

NEGATIVE EXPECTATIONS OF TREATMENT: SOME IDEAS ABOUT THE SOURCE AND MANAGEMENT OF TWO TYPES

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In ordinary circumstances the client's anticipation of help—his or her positive expectation of the helper—is sufficient to bring about a treatment alliance. The treatment alliance refers to the client's growing ability to join with the therapist in observing and working on his dysfunctional behavior. This necessary condition, the treatment alliance, has sometimes been called "rational transference" or "mature transference." However, it should be distinguished from the concept of transference which denotes an inappropriate repetition of the past (Greenson, 1965). Instead, the alliance depends on the client's ability to form realistic positive expectations of the therapist. These expectations may, of course, be grounded in earlier relationships where help-seeking and dependency were prominent features. Naturally strong negative expectations are a major impediment to formation of a treatment alliance.

In clinical social work we often encounter situations where many clients come to treatment with serious misgivings about treatment. Our experience suggests these negative expectations are related to treatment failure. And this impression is borne out by considerable empirical study. One line of research shows that continuance in casework is related to the client's positive expectations (Levinger, 1960; Ripple, 1964).

Similar conclusions are drawn by Goldstein (1962) from his extensive review of the research which indicates that moderately positive client expectations are predictive of treatment success. A new note is added, however, when he concludes that even unduly high expectations are correlated with treatment failures. Another intriguing line of empirical investigation focuses attention on the importance of shared expectations, even if it is doubt that is shared between the client and caseworker. Some data suggest, for example, that skeptical clients may continue longer in treatment when the client and the therapist share their mutual reservations about the efficacy of treatment (Freedman, 1958; Overall, 1963). In short, any departure from the concept of treatment as a joint and mutual endeavor jeopardizes its outcome.

Consistent with these findings, it will be assumed in this paper that negative expectations are potentially destructive of the treat-

ment alliance. Our effort will be to make these findings more meaningful by showing how we can understand and modify negative expectations. Toward this end two types of negative expectation will be distinguished according to their source and the major ego mechanism implicated. Since each type will be shown to utilize a different ego mechanism, the dominant ego mechanism will be used to classify the two types of negative expectations. In addition some suggestions will be offered relative to facilitating the development of positive expectations by creating an appropriate therapeutic climate.

The Source of Negative Expectations

Treatment may be thought of as an opportunity for a troubled person to work with an empathic and skilled clinician toward the resolution of problems. The emphasis on hope and positive expectations implicit in this definition constitutes the basis of a treatment alliance. But difficulties arise almost immediately because treatment may also set in motion certain regressive forces which are destructive of the treatment alliance. Self-observation can easily become confession on demand and with it the client's self-critical tendencies are heightened. Even the prospect of treatment focuses the client's attention on his own shortcomings. As the client moves closer to treatment the tendency to dwell on his inadequacies is likely to be intensified. And if, or rather to the extent the client has been pressured into treatment, external agents have reinforced the sense of inadequacy.

Another set of forces becomes activated by the functional resemblance of the treatment process to relationships with earlier parental and authority figures. The analogy between treatment and early experiences in childhood is based on the seeming gulf between the client's helplessness and the therapist's power. Thus treatment may revive the feelings originally associated with parents and their surrogates. Since the self-critical capacity was originally acquired from parental objects which were introjected from the environment, there exists a tendency to "unfold" mounting self-criticism onto the person of the clinician (Sandler, 1960). To the extent that the client unfolds his self-critical tendencies onto the clinician, he or she is unable to view the clinician as a potentially helpful person.

In short, as the client becomes more self-critical, he or she is increasingly likely to hold the clinician responsible for the felt criticism. When the result is a perception of the therapist as a person unwilling to help, a major obstacle to the treatment alliance has arisen.

The dominant ego mechanisms used to transform the client's self-critical tendencies into negative expectations provide the basis for differentiating the two types of negative expectation. Our concern will be the negative expectations which are given expression by the mechanisms of either projection or displacement. Although the

boundaries between these mechanisms are not always clearly marked, an effort to make the distinction is warranted since the timing and severity of the negative expectations will tend to vary according to the ego mechanisms employed. In this paper the mechanisms will be distinguished according to a) the timing of their appearance, b) the magnitude of the resulting distortion, and c) the extent to which they have a basis in current realities or past experience (Kline, 1972).

