UNIVERSIDADE D
COIMBRA

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EXPECTATIONS SCALE FOR FAMILY THERAPY (ESFT): DEVELOPMENT AND PSYCHOMETRIC PROPERTIES

Dissertação no âmbito do Mestrado Integrado em Psicologia, área de especialização em Psicologia Clínica e da Saúde, subárea de especialização em Psicoterapia Sistémica e Familiar, orientada pela Professora Doutora Luciana Maria Lopes Sotero e pela Professora Doutora Cristina Günther Bel e apresentada à Faculdade de Psicologia e de Ciências da Educação.

Julho de 2020

Escala de Expetativas para a Terapia Familiar (EETF): Desenvolvimento e propriedades psicométricas

No contexto de psicoterapia, as expetativas dos clientes são consideradas um fator comum bastante importante porque influenciam o processo terapêutico de mudança, a eficácia, o envolvimento na terapia e a aliança terapêutica. Todavia, a investigação sobre as expetativas dos clientes na terapia familiar é escassa, bem como os instrumentos que permitem avaliar as expetativas nesta modalidade terapêutica. O objetivo geral deste estudo é então desenvolver um instrumento que permita avaliar as expetativas dos clientes na terapia familiar, a Escala de Expetativas para a Terapia Familiar (EETF). Para tal foi recolhida uma amostra de 257 participantes, com idades entre os 18 e 69 anos, a quem foi aplicado um protocolo de investigação composto por um consentimento informado, um questionário sociodemográfico, a Escala de Expetativas para a Terapia Familiar (EETF), a Escala de Auto-Eficácia Geral (GSE), o *Systemic Clinical Outcome Routine Evaluation* (SCORE-15), a dimensão Propensão para a Procura de Ajuda do Inventário de Atitudes face à Procura de Serviços de Saúde Mental (IAPSSM) e a Escala de Expetativas de Melhoria (EEM). Em termos de validade de constructo e fiabilidade, os resultados obtidos mostraram que a EEFT tem uma estrutura fatorial composta por três fatores e indicadores de consistência interna que variam entre o bom e o aceitável (*Outcome* $\alpha = .85$, *Self* $\alpha = .70$ e *Others* $\alpha = .67$). Em termos de validade convergente, verificou-se que os fatores *Outcome* e *Self* se correlacionaram de forma significativa e positiva com a dimensão Propensão para a Procura de Ajuda e com a EEM. Por sua vez, o fator *Others* apresentou uma correlação significativa e negativa com o SCORE-15. Neste estudo foram ainda encontradas diferenças estatisticamente significativas nos resultados da EETF em função do género e da experiência anterior em terapia. Embora seja necessário continuar a desenvolver estudos acerca das propriedades psicométricas da EETF, considera-se que este trabalho contribui de forma pioneira para a investigação e prática clínica ao disponibilizar a primeira escala de avaliação das expetativas dos clientes na terapia familiar. Neste sentido, a EETF permitirá usar as expetativas dos clientes em favor da terapia (por exemplo, tornando possível ao terapeuta adaptar a sua intervenção) e medir as expetativas em distintos momentos do processo terapêutico.

Palavras-chave: expetativas dos clientes; terapia familiar; processo terapêutico; estudos psicométricos; Escala de Expetativas para a Terapia Familiar.

Expectations Scale for Family Therapy (ESFT): Development and psychometric properties

In psychotherapy context, clients' expectations are considered a very important common factor because they influence the therapeutic process of change, the effectiveness, the involvement in therapy and the therapeutic alliance. However, the investigation in clients' expectations about family therapy is scarce, as well as the instruments that allow to assess expectations in this therapeutic modality. The general aim of this study is then to develop an instrument that allows to assess clients' expectations in family therapy, the Expectations Scale for Family Therapy (ESFT). For this purpose, it has been collected a sample of 257 participants, aged between 18 and 69 years old, to whom it was applied an investigation protocol constituted by an informed consent, a sociodemographic questionnaire, the Expectations Scale for Family Therapy (ESFT), the General Self-Efficacy Scale (GSE), the Systemic Clinical Outcome Routine Evaluation (SCORE-15), the dimension Help-Seeking Propensity of the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS) and the Improvement Expectations Scale (IEM). In terms of construct validity and reliability, the results obtained showed that the ESFT has a factorial structure composed of three factors and internal consistency indicators that vary between good and acceptable (Outcome α = .85, Self α = .70 and Others α = .67). In terms of convergent validity, it was found that Outcome and Self factors were significantly and positively corelated with the dimension Help-Seeking Propensity and the IEM. In its turn factor Others was significantly and negatively correlated with SCORE-15. In this study, statistically significant differences were also found in the results of the ESFT according to gender and previous experience in therapy. Although it is necessary to continue to develop studies about the psychometric properties of the ESFT, it is considered that this work contributes in a pioneering way to research and clinical practice by providing the first scale to assess clients' expectations in family therapy. In this sense, the ESFT will allow to use clients' expectations in favor of therapy (for example, making it possible for the therapist to adapt the intervention) and measure expectations at different times in the therapeutic process.

Key Words: clients' expectations; family therapy; therapeutic process; psychometric studies; Expectations Scale for Family Therapy.

Agradecimentos

À Professora Doutora Luciana Sotero pela dedicação, acompanhamento, partilha de sabedoria e orientação nestes últimos dois anos.

À Professora Doutora Cristina Günther pela simpatia e disponibilidade em me acompanhar e orientar neste trabalho.

Aos meus pais que permitiram que todo este percurso fosse possível e que me apoiaram sempre em todas as minhas decisões.

Ao meu namorado pela paciência para me ouvir mesmo quando não percebe nada e por ter estado sempre ao meu lado nestes últimos cinco anos.

À minha tia Cristina Gouveia que fez parte do desenvolvimento deste estudo ajudando no processo de tradução do instrumento e nos aspetos gramaticais do Inglês.

À minha família e amigos mais próximos que me acompanharam e me ajudaram na divulgação do estudo e na recolha da amostra.

Às minhas colegas de turma pelo apoio, união e companheirismo vivenciado. Um agradecimento especial à Ana Rita por ter feito esta caminhada comigo, à Beatriz Pires por todas as partilhas e à Alexandra, Daniela, Raquel e Tatiana pela integração que me proporcionaram.

