant manner and were thus rated as displaying more appropriate activity and requiring less assistance from the therapist. This explanation is further supported by the observation that clients displaying severe psychopathology, including very passive behavior thought to be associated with very low scores on the Responsibility/Control Dimension, are underrepresented among the moderately well-adjusted treatment population of a university mental health service. Thus, what may be an inverted-U shaped relationship across the full range of psychopathology appears to be a linear relationship between responsibility and therapeutic activity and dependency upon the therapist in the sample employed in this study.

Overall, the findings of this investigation possess considerable import for the study of psychotherapeutic processes, including help-seeking behavior and premature termination. Further exploration of clients' mental health ideology and their behavior during treatment sessions is recommended. On a practical level, clinicians who are concerned about attracting and maintaining participants in counseling need to be sensitive to their clients' mental health ideology.

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