A Projective Type of Negative Expectation

One type of negative expectation involves the projection of superego content. The clinician becomes a ready target for the projection or externalization of the client's superego structure. Typically it occurs early in treatment and leads to a distortion of considerable magnitude; as a result it is often not recognized as a response to the treatment situation. Unfortunately this is encouraged by an artifact of our conceptual system. As Anna Freud points out, this form of projection or externalization is not included in the transference which requires a genuine cathexis of the person or object. In the case of projection the clinician is the indiscriminate target for the client's externalizations whereas in transference proper the worker becomes an object for the client's displaced wishes only after a relationship has been formed. Miss Freud's viewpoint is consistent with the widely held view that projection or externalization of the client's personality is to be kept separate from transference proper (Freud, 1965).

The unintended consequence of this distinction is that the clinical social worker is deprived of a concept (transference) that provides, as one of its functions, assistance in the management of negative client reactions. Another obstacle to the appropriate management of the projective type of negative expectation is found in its occurrence early in the treatment relationship. If it occurs in the first interview it may not even be recognized as something triggered by the treatment relationship. Also, it occurs before the clinician has become emotionally committed (or developed a rational counter transference) to the client (Loewald, 1960). The following case of a mother whose son had been referred for evaluation to a child guidance clinic by the juvenile court illustrates the projective type of negative expectation.

This mother, a welfare recipient, embodied in her manner and appearance the expression "tough as nails." During the early part of the first interview she responded to the most gentle and innocuous remarks with hostility and provocation. About midway in the interview she lit her third cigarette and half seriously, but also half humorously hurled the challenge, "I suppose you think I smoke too

much, *too*." Her remark was met with a hearty and spontaneous laugh. This exchange marked a turning point in the interview; one that was reflected in her unsolicited reference to a social worker who had been helpful to her in the past. She also volunteered information that previously had been withheld from others who had tried to help her. Hindsight suggests that the remarkable effect of the humorous response was due to the hope she was given that all her shortcomings need not be considered deadly serious.

To my surprise, she did not return for her next scheduled appointment, and further efforts to reach out to her met a wall of resistance. This disappointing outcome stimulated the following considerations. Apparently, the mere thought of clinical "evaluation" intensified the painful awareness of her own deficiencies which (according to the information available from the referral source) included serious acting out. This awareness seems to have evoked deep shame and excessive self-recrimination which then was projected onto the clinician. The harshness of these attacks on the self, however, are not to be taken as evidence for a mature conscience. In fact, the opposite conclusion is more likely. The greater the arrest of superego development, the harsher it is in the presence of the external object while it remains ineffective as an inhibitor of proscribed behavior (Greenacre, 1945). Thus, the self-critical behavior observed in the interview could not be relied upon to govern her behavior where it really mattered—in relation to her son.

From another perspective, the mother's use of the word "too" seemed neither to be redundant nor a chance pattern of speech, but rather to reflect her perception of the clinician as an external representation of her own self-destructive superego. This perception, arising out of the projection of superego content, was modified temporarily by the clinician's laughter. Apparently, the humorous intervention demonstrated approval of her wish to be less critical of herself. She also felt a little closer to her ideal self. Thus in the process of introducing a measure of self-acceptance and a more realistic perception of herself, she was able to perceive and accept the clinician as a potentially helpful person.

The brief duration of this treatment alliance and its collapse following separation from the social worker, illustrates the dynamic nature of the treatment alliance. As long as the clinician was present to reinforce her positive expectations or her perception of him as a benevolent figure, she was able to maintain a useful therapeutic orientation. But when the external, reinforcing object was withdrawn, her inability to internalize a conception of the benevolent object led to a collapse of the embryonic treatment alliance.

The projective type of impediment is exemplified again in the next case. Unlike the preceding case, however, it was not possible

for the clinician to identify with the client's ideals since these were largely unknown at the time of the first interview. Thus, this case illustrates a more general strategy designed to limit the client's projection of aggressive superego content by an active presentation of the caseworker as a benevolent figure.

John (age 8) was an adopted child. From the start one could not help but be struck with his exaggerated self-sufficiency. He opened his own doors, operated the elevator, and walked with an assuredness unusual for a child visiting the clinic for the first time. This defensiveness persisted even though several attempts were made to help him relax. Also noteworthy was John's greedy appetite for candy; but in keeping with the attempt to moderate his anxiety, no comment was made.

When asked, John said he was coming because he was bad. He had stolen money from his parents and thought he would have to go to court. An effort was made to reassure him which included the information that his parents had applied to the clinic even before he had stolen the money. With no response to the attempted reassurance he went on to tell about fights with his six-year-old sister and his stealing from her. Using the doll equipment, he alluded to sex play with his sister. The therapist responded with praise ("you are a brave boy to talk about such important matters") and suggested that he didn't need to tell "these things with his sister" all in the first interview. Spontaneously, John recounted two dreams that he has "every night." In the first, a "king or daddy" throws children off high buildings when they are bad. In the second, "a witch, the mother of a friend" tries to cut him up into small pieces.