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Introduction

Expectancy is one of the four common factors that contribute to change in therapy (Thomas, 2006). As defined by Nock and Kazdin (2001), expectations are the “anticipatory beliefs that clients bring to treatment” (p. 155). Client positive expectations influence the outcome of the therapeutic process, behavior toward seeking help, continuity in therapy and the development of a strong therapeutic alliance (Tambling, 2012). Indeed, expectations about therapy can be a determinant factor for the effectiveness of the therapy and this highlights the importance of measuring expectations before, during and after treatment (Villamarín, 1987).

However, although the clients’ expectations play an important role in the therapeutic process, its empirical study has been underestimated, there is only a few studies that assess expectations (Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011; Greenberg, Constantino, & Bruce, 2006). Particularly in family therapy there is a scarcity of empirical studies about expectations and a lack of measurements to assess them (Heafner, Kang, Ki, & Tambling, 2016). At present there is only one instrument that measure expectations and can be used in family therapy, the *Parent Expectancies for Therapy Scale* (PETS; Nock & Kazdin, 2001). In fact, it is required more investigation to develop or improve expectations measurements, that allow to increase and enhance the research on clients’ expectations about family therapy (Tambling, 2012).

Based on a recently developed measure to couple therapy, the *Expectations and Preference Scales for Couple Therapy* (Friedlander et al., 2019), the aim of this study is to create a measure to assess the clients’ expectations in family therapy, namely the *Expectations Scale for Family Therapy* (ESFT) and to conduct the respective psychometric studies in a Portuguese community sample. This study will provide the first Portuguese measure to evaluate the clients’ expectations about family therapy and will make available to researchers and clinicians a brief and practice-friendly measure, that allow to monitor pretreatment and during treatment clients’ expectations in family therapy.

I - Conceptual framework

1.1 Common factors in psychotherapy and in family therapy

Common factors are elements of therapy that are not specific to any approach, model or technique and that contribute to the therapeutic process of change and the effectiveness of therapy (Dew & Bickman, 2005). Lambert (1992) proposed a four-factor model of change and estimated the percentage of variance in outcome due to each factor. The proposed model is constituted by 1) extra-therapeutic change factors, 2) common factors, 3) technique factors and 4) expectancy factors. Miller, Duncan, and Hubble (1997) modified Lamberts' model and also estimated the percentages of the contribution to the process of change in therapy. The four common factors modified are: 1) client and extra-therapeutic factors (40%) – characteristics of personality and elements in the life and environment of the client, 2) relationship factors (30%) - strength of the therapeutic alliance, 3) model/techniques factors (15%) - theoretical orientation of the therapist, and 4) expectancy factors (15%) – clients' beliefs and hopes in the credibility of the treatment (Sprenkle & Blow, 2004; Thomas, 2006).

In marital and family therapy the research on common factors has been undervalued comparing to individual therapy (Sprenkle & Blow, 2004). According with Sprenkle, Davis, and Lebow (2009), there are four specific common factors for couple and family therapy, namely: 1) conceptualizing difficulties in relational terms (conceptualizing problems in a biopsychosocial approach and in terms of dysfunctional interactional cycles), 2) disrupting dysfunctional relational patterns (interrupt or disrupt the dysfunctional or pathological interactional cycles that keep systems stuck), 3) expanding the direct treatment system (involve more than the identified/willing patient and working with direct and indirect treatment system), and 4) expanding the therapeutic alliance (the extent to which the client and therapist feel understood and emotionally connected). Specific common factors of relational therapies are applicable in individual psychotherapy and vice versa (Sprenkle et al., 2009). For instance, expectancy factors are not specifically used for family therapy, but they can be applicable in that modality.

1.2 The critical importance of clients' expectations in therapy

As stated previously, expectations can be defined has "anticipatory beliefs that clients bring to treatment" (Nock & Kazdin, 2001, p. 155) and they are ''probability statements regarding the likelihood that an event will occur . . . or a condition will exist'' (Tinsley, Bowman, & Ray, 1988, p. 100). In this sense, expectations englobe convictions that clients have about what happens in therapy before they do therapy.

The role of the expectations in therapy has not received the appropriate attention (Greenberg et al., 2006). However, the interest in this area has been increased because patients' expectations affect both the course and outcome of the treatment and posttreatment and contribute to client change (Greenberg et al., 2006; Heafner et al., 2016). In fact, clients' expectations are an important contribute to the engagement and effectiveness of the psychotherapy (Greenberg et al., 2006).

Clients' expectations related to psychotherapy can be about, process, outcome, clients, therapists, effectiveness, duration, techniques, alliance, intervention, also about who participates in therapy and so on (Dew & Bickman, 2005; Glass, Arnkoff, & Shapiro, 2001; Nock & Kazdin, 2001; Norberg, Wetterneck, Sass, & Kanter, 2011; Tambling, 2012; Villamarín, 1987). According to the literature, there is a diversity of expectations' types but the majority of the authors distinguish between outcome and process expectations (Dew & Bickman, 2005; Glass et al., 2001; Norberg et al., 2011; Tambling, 2012). The present study focuses on outcome expectations (e.g., "I expect that our family relationship will improve as a result of family therapy.") and role expectations for Self (e.g., "I expect to bring up my concerns for discussion.") and for family members (e.g., "I expect that my family members will be reluctant to talk with the therapist."), the two types of expectations that will be measured by the scale that will be develop.

The outcome expectation is the belief that a certain behavior will be followed by a certain consequence (Villamarín, 1987). In other words is the expectation that therapy leads to improvements (Greenberg et al., 2006), or the prognosis about the consequences of engaging in therapy (Constantino et al., 2011). Participants who thought that a behavior was more likely to result in a specific favorable outcome, expressed more confidence in performing that

behavior, than those who do not believed in a strong relation between that behavior and that outcome (Maddux, Sherer, & Rogers, 1982).

Process expectations are expectations about what will happen during therapy (Norberg et al., 2011; Tambling, 2012). Within the expectations' process there are role expectations and expectations about the duration of the treatment (Norberg et al., 2011). Role expectations are patterns of behavior considered as appropriate or expected of a person in a given situation (Glass et al., 2001; Tambling, 2012), that is how a person should behave in a determined situation (Greenberg et al., 2006). Clients have role expectations about the therapist and about themselves (Glass et al., 2001). When clients' role expectations about the therapist are met, the trust in the therapist and the client participation in the therapy increases (Greenberg et al., 2006). A study that investigated expectations about therapists showed that a group of undergraduate students expect the therapist to be confident, warmly, expert, interest in the client, problem centered and confidential (Tinsley & Harris, 1976). These expectations about the therapist differ according to the age and the sex of the participant, in general students showed higher expectations for talking about their concerns as well as in seeing an experienced therapist, on the other side expectations about seeing a therapist in training were lower (Tinsley & Harris, 1976). More recently, a study of Schneider and Klauer (2001) about clients' role expectations upon themselves, demonstrated that patients with higher expectations in being active and involved in psychotherapy showed more improvements regarding their interpersonal functioning from pre to posttreatment, than patients with lower expectations.

Expectations that do not met reality and negative expectations can lead to premature termination and dropout. These expectations are associated with poor attendance in therapy (Heafner et al., 2016). In its turn, premature termination and dropout reduces the effectiveness of the therapy (Norberg et al., 2011).

According to Dew & Bickman (2005), expectations are a malleable pretreatment client characteristic easy to affect and manipulate by pretreatment preparation. Research revealed that information given to the patients before the sessions, influenced their interpretation and experience of clinical situations (Dew & Bickman, 2005). Also, Greenberg and colleagues

(2006) proved that the manipulation of patients' pretreatment expectations has a positive influence on the quality of the therapeutic process, improvement and relation. Clients with negative expectations would benefit with manipulation of expectations during therapy (Norberg et al., 2011). Some examples of expectations' manipulation are through verbal instructions, counseling interviews, printed materials, videotapes and audiotapes (Dew & Bickman, 2005). Bonner and Everett (1986) assessed the effects of client preparation and found that parents and children who had listened a preparation audiotape with a simulated interview with a child therapist, before the first therapy session, showed more positive outcome expectations and appropriate role expectations about therapy, than the group who had not listened an audiotape (Bonner & Everett, 1986).

In sum, clients' expectations are important to therapy because they interfere and have impact in the process and outcome of therapy, they also contribute to the involvement and improvement. Empirical studies showed that positive/higher expectations improved more the therapeutic outcomes than negative/lower expectations.

1.3 Clients' expectations assessment

The literature review pointed important limitations regarding the clients' expectation assessment in psychotherapy. Namely, diverse studies have measured expectations but the differences between this construct and others constructs such as perception, preferences, motivation and credibility were not clear (Constantino et al., 2011). Another problem are the instruments used to assess expectations, there is not a standard measure (Dew & Bickman, 2005) and most of the measures are brief and idiosyncratic (Constantino et al., 2011; Norberg et al., 2011; Tambling, 2012). So, the studies founded in the literature used different instruments, some of them doubtful (Dew & Bickman, 2005) and with poor or unestablished psychometric properties. The majority of the instruments used to assess clients expectations are focused on outcome expectations and showed lack of sensitivity and reliability (Norberg et al., 2011).

In Table 1 it is synthesized a literature review of the quantitative measures to assess clients' expectations. As shown, the majority of the measures assess expectations in individual therapy and there is not a specific original measure developed to assess clients' expectations in family therapy. There is only one instrument developed to the individual therapy that can be used in family therapy, the *Parent Expectancies for Therapy Scale* (PETS; Nock & Kazdin, 2001). This scale is constituted by 25 items and three subscales (Credibility, Child Improvement and Parent Involvement), and measures pretreatment parent's expectations for their child's psychotherapy in a scale of 5 points, with lower scores corresponding to lower expectations about treatment and higher scores to higher expectations about treatment (Nock & Kazdin, 2001).

Table 1. Quantitative measures of clients' expectations

Measure	Type of Expectation	Treatment Modality
Credibility/Expectancy Questionnaire (CEQ; Borkovec & Nau, 1972)	Outcome	Individual
Patient Prognostic Expectancy Inventory (PPEI; Martin & Sterne, 1975)	Outcome	Individual
Expectations About Counseling (EAC; Tinsley, Workman, & Kass, 1980)	Process and Outcome	Individual
Expectations About Counseling – Brief Version (EAC-B; Tinsley, 1982)	Process and Outcome	Individual
Escala de expectativas de cambio (Echeburúa & Corral, 1987)	Outcome	Individual
Parent Expectancies for Therapy Scale (PETS; Nock & Kazdin, 2001)	Process and Outcome	Individual and Family
Psychotherapy Expectancy Inventory-Revised (PEI-R; Bleyen, Vertommen, Steene, & Audenhove, 2001)	Process	Individual
Patients' Therapy Expectation and Evaluation (PATHEV; Schulte, 2008)	Outcome	Individual
Milwaukee Psychotherapy Expectations Questionnaire (MPEQ; Norberg et al., 2011)	Process and Outcome	Individual
Expectations of Active Processes in Psychotherapy Scale (EAPPS; Bitan, Lazar, & Siton, 2018)	Process	Individual
Expectations and Preference Scales for Couple Therapy (EPSCT; Friedlander et al., 2019)	Process and Outcome	Couple

The lack of instruments developed to assess expectations in family therapy highlight the need of research in this area. As stated, the present study was inspired in the *Expectations and Preference Scales for Couple Therapy* (EPSCT) recently developed by Friedlander et al. (2019), a measure, to assess clients' expectations in couple therapy constituted by nine items and three dimensions: (1) Self - to assess participants' expectations of their own behavior, (2) Partner - to assess expectations about the partner's behavior and (3) Outcome - to assess expected results.

In assessing expectations, measures can be administered before the treatment, during treatment and after treatment (Villamarín, 1987). As described, clients have process expectations and outcome expectations and those expectations are not static, they vary throughout the therapeutic process (Friedlander et al., 2019). In this sense, it is important not to administer the instruments that measure expectations only once in the therapeutic process, but in several distinct moments (Villamarín, 1987). Regarding the timing of expectations assessment, there is not a consensus, some studies measured expectations before the beginning of the therapy, others measured after the beginning and others in various moments of the therapy (Dew & Bickman, 2005). However, previous assessment of expectations is very important because permits the therapist to adapt the first session (Dew & Bickman, 2005).

In summary, the existing measures to assess clients' expectations are insufficient and have some limitations, so it is needed more research in this area like improving the existing measures or developing new measures, particularly to evaluate clients' expectations in family therapy.

II – Objectives

Based on the *Expectations and Preference Scales for Couple Therapy* (EPSCT; Friedlander et al., 2019), the principal aim of this study is to develop the *Expectations Scale for Family Therapy* (ESFT) and to conduct the psychometric studies in a Portuguese community sample.