John's exaggerated independence this first day in the clinic seemed to be a desperate move to ward off an adult who had the potential to be a destructive (child-killing) monster. Similarly, his greedy eating and his allusion to sexual play seemed designed to elicit a response from the therapist that would serve to confirm his perception of the therapist as a vindictive adult.

John's dreams appear to be a primitive expression of aggressive impulses that have been turned against the self by superego mechanisms. This formulation is consistent with our knowledge of his traumatic first year of life, a period in which he had four different mother figures. Moreover, his extreme reaction could not be explained by reference to his adoptive parents who were warm and competent parents. Instead, John's dreams appear to be an external expression of his destructive wishes which in turn arouse the fear of retaliation, namely that he will be destroyed.

The magnitude of John's projection, fortunately, is not commonly encountered with clients. In this instance John's primitive ego combined with the threat emanating from childhood instincts to

contribute to his projective tendencies. Nonetheless, the projection onto the therapist, observed here in exaggerated form, occurs frequently enough to be responsible for many of the problems of engaging clients in treatment. Consequently the management strategy should be geared to building in and strengthening benign superego images which as they are internalized, can become effective in the control of impulsivity. To achieve this goal, the therapist must dissociate himself from the harsh content of the client's superego projections and actively present himself as a benign and gratifying figure. Otherwise the therapist is ascribed the most punitive features of the client's superego.

Two examples have been offered to illustrate the type of negative expectations associated with the mechanism of projection. In both of these cases, projection was utilized in the first interview before meaningful emotional contact had been established. The projection took the form of an externalization of the client's superego and resulted in a substantially distorted perception of the therapist. The harshness of the projected images could not be readily explained by the client's past or present experiences, but rather seemed to derive some of their harshness from unneutralized aggressive impulses.

In the next section, a type of negative expectation characterized by the use of displacement will be discussed. The displacement type differs from the projective type in that a) it usually occurs only after meaningful emotional contact has been established, b) it results in less distortion of the therapist, and c) it can be explained primarily as an inappropriate transfer of past experience to the present situation rather than as an expression of primitive impulses.

A Displacement Type of Negative Expectation

The negative expectations expressed by the next client result from the displacement of critical superego attitudes onto the social worker and as such represent a form of negative transference. In the face of negative expectations stemming from the displacement type reaction, positive elements from the treatment alliance will have to be renewed in order to offset this form of negative transference. The following case illustrates how the treatment alliance can be renewed to offset heightened expectations associated with more difficult material.

Mrs. D. was an upper middle class black from Latin America and married to a native of this country. Initially, her many compulsive features foretold of her hypersensitivity to the possibility of criticism from others. She began by protests that she and her family would have to be treated differently because of their unusual creative and artistic interests. Despite this initial testing of the relationship, she settled into a comfortable treatment alliance.

Several months later, however, she became increasingly querulous. She complained repeatedly about not being given advice, about not being helped, etc. This coincided with a discussion of how some of her major problems seemed to be repeating themselves in the treatment relationship. Quite unexpectedly she offered the following material: Some time ago, she had a remarkable professor whom she greatly admired but also feared. On one occasion an illness caused her to pass in an assignment late. Instead of the criticism she expected, the professor offered his sympathetic concern. This made a deep impression on her and strengthened her desire to govern her life according to the intellectual and ethical principles upheld by this man. Unfortunately, while he was able to be comfortably indifferent to many social conventions, she had to compulsively defy them.

It was not difficult to draw her out on the admired qualities of this man and in so doing recognition and approval could be given to her ideal. And, in the process the client's negative expectations of the clinician were transformed into a perception of him as an ally in her effort to become less compulsive in attendance to detail, appearance, and convention. Consequently, she was better able to examine her unreasonable responses and expectations of the therapist.

This case illustrates the displacement of punitive superego attitudes onto the therapist. These attitudes which earlier had been introjected from parental objects were displaced onto the worker and resulted in negative expectations of treatment. This process was countered by an appeal to the client's ideal self and this in turn elicited positive expectations which resulted in a restoration and extension of the former treatment alliance.

Creating a Therapeutic Climate to Promote The Client's Positive Expectations of Treatment

The above excerpts illustrate how the client's self-critical tendencies may be heightened by forces inherent in treatment. These tendencies when transformed by projection or displacement result in negative expectations of treatment and a weakened treatment alliance. These same regressive forces may be offset by some combination of the client's own capacity, an accepting treatment climate, and by specific interventions aimed at countering these regressive forces. This final section will focus on how the therapist can create an accepting climate, thus minimizing the development of the client's self-critical tendencies and thereby reducing the necessity to project or displace these onto the therapist. It will include some suggestions for reducing the likelihood that the client will negatively interpret the therapist's intentions.