The specific objectives are:

i) To explore the construct validity of the ESFT through an exploratory factor analysis;

ii) To analyze the reliability of the ESFT through the Cronbach's alpha;

iii) To evaluate the convergent validity of the ESFT through the Pearson correlations with the GSE, SCORE-15, Help-Seeking Propensity dimension of IASMHS and IEM;

iv) To analyze the results of the ESFT according to sociodemographic variables (gender, age, current relational situation and experience in therapy).

III – Methodology

In this section are described the sociodemographic characteristics of the participants, the measures used and the adopted procedures to respond to the main and specific objectives.

3.1 Participants

The sample was constituted by 257 participants [214 participated online (83.27%) and 43 participated in person (16.73%)], 181 were female (70.4%) and 76 were male (29.6%), with ages between 18 and 69 (M = 32.19; SD = 12.13), with median equals to 26 and mode equals to 22. The majority of the participants were emerging adults (Arnett, 2000), with ages between 18 and 25 (47.1%), have a degree (35%), are single (58%), are working (68.1%), live in the Center sub-region of Portugal (58%) and in an urban area (49.4%) (see Table 2).

In relation to the household, 142 participants live with at least one parent, with or without siblings (55.3%), 85 live with their partner, with or without children (33.1%), six live alone (2.3%), 12 live only with their children (4.7%), one with their grandparents (0.4%) and three do not fit into any of the previous groups (1.2%).

Relatively to past experience in therapy, 53 participants attended therapy (20.6%) and 10 are currently attending individual therapy (3.9%). Of the 53 participants that attended therapy in the past, 51 attended individual therapy (96.2%) and two couple therapy (3.8%) (see Table 3).

Table 2. Sociodemographic characteristics of the sample

		N	%
Gender	Female	181	70.4
	Male	76	29.6
Age	18-25	121	47.1
	26-35	49	19.1
	36-45	44	17.1
	46-55	28	10.9
	56-65	14	5.4
	>65	1	0.4
Level of schooling	4th year	1	0.4
	6th year	2	0.8
	9th year	11	4.3
	12th year	84	32.7
	Degree	90	35.0
	Master' degree	57	22.2
	PhD	5	1.9
	Other	7	2.7
Current relation situation	Single	149	58.0
	Non-marital partnership	29	11.3
	Married	64	24.9
	Separate/Divorced	12	4.7
	Remarried	3	1.2
Residence area	Urban	127	49.4
	Moderately urban	70	27.2
	Rural	60	23.3
Profession	Student	62	24.1
	Working student	1	0.4
	Worker	175	68.1
	Unemployed	8	3.1
	Retired	1	0.4
	Missings	10	3.9
Sub-regions from Portugal	North	50	19.5
	Center	149	58.0
	Metropolitan Area of Lisboa	25	9.7
	Alentejo	14	5.4
	Algarve	11	4.3
	RAA	4	1.6
	RAM	2	0.8
	Missings	2	0.8
Household	Parent(s)	142	55.3
	Partner	85	33.1
	Alone	6	2.3
	Only with their children	12	4.7
	Grandparents	1	0.4
	Others	3	1.2
	Missings	8	3.1

Note: RAA - Autonomous Region of Açores; RAM - Autonomous Region of Madeira

Table 3. Sample data regarding experience in therapy

		N	%
Past experience in therapy	Yes	53	20.6
	No	204	79.4
Current therapy experience	Yes	10	3.9
	No	247	96.1

3.2 Measures

The research protocol developed to the present study is constituted by a sociodemographic questionnaire and five self-report measures that will be described below.

3.2.1 Sociodemographic questionnaire

The sociodemographic questionnaire was built to this study to collect participants' data, namely the gender, age, level of schooling, current relational situation, residence area, profession, residence district, household members and past experience and attendance in therapy.

3.2.2 Expectations Scale for Family Therapy (ESFT)

The ESFT was developed for this study, inspired in the *Expectations and Preference Scales for Couple Therapy* (EPSCT) of Friedlander et al. (2019). The EPSCT is composed by two scales, one of them to measure clients' expectations in couple therapy and the other to evaluate clients' preferences for interventions (Cognitive-Behavioral, Emotionally-Focused and Family Systems). In the present study we just describe the expectations scale because it is focused on the research topic.

The original scale refers to couple therapy so to develop the ESFT the instructions and the items were adapted to family therapy, mentioning family members and family therapy instead of partners and couple therapy.

Like the expectations scale of the EPSCT, the EETF is composed of nine items, three for each dimension: Self – items 3, 4 and 6 (e.g., "I expect to bring up my concerns for discussion."), Others – items 1, 7 and 8 (e.g., "I expect that my family will be reluctant to talk with the therapist.") and

Outcome – items 2, 5 and 9 (e.g., "I expect that our family relationship will improve as a result of family therapy."), that measure what people might expect to happen in family therapy. Items are quoted on a Likert scale from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*), with higher scores representing more favorable clients' expectations about family therapy. Items 1, 7 and 8 are reversed.

Concerning the reliability, the psychometric properties of the original study showed a good internal consistency α = .84 (Outcome), α = .80 (Self) and α = .75 (Partner) (Friedlander et al., 2019). In the present study the Cronbach's alpha values are α = .85 (Outcome), α = .70 (Self) and α = .67 (Others).

3.2.3 General Self-Efficacy Scale (GSE; Schwarzer & Jerusalem, 1995; Portuguese version of Araújo & Moura, 2011)

The GSE assesses the general feeling of personal competence to deal effectively with stressful situations. It is a one-dimensional scale constituted by 10 items (e.g., "I can usually handle whatever comes my way."), measured on a Likert-type scale from 1 (*Not at all true*) to 4 (*Exactly true*), with higher scores representing higher general self-efficacy. The GSE Portuguese version presents good psychometric properties with the Cronbach's alpha equals to .87 (Araújo & Moura, 2011). In the present study the alpha is equal to .85.

3.2.4 Systemic Clinical Outcome Routine Evaluation (SCORE-15; Stratton et al., 2014; Portuguese version of Vilaça, Silva, & Relvas, 2014)

The SCORE-15 is a self-report scale that measure several aspects of family functioning that are sensitive to therapeutic change. SCORE-15 is constituted by 15 items, five for each one of the three dimensions: 1) Family Resources – items 1, 3, 6, 10 and 15 (e.g. "We are good at finding new ways to deal with difficulties."); 2) Family Communication – items 2, 4, 8, 12 and 13 (e.g., "In my family we often don't tell each other the truth.") and 3) Family Difficulties – items 5, 7, 9, 11 and 14 (e.g, "Things always seem to go wrong for my family."). The participants respond on a Likert scale from 1 (*Describes us: Very well*) to 5 (*Describes us: Not at all*), with higher scores representing

more family difficulties. Items 2, 4, 5, 7, 8, 9, 11, 12, 13 and 14 can be inverted. The original study of the Portuguese version showed a good internal consistency for the total score and the dimensions, namely: α = .84 (Total), α = .85 (Family Resources), α = .83 (Family Communication) and α = . 82 (Family Difficulties) (Vilaça et al., 2014). In the present study the Cronbach's alfa values are α = .61 (Total), α = .89 (Family Resources), α = .81 (Family Communication) and α = . 82 (Family Difficulties).

3.2.5 Inventory of Attitudes toward Seeking Mental Health Services (IASMHS; Mackenzie, Knox, Gekoski, & Macaulay, 2004; Portuguese version of Fonseca, Silva, & Canavarro, 2017)

The IASMHS assesses attitudes towards seeking formal help to deal with mental health problems. It is composed of 24 items, eight for each dimension: 1) Psychological Openness – items 1, 4, 7, 9, 12, 14, 18, 21; 2) Help-Seeking Propensity – items 2, 5, 8, 10, 13, 15, 19, 22; and 3) Indifference to Stigma – items 3, 6, 11, 16, 17, 20, 23, 24. Items are quoted on a Likert-type scale from 0 (*Disagree*) to 4 (*Agree*), with higher scores indicating more positive attitudes towards seeking formal help. Items 1, 3, 4, 6, 7, 9, 11, 12, 14, 16, 17, 18, 20, 21 and 24 are inverted.

In the present study it was only used the dimension Help-Seeking Propensity of the IASMHS to measure availability and perceived capacity to seek help for psychological problems (e.g., "I would want to get professional help if I were worried or upset for a long period of time.").

The original study of the Portuguese version presents acceptable psychometric qualities with the Cronbach's alpha of the dimension Help-Seeking Propensity equals to .75 (Fonseca et al., 2017). In the present study it was verified a very good internal consistency with the Cronbach's alpha equals to .82.

3.2.6 Improvement Expectations Scale (IEM; adapted version of Echeburúa & Corral, 1987)

To measure the degree of improvements' confidence as a result of a psychological treatment, it was created a scale inspired in the Change

Expectations Scale (Echeburúa & Corral, 1987), consisting of only one item evaluated on a Likert-type scale from 0 (*Nothing*) to 10 (*Very Much*), with higher scores representing higher confidence in the effectiveness of the treatment.

3.3 Procedure

It was analyzed and discussed the instruments used to evaluate the construct validity of the ESFT, these instruments were chosen according to those used in the original study and were selected instruments validated for the Portuguese population. After the authors' authorization to use their instruments and the cross-cultural adaptation process of the ESFT, it was built the research protocol constituted by the measures described above to study the validity of the ESFT.

In order to adapt the expectations scale of the EPSCT for family therapy, it was used a cross-cultural adaptation process suggested by Gjersing, Caplehorn, and Clausen (2010): 1) two translations (English-Portuguese) of the expectations scale for couple therapy made by two experts in both languages, 2) synthesis of the two translations by the research team, 3) two back-translations (Portuguese-English) made by two new experts in both languages, 4) synthesis of the two back-translations by the research team, 5) comparisons of the synthesized back translation with the original instrument in English. After all this process, and with a Portuguese translation of the *Expectations Scale for Couple Therapy,* it was adapted a Portuguese version for family therapy, the Expectations Scale for Family Therapy, replacing couple therapy with family therapy and partner with family members in the instruction and all items except item 3.

After finishing the research protocol, it was made a pilot study ($n = 4$) to gather information about the duration of the form fill, the clearness of the instructions and items, as well as suggestions of alterations. According to this, it was added the following sentence to the ESFT and IEM instructions "Please consider each statement as if you are considering starting Family Therapy, even if you have never done Family Therapy or have no intention of seeking professional help in the future.". Finally, it was concluded the online protocol done in the LimeSurvey software and it was also concluded the paper protocol.

This study was constituted by a community sample, collected using a non-probabilistic method, a convenience and snowball sample. The online and presential sample were recruited through virtual and personal social networks. The inclusion criteria were participants with at least 18 years and having Portuguese nationality. The exclusion criteria were participants who were professionals of mental health (e.g., psychologists, psychiatrists) and/or professionals of other areas with specific formation on family/couple therapy.

The data collection process took place between January and May of 2020. Participants took 10/15 minutes to fill the research protocol organized and composed as described: 1) the informed consent request, that guaranteed the confidentiality of the participants and explained synthetically the main goal of the current study, 2) the sociodemographic questionnaire, 3) the ESFT, 4) the GSE, 5) the SCORE-15, 6) the dimension Help-Seeking Propensity of the IASMHS and 7) the IEM. Due to the worldwide pandemic of COVID-19 the presential data collection could not be concluded as expected.

3.4 Statistical analysis

Finished the data collecting process, the analysis process has begun, and it was used the software IBM SPSS Statistics 22 for the statistical treatment of data. To perform data analysis it was necessary to group some sociodemographic variables, age was categorized in six groups, professions in five groups, household in six groups and the residence districts were grouped accordingly to NUTS II (INE, 2015).

It was used the Exploratory Factor Analysis (EAF) through Principal Component Analysis with Varimax Rotation to determine the factorial structure of the set of variables and the number of latent constructs (factors). It was preferred the EFA instead of Confirmatory Factor Analysis (CFA), to test the adequacy of the model to our sample without imposing any preconceived structure. The fact that there is little theory, only one study about the original instrument EPSCT and its common factors also contributed to this choice (Fabrigar, Wegener, MacCallum, & Strahan, 1999).

To measure the internal consistency of the ESFT it was used the Cronbach's alpha because the items were measured in an ordinal scale. To

verify if there were significant differences between the scores of the three dimensions of the ESFT, it was performed the Friedman and Wilcoxon Test. The convergent validity was measured through Pearson correlations. Finally, to evaluate the sociodemographic comparison, were realized independent-samples t-test, one-way between-groups ANOVA and the Kruskal-Wallis Test.