Clinicians need to be reminded that turning to treatment is not an accepted mode of problem-solving for many subcultures in our

society. Even in more common and fully sanctioned situations, high levels of anxiety may be aroused. Consider, for example, the prospect of dealing with the family physician, the potential employer, or the loan officer. Our hope is that these individuals will be direct but not abrupt, and kindly but not evasive. In his day-to-day activity the clinician often deals with issues that are even more threatening. The client rather than being concerned with his body or his job senses that his worth and integrity as a whole person is at stake. And because he has often delayed seeking help until he feels desperate, it is doubly important to interrupt a process that evokes feelings of powerlessness and tends to impoverish his role as a mature and adequate human being (Landy, 1965).

Consequently, the earliest arrangements relative to time, office, fee, etc. are likely to be regarded as a concrete measure of the social worker's estimate of the client's worth. Thus, these arrangements which otherwise might be dismissed as merely mechanical details assume a significance well beyond their intrinsic merit. For the same reason the client's habits must be seen as a form of symbolic protection from the threat of radical change inherent in a treatment relationship. Thus any decision to discuss habits such as tardiness or "borrowing" cigarettes should be undertaken, if at all, with the expectation that the client will experience it as a challenge and perhaps a criticism. A similar attitude should be adopted for client requests whether it be a request for additional time or a reduction in fee as they often represent a test of the clinician's estimate of the client's worth. If these requests are to be denied the social worker must be prepared to help the client with the feelings of hurt and anger brought on by the denial.

Since the client typically feels weak and helpless in the early interviews, it is especially important to avoid being cast in an arbitrary or excessively authoritarian role. Thus a change in procedure will usually call for an explanation. Consideration should be given to answering questions as directly as possible and avoiding a response that is another question. Interpretive or clarifying remarks should be phrased in such a way that the client is being asked to consider the therapist's observations rather than being compelled to submit to his judgements.

Even the most sophisticated client may be ready to believe that the social worker harbors harsh and punitive attitudes until there is evidence to the contrary. This means that the apparent candor of a client cannot be accepted simply as evidence of unusual trust or motivation, since it may be a test of her fear that she will be cornered or ambushed by an interpretation. Sexual and aggressive feelings, especially when they are directed toward the clinician, represent the most difficult form of test for the clinician. Since these feelings are

assumed to be among the foremost obstacles to successful treatment, it is important to manage their expression so that they do not exceed the capacity of the treatment alliance. It often will be helpful to comment on the universality of these feelings rather than draw attention to the present relationship where the therapist is the target of these feelings.

These suggestions have a simple purpose—avoid raising the proverbial “hackles” for inconsequential matters. For there are times in treatment when the clinician must incur the risk of hurting the client’s feelings and provoking anger. Such ventures can be undertaken, however, only when the client has come to expect that he will not be asked to tolerate even more anxiety unless it is necessary to achieve an important mutually determined objective. In general, the greater the client’s feeling of mutuality with the therapist, the more likely he will be to work with him. Consequently, a manner that can be interpreted as patronizing will impair the desired mutuality. Likewise the deadening sameness or seriousness sometimes mistakenly considered a hallmark of a good therapist will depress the client’s positive expectations of the therapist.

SUMMARY

The client’s self-critical tendencies may be significantly altered by the therapeutic climate created by the therapist. An approach has been outlined that aims at strengthening the client’s realistic positive expectations and minimizing his self-critical tendencies. However, even the most careful sensitivity to the client’s self-critical tendencies may not prevent their projection or displacement onto the therapist. These mechanisms transform the client’s self-critical tendencies into a negative expectation of the therapist. As a consequence, he or she no longer represents a benevolent person who is willing to help the client. And although children and severely disturbed adults are more apt to make extensive use of this projection, it is not unusual for other kinds of clients to use projection and displacement to ward off self-critical tendencies. Of the two, projection poses a greater risk for the treatment alliance because it occurs earlier in treatment and involves greater distortion of the therapist.

To offset the negative expectations resulting from the projection or displacement of self-critical tendencies onto the clinician, two kinds of interventions were suggested. One involves the clinician in an active presentation of himself as a benevolent figure. The second involves an appeal to, and alliance with, the client’s ideals and aspirations.

While this paper has focused upon the therapist's perceived willingness to help, it does not by itself completely account for the client's positive expectations. For, in the end, the client's positive expectations rest on a perception of the therapist's power to help, as well as his willingness to help (French, 1959).

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