IV - Results

4.1 Construct Validity: Exploratory Factor Analysis (EAF)

The Kaiser-Meyer-Olkin Test was .749 (> .6), showing a good adequacy of the sample, and the Bartlett's Test of Sphericity was significant ($p < 0.001$), meaning that exist a significant association between the items of the ESFT, with these values it can be concluded that the factor analysis is appropriate (Pallant, 2011).

The proposed solution extracted 3 factors with eigenvalues > 1, the same as the scree plot (see Annex A), and the total explained variance was 67.98% (Yong & Pearce, 2013).

Through the Rotated Component Matrix it can be seen that items 9, 5 and 2 belong to Factor 1, items 4, 3 and 6 to Factor 2 and items 1, 8 and 7 to Factor 3 (see Table 4). Items loading was higher than 0.5 (Dancey & Reidy, 2017). In the present study Factor 1 correspond to Outcome, Factor 2 to Self and Factor 3 to Others.

Table 4. Exploratory factor analysis (Varimax rotation) of the ESFT

Items	Factors		
	1	2	3
9	.887		
5	.823		
2	.780		
4		.831	
3		.801	
6		.591	
1			.825
8			.814
7			.659
% explained variance	25.971	21.388	20.625

4.2 Reliability of the ESFT

The Cronbach's alpha for dimension Outcome was equal to .85, classified as very good, for the dimension Self α = .70, classified as respectable, and for the dimension Others α = .67, classified as minimally acceptable (DeVellis, 2012). Only in the dimension Others, if removing the item 7, the Cronbach's alpha would increase to .74. Corrected item-total correlations are all above .3, showing that items represent the construct that each dimension intends to measure (see Table 5) (Pallant, 2011).

4.3 Descriptive statistics of the ESFT

The results of the Friedman Test indicated that there was a statistically significant difference in the scores of the three dimensions of the ESFT X^2 (3, N = 253) = 471.05, p < .001. The Wilcoxon Test revealed that between dimension Self (*Md* = 12) and Outcome (*Md* = 11) *Z* = -5.87, Self and Others (*Md* = 9) *Z* = -7.21 and Outcome and Others *Z* = -9.62 there were significant differences with all $p < .001$. Concluding, one can say that participants reported higher expectations for Self then for Outcome and then for Others.

Table 5. Items, descriptive statistics and reliability of ESFT

Items	*M*	*DP*	Mode	Amplitude	Skewness	Kurtosis	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Self	11.69	1.97	12	4-15	-0.62	0.84		
3. I expect to bring up my concerns for discussion.	3.84	0.84	4	1-5	-0.91	1.23	.63	.45
4. I expect to listen to my family members concerns.	4.16	0.67	4	1-5	-1.14	4.03	.48	.65
6. I expect to talk about how my personal problems affect the family relationship.	3.69	0.97	4	1-5	-0.95	0.67	.47	.69
Others	9.23	2.49	8	3-15	0.16	-0.12		
1.[a] I expect that my family members will be reluctant to talk with the therapist.	2.93	1.13	2	1-5	0.11	-0.89	.57	.43
7.[a] I expect that my family will blame me.	3.64	1.01	4	1-5	-0.46	-0.32	.34	.74
8.[a] I expect that my family members will be reluctant to discuss personal matters with the therapist.	2.66	1.07	2	1-5	0.35	-0.52	.54	.48
Outcome	10.89	2.22	12	4-15	-0.57	0.43		
2. I expect that our family relationship will improve as a result of family therapy.	3.62	0.83	4	1-5	-0.55	0.13	.68	.83
5. I expect that my family members and I will feel better about our relationship as a result of family therapy.	3.76	0.86	4	1-5	-0.61	0.43	.74	.77
9. I expect that my family members will feel better about our relationship as a result of family therapy.	3.51	0.84	4	1-5	-0.48	0.58	.74	.77

[a]Inverted items

4.4 Convergent Validity

In relation to the dimension Self, it was only founded significant correlations with the dimension Help-Seeking Propensity ($R^2 = 9.2\%$) and the IEM ($R^2 = 13.8\%$), it was found a positive and weak correlation, meaning that self-expectations about family therapy were associated with propensity to seek professional help and confidence of improvement as a result of a psychological treatment (Dancey & Reidy, 2017).

Dimension Others was only significant correlated with the SCORE-15 ($R^2 = 17.6\%$), it was found a negative and moderate correlation, showing that more difficulties in family (higher scores in SCORE-15) were associated with unfavorable expectations about family members in family therapy.

Concerning the dimension Outcome, it was only founded significant correlations with dimension Help-Seeking Propensity ($R^2 = 8.9\%$) and IEM ($R^2 = 21.5\%$), it was found a positive association with weak and moderate correlation respectively, showing that favorable outcome expectations about family therapy were associated with propensity to seek professional help and confidence of improvement as a result of a psychological treatment. Correlation coefficients and *p* values are described in Table 6.

Table 6. Convergent validity of the ESFT

	Self	Others	Outcome
GSE	-.015	.080	-.081
SCORE-15	-.023	-.419***	-.008
Dimension Help-Seeking Propensity	.303***	.102	.299***
IEM	.371***	-.017	.464***

*** $p < .001$

4.5 Sociodemographic comparisons

4.5.1 Gender

An independent-samples t-test was conducted to compare the dimensions of the ESFT scores for males and females. There were significant differences in dimension Self scores for females (M = 11.99, SD = 1.84) and males (M = 10.96, SD = 2.095); $t\,(123.62) = -3.72, p < .001, d = 0.52$ (medium effect size), with a confidence interval of 95% between -1.59 and -.488. There were significant differences in dimension Outcome scores for females (M = 11.16, SD = 2.25) and males (M = 10.24, SD = 2.02); $t\,(255) = -3.10, p = .002$,

d = 0.43 (small effect size), with a confidence interval of 95% between -1.51 and -.34. The results showed that gender affects self and outcome expectations, women had more favorable self and outcome expectations relatively to family therapy than men (Cohen, 1988).

4.5.2 Age

A Kruskal-Wallis Test did not reveal a statistically significant difference in the three dimensions of the ESFT across six different age groups (see Table 7).

Table 7. Median of the ESFT scores for age

Age	Self	Outcome	Others
18-25	12.00	11.00	9.00
26-35	12.00	11.00	9.00
36-45	12.00	12.00	10.00
46-55	12.00	11.00	9.50
56-65	11.50	11.00	10.00
>65	12.00	13.00	12.00

4.5.3 Current relational situation

A one-way between-groups ANOVA was conducted to explore the impact of current relational situation on the three dimensions of the ESFT. There was not a statistically significant difference in the three dimensions scores for the five current relational situations groups (see Table 8).

Table 8. Means and (standard deviations) of the ESFT scores for current relational situation

Current relational situation	Self	Outcome	Others
Single	11.65 (1.97)	10.88 (2.16)	9.09 (2.48)
Non-marital partnership	12.21 (1.72)	11.48 (2.03)	9.21 (2.64)
Married	11.52 (2.11)	10.59 (2.25)	9.41 (2.48)
Separate/Divorced	11.83 (1.64)	11.08 (2.78)	9.58 (2.28)
Remarried	12.00 (3.00)	11.00 (4.00)	11.33 (3.22)

4.5.4 Experience in therapy

An independent-samples t-test showed that there were only significant differences between participants who had attended therapy (M = 11.43 SD =

2.09) and who had not (M = 10.75 SD = 2.23) in dimension Outcome t (255) = -2.03, p = .044, d = 0.31 (small effect size), with a confidence interval of 95% between -1.36 and -.019. Showing that experience in attending therapy affects outcome expectations about family therapy, participants who had attended therapy showed more favorable outcome expectations than those who had not (Cohen, 1988).

V - Discussion

The principal objective of the present study is to develop the Expectations Scale for Family Therapy and contribute to reducing the scarcity of instruments that measure clients' expectations in family therapy. This study allowed the development of the first scale for assessing client expectations in family therapy. The psychometric studies performed permit to affirm that the ESFT presents good indicators of reliability and validity.

In respect of construct validity, it was obtained the same factorial structure and the items corresponding to each factor of the original study (Friedlander et al., 2019). The three dimensions are: 1) Self - that evaluates role expectations for self, this is how people expect to behave during family therapy and the items refer to the client being involved in the therapy and talking to the therapist; 2) Outcome – that assesses outcome expectations, how people expect family therapy results to be and items referring to how the family relationship will be as a result of family therapy and 3) Others – that measure role expectations for family members, how people expect their family members to behave during family therapy and items referring to reluctance to talk to the therapist and blame (Friedlander et al., 2019).

Relative to internal consistency, the Cronbach's alphas for the three dimensions of the ESFT in the present study were similar to the original study (Friedlander et al., 2019), in order from highest to lowest, being the internal consistency better in dimension Outcome then Self and then Others/Partner. However, the original study presents better internal consistency for dimension Self and Partner with respectable and very good alphas (DeVellis, 2012). Removing the item 7 "I expect that my family will blame me" would increase the internal consistency of the dimension Others. Though the literature claim that each factor should have at least three variables (Fabrigar et al., 1999;

Yong & Pearce, 2013). With these results, item 7 should be changed instead of being removed. Analyzing item-total correlation, it can be verified that item 7 adequately represents the construct that the factor intends to measure. One possible change would be clarifying the content of the item, for example “I expect that my family will blame me for our family problems” or “I expect that my family will blame me for being in therapy”.

One result that supports the results of the original study is the existence of significant differences between the three dimensions of the ESFT, in both studies the mean of the dimension Self is higher than dimension Outcome and the mean of dimension Outcome is higher than dimension Others/Partner (Friedlander et al., 2019). This indicates that participants in both studies reported more favorable expectations for their own behavior in therapy, then for the outcome of the therapy and in last for the behavior of their family members/partners in therapy. In other words, participants showed higher favorable expectations for what depends on them (their own behavior) and lower favorable expectations for what depends on others (their family’s behavior).

The convergent validity shows that Self expectations about family therapy are positively associated with dimension Help-Seeking Propensity and the IEM. This corroborates the results of the original study, in which participants with favorable role expectations reported more positive attitudes about help seeking (Friedlander et al., 2019). Our results also corroborate those of Norberg, Wetterneck, Sass, and Kanter (2011) that stated that lower process expectations are associated with a reduced likelihood of participating in therapy. The results demonstrate that more difficulties in family (higher scores in SCORE-15) are negatively associated with unfavorable expectations about family members in family therapy (lower scores in dimension Others). In other words, participants who have less family difficulties show more favorable expectations about their family members in family therapy. This suggests that family functioning affects the way people see their family members in therapy. In Friedlander et al. (2019) study about couples it was verified that couples who perceived themselves as functioning well tended to have more favorable Self and Outcome expectations, unlike our study in which Self and Outcome expectations about family therapy were not

significantly correlated with family functioning. Between dimension Outcome of the ESFT and dimension Help-Seeking Propensity of the IASMHS and the IEM there is a significant and positive association, showing that favorable outcome expectations about family therapy are associated with the propensity to seek professional help and confidence of improvement as a result of a psychological treatment. These results support those of the original study that showed that participants with favorable outcome expectations reported more positive attitudes about help seeking (Friedlander et al., 2019). Vogel, Wester, Wei, and Boysen (2005) also verified that positive or negative outcome expectations influenced intentions and attitudes to seek professional help. Greenidge (2007) affirmed that people were more likely to seek professional help if they believed that the therapy would lead to a decrease in their symptoms or other positive outcomes.

Regarding to sociodemographic comparisons, gender influence differently Self and Outcome expectations about family therapy, women show more favorable expectations than men. These findings corroborate the original study, in which women reported significantly higher self-expectations than their partners (Friedlander et al., 2019). Our results also supported the ones of Bleyen, Vertommen, Steene, and Audenhove (2001) study, in which females had higher role expectations than males, and Tinsley, Workman, and Kass (1980) results that showed that women had stronger expectations than men.

Comparing participants who attended therapy and participants who did not, it was verified that experience in attending therapy influence outcome expectations. Namely, participants who attended therapy show more favorable outcome expectations about family therapy than those who did not attended. Constantino, Arnkoff, Glass, Ametrano, and Smith (2011) states that expectations about the future are affected by learning experiences and suggests that a positive treatment experience may influence future treatment experiences positively. Our results corroborate the results of Kakhnovets (2011) study that also found significant differences between those who had previous counseling experience and those who had not. However, our findings refute the results of Norberg et al, (2011) study that discovered that those who participated in therapy and those who did not had equally high outcome expectations.

This study contributes to clinical practice allowing to evaluate clients' expectations about family therapy, particularly in what they expect it will happen during therapy and how the results will be. Clients' expectations are important to therapy because they influence the effectiveness, the involvement and the process of change (Greenberg et al., 2006). It is very important to measure clients' expectations before the first session, because by knowing clients' expectations about therapy, therapists can adapt the intervention and improve clients' negative expectations (Dew & Bickman, 2005; Norberg et al., 2011).

5.1 Limitations and suggestions for future studies

The current study presents limitations due to the non-probabilistic nature of the collecting sampling, which was recruited through convenience and snowball methods, that contributed to a more homogeneous sample. Future studies should consider the psychometric properties of the ESFT with more heterogeneous samples. This will allow to determine whether the ESFT performs similarly across different samples.

Another limitation is the fact that it was not realized a test-retest to analyze the temporal stability. Due to the conditions of isolation experienced due to the world pandemic COVID-19, the presential collection could not be concluded. An analysis that should be done in the future with the ESFT is the test-retest to measure the temporal stability, to perceive if the results are similar in different moments of application (Souza, Alexandre, & Guirardello, 2017).

Relatively to the ESFT and item 7, more research is needed to replicate our results and to see if item 7 really needs alterations. If our findings are corroborated, a literature review is needed about role expectations, specifically expectations about the behavior of family members during therapy sessions.

Also, replicating these results in a clinical sample would provide strong validity for the measure and would enable the different characteristics of clients' expectations to be compared within a community sample. Regarding family process research, it is also interesting to study a clinical sample to verify if there are differences in clients' expectations in several

stages of family therapy (before, during and at the end of the treatment, for instance).

There is a lot of studies that assess outcome expectations, and more research is needed about process expectations, mainly role expectations about how clients expect themselves to behave in therapy and how clients expect their family members to behave in therapy. It was very difficult to compare our results with the literature because of the lack of research in this area.

VI - Conclusions

The present thesis shows the importance of assessing expectations in family therapy and provides the first instrument to assess expectations about family therapy. The results demonstrated that the ESFT presents a three-factor model with acceptable internal consistency. It was found significant differences between the three dimensions of the ESFT and it was verified that Self and Outcome expectations about family therapy were positively correlated with propensity to seek professional help and confidence of improvement as a result of a psychological treatment. Another conclusion is that expectations for family members about family therapy were negatively correlated with family functioning. It was also discovered that gender and experience in therapy influenced significantly ESFT scores.

Although it is necessary to continue to develop studies about the psychometric properties of the ESFT, this scale is a reliable instrument, useful to the clinical practice and investigation, that enables a better understanding of expectations in family therapy. In clinical practice it will be possible to measure expectations in several stages of the therapeutic process and with the use of a measurement tool it is also permitted to check how the expectations are changing through the course of therapy and if the initial expectations coincide with the outcome of the therapy (Heafner et al., 2016). Therapists will be allowed to know their clients' expectations and use those expectations in therapy favor, this capacity to assess expectations permits the therapists to adjust the intervention (Heafner et al., 2016). It is proven that information given to the patients prior the first therapy session has a positive influence on the quality of the therapeutic process, improvement and relation (Greenberg et al., 2006).

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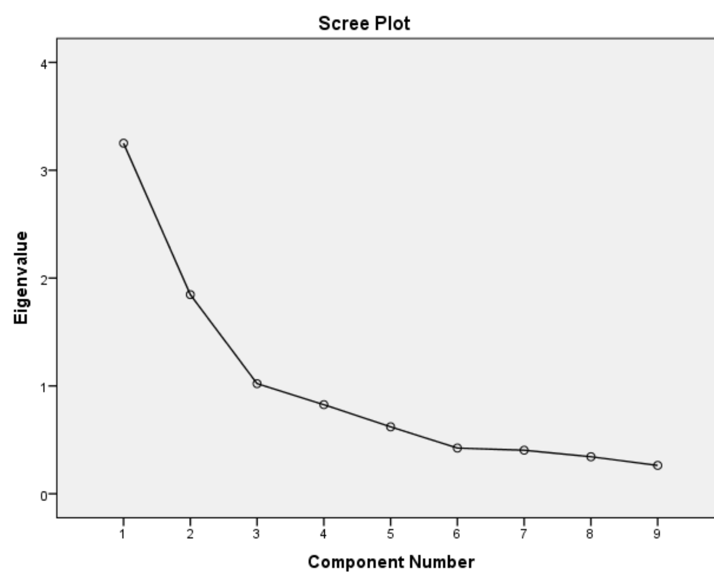
Annexes

Annex A - Scree Plot of the Exploratory Factor Analysis of the ESFT



Annex B – Informed consent

Caro(a) Participante:

Vimos pedir a sua colaboração para o projeto de investigação "**Avaliação das Expetativas na Terapia de Casal e Familiar**", que está a ser desenvolvido na Faculdade de Psicologia e de Ciências da Educação da Universidade de Coimbra.

Qual o objetivo do estudo?

O presente estudo tem como objetivo principal desenvolver para Portugal duas escalas de avaliação das expetativas na Terapia de Casal e Familiar.

Quem pode participar?

Qualquer pessoa com **idade igual ou superior a 18 anos** e de **nacionalidade portuguesa**, à exceção de profissionais de saúde mental (e.g., psicólogos, psiquiatras) e/ou profissionais de áreas afins com formação específica em terapia familiar ou de casal.

Como posso participar?

A participação é **voluntária** e **confidencial** e, para participar, pedimos que responda ao conjunto de questões que se seguem. Informamos que não existem respostas certas ou erradas, o importante é que as suas respostas exprimam o que pensa, sente ou faz em cada caso. O tempo médio de preenchimento é de **aproximadamente 10/15 minutos**.

A confidencialidade dos dados está garantida?

Os dados recolhidos serão exclusivamente utilizados no âmbito da investigação à qual se destinam, estando garantida a confidencialidade das suas respostas. Poderá, ainda, contactar a equipa de investigação, através do e-mail gaif@fpce.uc.pt, para esclarecer eventuais dúvidas.

Se aceitar participar neste projeto de investigação, por favor coloque um X no quadrado abaixo:

☐ Declaro que tomei conhecimento das informações acima prestadas e que quero dar o meu contributo nesta investigação.

O seu contributo é extremamente importante para o prosseguimento deste estudo.

Como tal, agradecemos a sua disponibilidade e colaboração!

A equipa de investigação:

Ana Paula Relvas
Beatriz Pires
Cristina Günther
Gabriela Lopes
Luciana Sotero